HOME VISITING ALLIANCE

Early Childhood Home Visiting in Ireland

Feasibility Study – Full Report

Home Visiting Alliance
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WHAT WORKS
SHARING KNOWLEDGE
Improving Children's Futures

An Roinn Leanaí, Comhionannais, Míchumais, Lánpháirtíochta agus Óige
Department of Children, Equality, Disability, Integration and Youth

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Executive Summary

Background, Rationale and Current Context

Early childhood home visiting is an evidenced-based service delivery strategy that helps children and families thrive and paves the way to a healthier, safer and successful future for families. It connects parents-to-be and parents of young children with a Home Visitor who guides them through the early stages of raising a family. It is a unique intervention, as outlined below in Figure 2. It is:

- Relational - It provides a trusted relationship between parents and a Home Visitor over time.
- Reduces barriers to engagement - It is positively acceptable to all families, resulting in high engagement and retention rates.
- Contextual – Information and coaching occur in the environment where Parents are parenting, making advice and guidance tangible and pragmatic.
- A whole-family approach –All the family are encouraged to get involved, and wider family needs are responded to, which, if not addressed, could limit engagement.

Home visiting has a long history since its origins in the United States (US) in the 1960s. During this time, home visiting has diversified, undergone significant research and grown internationally as providers, policymakers, researchers, philanthropists and commissioners seek solutions to many societal issues. Home visiting demonstrates a range of evidence-based outcomes that vary from Programme to Programme but are reflected in Figure 1 from the US Maternal, Infant, and Early Childhood Home Visiting (MIECHV)Programme.

- Improve: maternal & child health
- Prevent: child abuse & neglect
- Increase: family education & earning potential
- Promote: children's development & readiness to participate in school
- Connect: families to needed community resources & support.

Figure 1 Home visiting outcomes for children & families (HRSA Maternal & Infant Health Bureau, 2023)

More recently, this longevity has generated considerable focus at a government level. In the US, the first legislation to advance funding models for home visiting commenced under the Obama presidency (Executive Office of the President of the United States, 2014)[1] In Ireland, home visiting was recognised at a national policy level in *First 5 – A Whole of Government Strategy for Babies, Young Children and their Families*[2] (Department of Children and Youth Affairs, 2018).

There is substantive scientific evidence for the importance of prevention and early intervention (PEI) initiatives, specifically home visiting from an individual and population level regarding health, education and an economic perspective. Systematic reviews and evolving neuroscience demonstrate the importance of early life contexts during pregnancy and up to 5-6 years, focusing more on the earliest stage represented by the phrase '*first 1000 days*[3]'. We know that responsive caregiving, reducing sources of stress, supporting maternal mental health and empowering parents to advance their child's learning and development are essential for the best outcomes for all children[4].

After decades of studying the longitudinal impacts of early childhood programmes from the 1960s, Heckman's phrase '*skills beget skills'* exemplifies the multiplying effect of the earliest interventions (Heckman, 2000; García et al., 2017; Zhou et al., 2021). Heckman (2007) outlined a 7-13% return on

[1] A list of sources referenced within this document is available in the full document.
[2] To be referred to as First 5 hereafter.
[3] The first 1000 days represent the time frame from the start of pregnancy to 2 years.
[4] Shonkoff & Phillips (2000); WHO, (2020); National Scientific Council on the Developing Child (2020).

investment through high-quality early childhood interventions (Heckman & Masterov, 2007; Heckman, 2000).

We also know that early intervention, such as home visiting, can mitigate the worst impacts of early life trauma or Adverse Childhood Experiences (ACEs) on mental, physical and social outcomes (Felitti et al., 1998; Lacey et al., 2020). From an economic perspective, research estimated that the costs attributable to Adverse Childhood Experiences (ACEs) in Ireland were $7.7 billion or 2% of GDP (Hughes et al., 2021).

This study, compiled by members of the Home Visiting Alliance (HVA), demonstrates that home visiting in Ireland developed in response to needs identified at a local level against the odds. Home visiting programmes emerged in a policy and service delivery context that could not provide the necessary infrastructure, research, funding or strategic planning and support required. Relying on ad hoc funding opportunities does not enable sustainable, high-quality, evidence-based home visiting to maximise its impact and grow to any level scale necessary to reach a significant population of children and families.

The Home Visiting Alliance (HVA)

The HVA was developed in 2021 as a collective of five Irish evidence-based home-visiting programmes in response to shared challenges regarding sustainability and growth. Those programmes are:

- The Community Mothers Programme (CMP)
- Infant Mental Health Home Visiting – Let's Grow Together!
- Lifestart
- ParentChild+
- Preparing for Life (PFL).

Building on the First 5 action to agree on '*a national approach to home visiting*', the HVA recognised the need to outline the feasibility of home visiting in Ireland in 2023. A funding opportunity through the '*What Works Sharing Knowledge Fund*' (DCEDIY, 2023) enabled the HVA to work collaboratively to explore the barriers and enablers to implementing home visiting.

Methodology

This study explores the extensive literature and scientific best practice for implementing, replicating, adapting and scaling up home visiting. The science outlines a theoretical ideal of implementing and scaling home visiting that is currently well beyond the reach of all Irish home-visiting programmes. The history of how home visiting grew and was impacted by changing policy and strategic national developments in Ireland is outlined along with the current status of each home visiting programme. Finally, a consultation with a range of different stakeholders is included and resulted in addressing several factors, including the importance of clarifying the role and function of home visiting as a unique service delivery model that should be differentiated from other ways of working with parents in pregnancy and beyond (Figure 2 below).
The profile of home visiting in Ireland in 2023 is summarised in Figure 3 below. In addition to the information in Figure 3, it is essential to note that approximately 71% of funding received by the programmes is from Tusla, the Child and Family Agency (Tusla). Programmes also receive funding from the following sources:

11% from the Health Services Executive (HSE), 11% from philanthropy/corporate donation and 7% of 'other' funding consisting of one-off grants or smaller funding streams.

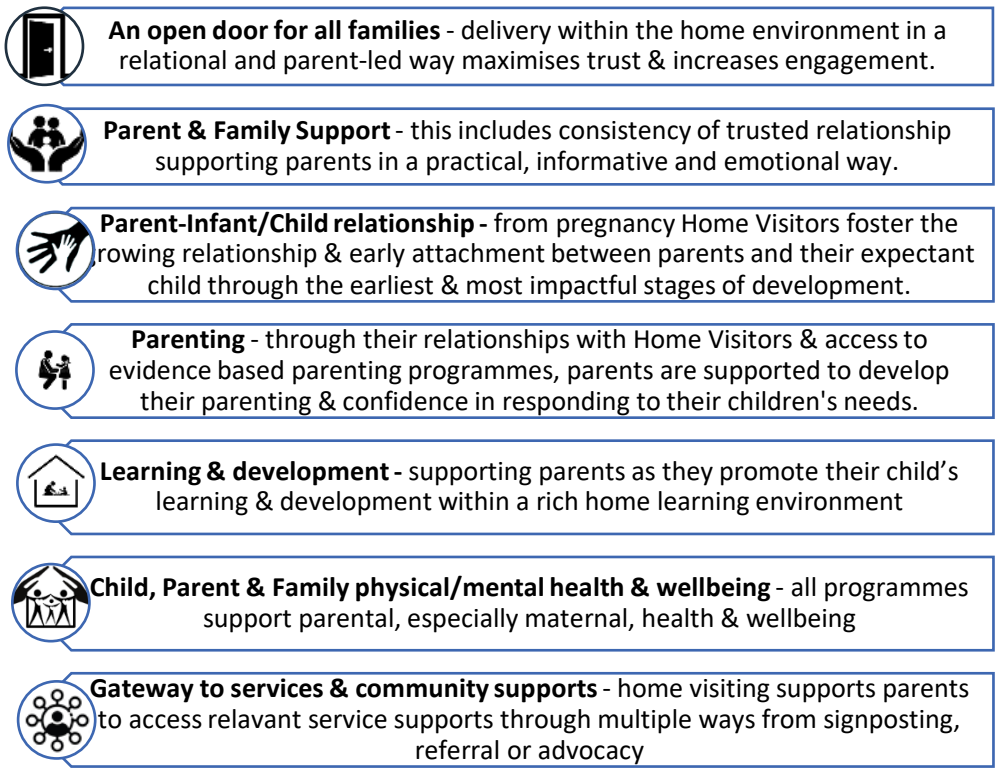

Figure 2 Unique role and function of Early Childhood Home Visiting

Summary of findings

1. **There is a lack of clarity about Early Childhood Home Visiting (ECHV) and the distinct role it can play in the lives of children and families.** The small scale of home visiting and the absence of a recognised 'sector' has resulted in a lack of clarity about ECHV and whether it is a programme, a service or both. Furthermore, the unique skill set and role of Home Visitors are undervalued in terms of pay and terms and conditions. Home visiting is not explicitly differentiated from other professions and functions working with parents from pregnancy to school age. Figure 2 above outlines the unique offering of ECHV.

2. **Current funding models for direct delivery of home visiting are insufficient to cover the 'real costs'.** Current funding models do not reflect the total implementation costs nor recognise the need for adequate remuneration for home visiting staff, programme development costs, training, ongoing professional development supports and ICT/database costs. Funding is negotiated on an annual basis, creating uncertainty for all programmes.

3. **The sustainability and growth of home visiting are dependent on effective national support structures for each home visiting Programme**. The study outlines the complex role required to support home-visiting programmes. This includes collecting and monitoring local data, ongoing training, practice development, overseeing fidelity and growing the Programme's evidence base for all existing sites. It also delivers an essential role for new sites, ensuring fidelity to the programme by assessing implementation readiness and providing training and mentoring as organisations adopt the Programme into their service provision models.

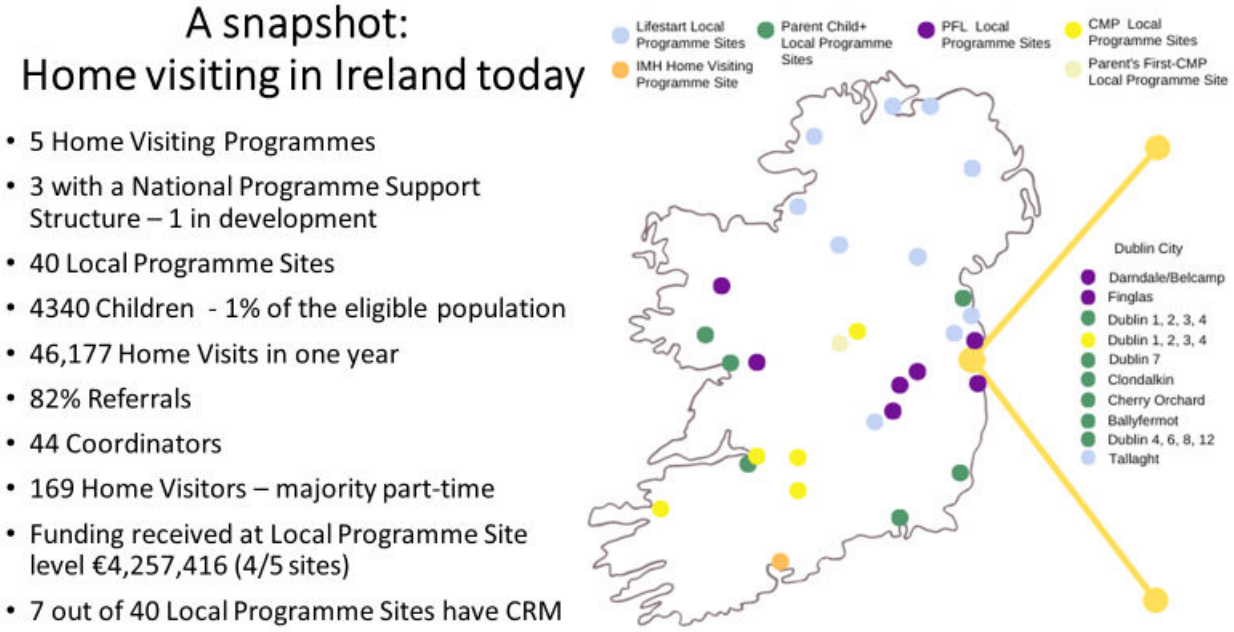

Figure 3 A snapshot of home visiting in Ireland in 2023

4. **There is no dedicated or sustainable funding for national programme support structures.** Funding for the delivery of home visiting programmes is commissioned at a local level. There is no formal recognition of the role and necessity of national programme support structures. As the report outlines, programmes fund this function in ad hoc and unsustainable ways.

5. **The 'development mechanism' for programmes is not sustained once efficacy is proven.** Development mechanisms for home visiting programmes frequently include partners working together, such as implementation organisations, philanthropy or funders and research or academic institutions. Such partnerships are essential for programme development but also for ongoing programme support. While there can be enthusiasm to develop new models of practice with a range of funded partners available at the start of a programme, this is frequently not sustained, leaving national implementation organisations without the necessary research or funding support to grow, improve or continue to evidence new developments within the Programme[5].

6. **Securing an evidence base for programmes is challenging and expensive, making it unfeasible and out of reach for many programmes.** Securing the necessary funding for research relies heavily on philanthropy or ad hoc funding through chance opportunities. An additional challenge unique to home visiting is the requirement for lengthy and complex research methodologies due to its duration of intervention and its integration into local service delivery infrastructures. This makes RCTs for home visiting more expensive than for other shorter-duration parent support initiatives.

7. **There is a lack of clarity on what evidence-based means across sectors and government departments.** The term is used frequently but sometimes differently in Health, Children and Families, Child Welfare and Prevention and Early Intervention sectors. This can result in differing expectations from different government departments and agencies.

[5] While PFL has a sustained relationship with the Geary Institute in UCD, this is limited to the longitudinal study of programme delivery in one area with the original cohort. To date, no research mechanism is mapping the delivery of home visiting programmes at scale in Ireland.

8. **Investing in newer programmes at the risk of pre-existing programmes in the same area has led to the closure of some local sites.** Some programmes experienced poor long-term ongoing developmental investment. The absence of a strategic approach connecting national policy priorities to local and national commissioning has resulted in overlooking these programmes in favour of newer initiatives. Instead of building on existing programmes, there are examples where the delivery of home visiting has been displaced, leaving some areas without access and an overall diminishing of some Programmes.

9. **Collating data across and within home visiting programmes is difficult due to an absence of data collection mechanisms at local and national levels.** Funding at a local level is directed to day-to-day costs, predominantly staffing costs, rather than once-off or ongoing development investments. The initial and ongoing cost of having an adequate ICT system is beyond the reach of many local and national programme structures.

Recommendations

1. **Establish a national four-layered infrastructure with targeted actions at each level to sustain, implement and bring home visiting programmes to scale.** This is outlined within the document (Figure 13). Such a structure could be considered under the First 5 reference to agree *'a national approach to home visiting*' coordinated by the Parent Support Policy Unit. This proposal aims to build on existing structures, ensuring integration across Government departments at a national level and sectors, agencies and structures at a local level, ensuring top-down and bottom-up connectivity. It aims to address the following:
    a. national strategic planning and coordination
    b. strategic inter-agency/departmental approach to commissioning aligned with data gathering
    c. develop national programme support structures to develop and scale home visiting
    d. access to national and local research.

2. **Build on the First 5 action to '*agree a national approach to home visiting*' through the creation of a centralised national office within the Parenting Support Policy Unit** with responsibility for home visiting in Ireland, reporting to a cross-departmental policy structure to:
    a. strategically lay the foundations for the implementation of home visiting to meet a range of child outcomes through a joined-up Government approach ensuring cross-departmental funding for home visiting from Children, Health, Education, Community and Rural Affairs and Justice
    b. collect and collate national data on home visiting and enable a bottom-up influencing of national policy, aligning it to national data on outcomes for children and families
    c. coordinate the gap between national funding for programme support structures and collaborate with local commissioners to align this with implementation site funding at the local level.

3. **Adequately fund the implementation of home visiting programmes at a local level through a multiannual cross-sectoral mechanism.** Additionally, fund the national programme support structures required to oversee, support, develop and scale home visiting.

4. **Professionalise the home visiting sector to develop and advance home visiting in Ireland.** Invest in the sector's professional development through home visiting qualifications, training and professional development across all levels of practice.

5. **Recognise the full potential of home visiting in engaging and supporting all parents across the continuum of need to reach those families less likely to engage in centre-based or more structured external supports.** HVA members outline their programmes support many families with higher levels of need whilst also providing preventative, early intervention and universal support. Acknowledge the wider role of home visiting in health and education, e.g. child, parent and family mental and physical health and early home learning, language and building the foundations for literacy and positive school engagements.

6. **Agree a national definition of 'evidence-based', which enables innovation and is practice-focused rather than programme-focused**. This should be a pragmatic definition that does not stifle innovation and needs to be 'feasible' with accessible mechanisms for all programmes to secure the necessary efficacy research.

7. **Develop and fund national and reciprocal local data collection methodologies**:
   a. define key national metrics for all home visiting programmes
   b. as part of local commissioning, provide funding for the design and implementation of CRM/data gathering mechanism to ensure accurate real-time data collection at a local level.

8. **Support Programmes to achieve, grow and sustain an evidence base by establishing a national research function as outlined above.** Programmes should be supported either directly or through the provision of funding to carry out the following:
   a. initial and longitudinal research
   b. innovative supports to ensure adaptations or programme changes can also be reflected in the evidence base to ensure home visiting programmes are innovative and responsive to new emerging research and population-level needs
   c. carry out replication evaluations of international programmes in Ireland and replications of Irish programmes in different contexts in Ireland, e.g., urban areas of disadvantage to rural areas.

A Vision for Early Childhood Home Visiting in Ireland

The recommendations above set the stage to advance home visiting in Ireland in a gradual and sustained way. Ultimately, the vision for Ireland is that every child in Ireland would be offered a home visiting programme. This vision requires considerable scaling, and the overarching principle should be **'sustainable strategic scaling'** rather than an unplanned race to scale. There is much to learn from the literature regarding scaling too fast. Learning from the complex scaling of services and projects will be essential, and a sustainable and strategic approach to the scalability should be a priority if we are to achieve a vision of providing a service to all children in Ireland.

Cost to Deliver High-Quality Home Visiting Across Ireland

This document outlines estimated costs for direct implementation and the essential investment in supporting infrastructure to ensure scaling is effective, quality assured and meets the needs of children, families, communities and commissioners.

The starting point is to secure sustainability whilst delivering to nearly 5,000 children, costing €15,240,000[6].

Table 3 (within the document) outlines a long-term approach to sustainable scaling, ensuring all children who need the programme (30% of the population) should have access to a programme within 10 years at a total cost of €339,247,092. There are multiple caveats about these cost estimations, as outlined in detail within the document. However, they provide broad indicators of cost requirements for a sustainable ECHV sector. Securing a solid foundation for this ambition is required, as outlined in Figure 12 in the document and summarised below.

1. **Ensure sustainability of existing services & learn from real-time data gathering.**
2. **Build national & local infrastructures to support scaling.**
3. **Adopt & fund mechanisms for the development of an evolving real-time innovative evidence base aligned to national outcomes.**

[6] Cost for local implementation €14,740,000 in addition to infrastructure costs of €500,000 per Programme.

Conclusion

The current policy context in Ireland allows a unique opportunity to develop an integrated strategic approach to early childhood home visiting. The recommendations outlined herein align with the aspirations of First 5 across all goals, particularly:

- Goal A, action 2.2 specifically - '*an approach to home visiting will be agreed*' as part of a tiered model of parenting services supporting a continuum of need.
- Goal D, building blocks 3 and 4 as foundational steps towards an effective early childhood system - Building Block 3: Skilled and sustainable workforce.
  Building Block 4: Research, data, monitoring and evaluation

Irish home-visiting programmes are listed across three HSE catchment areas[7] as valued parental support before and after a baby is born within the HSE response to the Maternity Experiences Survey, Listening, Responding and Improving (HSE, 2020). Home visiting is also outlined as an action within the Tusla Parenting Support Strategy Implementation Plan 2021-2023 (Tusla, 2022a) regarding implementation and scaling. A final policy window is within the HSE Mental Health Promotion Plan as a 'Starting Well' action is to:

'Increase coverage of home-visiting programmes nationally in line with the goals of Supporting Parents, the national model of parenting support services' (HSE, 2022).

Home visiting is not adequately funded at a local level as it delivers a service to 1% of the current eligible child population. It is clear from this report that a strategically funded approach supporting these programmes at a national level is required. A top-down – bottom-up integrated national and local level infrastructure is needed to equip home visiting programmes to implement high-quality, evidence-based services and to grow sustainably in response to national policy and local needs. An aspiration to ensure all children and families have access to a home visiting programme from pregnancy to 5 years of age seems dauntingly ambitious. However, by building a viable infrastructure to support the sustainable growth of home-visiting incrementally over the next ten years and beyond, it is hoped that access to such invaluable parental support could grow from its current 1% reach to 30% of the eligible population with clear benchmarks of how to ensure the whole child population are offered a programme.

[7] Limerick Community Mothers Programme – University Maternity Hospital
Clonmel Community Mothers Programme – South Tipperary General Hospital
Preparing for Life - CHO 9: Dublin North City & County Public Health Nursing Services

Acronyms

ABC	Area Based Childhood
ACE	Adverse Childhood Experience
BOBF	Better Outcomes Brighter Futures
CDC Harvard	Centre on the Developing Child, Harvard
CDI	Childhood Development Initiative
CE	Community Employment
CES	Centre for Effective Services
CFSNs	Child and Family Support Networks
CHO	Community Healthcare Organisation
CHN	Community Healthcare Network
CLG	Company Limited by Guarantee
CM	Community Mother
CMP	Community Mothers Programme
CPC	Child Protection Conference
CRM	Customer Relationship Management
CSO	Central Statistics Office
CVO	Community & Voluntary Organisation
CYPSC	Children and Young People's Services Committee
DCYA	Department of Children and Youth Affairs
DCEDIY	Department of Children, Equality, Disability, Integration and Youth
DES	Department of Education and Skills
ECHV	Early Childhood Home Visiting
EHB	Eastern Health Board
ELI	Early Learning Initiative
EPIC	European Platform for Investing in Children
FDN	Family Development Nurse
FPHVS	First Parent Home Visiting Scheme
GP	General Practitioner
HVA	Home Visiting Alliance
HVP	Home Visiting Programme
HSE	Health Services Executive
IMH	Infant Mental Health
IMHHV	Infant Mental Health Home Visiting Programme
KHF	Katharine Howard Foundation
LF	Lifestart Foundation
LHO	Local Health Office
LSL	Lifestart Services Limited
MIECHV	Maternal, Infant and Early Childhood Home Visiting Program
NGO	Non-Governmental Organisation
PEI	Prevention and Early Intervention
PEIP	Prevention and Early Intervention Programme
PFL	Preparing for Life
PHN	Public Health Nurse
PPFS	Prevention, Partnership and Family Support
QED	Quasi-Experimental Design
QQI	Quality and Qualifications Ireland
RCT	Randomised Controlled Trial
SLA	Service Level Agreement

Glossary

Please note that, as with all literature and terminology, there can be different interpretations or definitions depending on ideological perspectives and contexts.

Adaptability: 'Refers to the degree to which the intervention can be changed while maintaining effectiveness' (NSW Health, 2014).

Adaptation: It is a process of exploration and decision making which occurs when implementing an evidence-based Programme in a new context, necessitating an adjustment of the Programme for different target populations, localities and organisational factors without impacting fidelity or the core components of the original Programme (Escoffery et al., 2018; NSW Health, 2014).

Early Childhood Home Visiting: Early childhood home visiting is an evidenced-based service delivery strategy that helps children and families thrive and paves the way to a healthier, safer and more successful future for families. It connects expectant parents and parents of young children with a Home Visitor who guides them through the early stages of raising a family, from pregnancy to a child is preschool/school-going age. This will be abbreviated in this document as home visiting.

Evidence-based practice/programme: A programme that has consistently been shown to produce positive results by independent research studies conducted to a particular degree of scientific quality (Tusla, 2013).

Evidence-informed practice/programme: Practice based on integrating experience, judgement and expertise with the best available external evidence from systematic research (Tusla, 2013).

Fidelity: 'Refers to the extent to which the implementation of the programme or intervention is consistent with programme/intervention protocols previously found to be effective' (NSW Health, 2014).

Replication: This scientific term is often misunderstood as 'copying' a previous experimental design and testing the intervention a second time. However, in the social sciences and 'real world' settings, it is impossible to mirror the same previous context and 'copy' an intervention as so many uncontrollable variables are inevitable. Replication studies are considered invaluable in bringing home visiting to scale – they test if the original research outcomes were 'a fluke' and provide evidence of the barriers and enablers to bring a programme to scale across different locations (Ali-Ubaydli et al., 2021).

Randomised Controlled Trial (RCT): A randomised control trial is one in which children and their families are assigned to receive the treatment or an alternative condition by a random process, such as the toss of a coin or a table of random numbers (Shadish et al., 2002).

Quasi-Experimental Design (QED): Sometimes called pre/post-test evaluations, differing from RCTs as they do not have randomisation. This approach to evaluation is often used when randomisation is impossible or the evaluation process is applied to a predefined intervention group.

Scaling-up/Scaling/Bring to scale: Increasing the reach or impact of a Programme that has proven to have a positive effect on individuals to meet an identified need (Centre for Effective Services, 2023).

Systematic review: A systematic review is a literature review focused on a research question that tries to identify, appraise, select and synthesise all high-quality research evidence relevant to that question (Patton, 2002).

Contents

1. Background, rationale & methodology

Introduction to the background & rationale for the study

What is early childhood Home Visiting?

Early childhood home visiting is an evidenced-based service delivery strategy that helps children and families thrive and paves the way to a healthier, safer and more successful future for families. It connects parents-to-be and parents of young children with a Home Visitor who guides them through the early stages of raising a family. For many, it is a bridge to becoming the kind of parents they want to be to unlock their child's potential.

It is a unique service provision, and given its small scale in Ireland, it is a service that is unfamiliar to many parents. It is also unknown to policymakers and service delivery managers as it has no recognisable professional infrastructure despite being delivered in Ireland for over 40 years. Given this, it is easy to conflate its role and function with other disciplines, professionals or practitioners (Section 3.3. outlines this in greater detail).

The origins of home visiting in Ireland date back to the 1980s and this will be explored further in this document. Two decades earlier, the proliferation of home visiting programmes began in the United States (US) in the 1960s. Following this movement in the US, widespread interest from policymakers, economists and academics grew internationally in line with new and evolving scientific evidence about early childhood, brain development and the importance of responsive caregiving to influence child outcomes. This interest, coupled with large-scale robust experimental research on the effectiveness of home-visiting programmes, began to promote home visiting as an essential intervention to tackle various challenges facing children and their families. Challenges such as social and emotional well-being, school readiness, school attainment and retention, cognitive development, language and literacy development, reductions in juvenile offending or anti-social behaviour, unemployment, adult chronic health problems, and so on – early childhood home visiting has been seen as a panacea to address a range of complex and societal challenges.

Of course, home visiting is not a 'magic bullet'. Policy and political cycles frequently expect impact within a tight time frame, and complex societal challenges can take one or two generations for real change to be evidenced. Furthermore, without integrated government responses, programmes that work with families in the early years cannot address 'wicked problems' in isolation, such as housing, employment or poverty at a population level.

Every context in which a home visiting programme is implemented has unique challenges. These can be cultural, bureaucratic-administrative, or, at times, the family or community needs are more complex to be addressed by home visiting alone, e.g. homelessness.

Limited local resources and capacity also present challenges. Delivering a programme consistently in one area is challenging, but replicating it in another region or country and bringing it to scale across a wider geographic spread brings considerable challenges.

To do this, it is essential to know ‘what works’ in home visiting. All home visiting programmes must be grounded in evidence and delivered in accordance with this evidence. In many ways, this evidence is on two levels.

The evidence base at the macro population level: At a macro level, scientific evidence demonstrates broad principles we now know work to make a difference in the lives of children and their families. Jack Shonkoff and the team at the Center on the Developing Child (CDC) at Harvard summarise these as a family, two-generational approach targeting both the parent and child through the family, home and community:

1. reduce sources of stress
2. support responsive caregiving
3. strengthen core skills (Center on the Developing Child at Harvard University, 2021)

At a population level, we also know that intervention and support at the earliest stage possible in a child's life results in a more significant impact on their life outcomes (National Scientific Council on the Developing Child, 2020; Rochford, Doherty, & Owens, 2014). After decades of studying the longitudinal impacts of early childhood programmes from the 1960s, Heckman's phrase' skills beget skills' exemplifies the multiplying effect of the earliest interventions (Heckman, 2000; García et al., 2017; Zhou et al., 2021).

Nutrition also plays a significant role in child outcomes (Center on the Developing Child, 2010; Child, 2020; WHO, 2018). The World Health Organisation (WHO) developed a Nurturing Care Framework (WHO, 2018) and Guidelines to Improve Child Development (WHO, 2020). Including nutrition, this framework outlines best practice for integrated community-level service provision to promote parental participation and engagement. The framework focuses on the following four pillars:

- support responsive caregiving
- promote early learning – supporting parents to support their child's learning & development
- integrate caregiving and nutrition interventions
- maternal mental health.

This approach to evidence-based practice takes these core elements of what we know works and asks policymakers and service delivery agencies to embed them within direct provision to children and their families.

Evidence base at the Programme level: In line with the proliferation of home visiting programmes over the last 40-60 years, there has been a reciprocal proliferation of scientific research in these programmes. Additional research in implementation science has also grown and is beginning to explore what works to implement such programmes successfully in one location and at scale across multiple populations. However, we are still far from having quick or easy solutions to bring evidence-based programmes to scale.

Saying a programme has an evidence base does not mean it addresses the specific need a policymaker wants to address. Knowing that a programme or intervention works in one area is insufficient to deliver a significant impact at a population level impacting the whole country. Coupled with a lack of clarity about what evidence base means, the decision-making process underpinning what to scale is complex. To answer this question, policymakers and commissioners must know:

- what is it that works – programme or practice
- what it takes to work – the national and local infrastructure and context to enable it to work
- who it works for[8] – what population, location, demographics, needs, circumstances, age
- why it works - the 'magic ingredient' or core components which deliver the impact
- how it works – the mechanisms required to ensure the core components are effectively delivered to the required standard – recruitment, training, duration, frequency, ongoing practice development,
- the impact – what changes for children, their parents and families, but also what doesn't change.

[8] Equally it should be more explicit about those cohorts where there is no evidence of programme efficiacy. Many studies do not comprehensively outline their engagement approach mapping who didn't engage and the reasons for this. Furthermore many studies don't include comprehensive analysis for drop outs or retention rates and these are equally important for commissioners as often this is the cohort that funders want to target.

Some terminology

Within the field of home visiting, implementation science and the science of implementing at scale, there is a range of complex terms and 'jargon'. With this in mind, a glossary of commonly used terms has been outlined at the document's start. However, the following terms have been agreed upon by the HVA for use in this document to define the different levels of structure involved in implementing a Programme at scale.

1. **National Programme Support Structure:** This is the primary 'driver' of a Programme within a region needed to support the delivery of a home visiting Programme in more than one location. This structure is responsible for the governance, development, training, 'licencing' and ongoing support for local implementation. In Ireland, these structures have developed from a grassroots level and are currently governed by Community and Voluntary Organisations(CVO)[9]. In the US and the UK, the majority are also Non-Governmental Organisations (NGOs), but there are examples of these structures directly delivered by the state. For example, the Family Nurse Partnership National Unit in the UK is within the Office for Health Improvement and Disparities (OHID) under the Department of Health and Social Care (DHSC).
2. **Local Implementation Site:** This is where an organisation delivers the Programme directly to children, parents and families. In Ireland, these are predominantly[10] provided by local CVOs as one element of a range of offerings.

What is the Home Visiting Alliance?

Established in November 2020, the Home Visiting Alliance (HVA) is a collaboration of five evidence-based early childhood home visiting programmes currently being delivered in Ireland. They are the Community Mothers Programme (CMP), Lifestart, ParentChild+, Preparing for Life (PFL) and Infant Mental Health (IMH) Home Visiting Programme.

The HVA is motivated by a shared commitment to promoting the effective use of home visiting to enhance the health and well-being of children, parents, families and communities. The HVA seek to provide primary prevention and early intervention to prenatal and early childhood through evidence-based home visiting on a national scale and to make early childhood home visiting an integral service focused on promoting positive outcome for all children.

While each home-visiting model is unique in intervention goals and outcomes, aspects of national, regional, and local mechanisms of early childhood home-visiting implementation pertain to all.

The HVA aims to:

- ✓ Promote home visiting from pre-birth or during pregnancy as an essential early years vital service for children, parents and families.
- ✓ Support member organisations, collectively and individually, to strengthen and broaden the impact of Home visiting in Ireland.
- ✓ Contribute to policy development and implementation in relation to early childhood Home visiting and parent support locally, nationally and internationally.
- ✓ Share common learning at the programme, implementation, sustainability and policy levels.

Rationale for the feasibility study

The development of the HVA resulted, for the first time, in collaboration across the five home visiting programmes delivered in Ireland. This collaboration involved increasing transparency regarding the shared challenges and barriers each Programme faced as they tried to develop and grow their evidence base,

[9] While the CMP remains predominantly under the governance of CVO, one site is governed by the HSE. Furthermore, a proposal to revise CMP to a Community Families model is under the governance of two statutory agencies, the HSE and Tusla.
[10] The CMP site in Kerry is delivered by the HSE but this is solely at a regional level with no national support or infrastructure.

implement their Programme with fidelity, and scale within a challenging commissioning and resource-limited landscape.

The action to outline a *'national approach to home visiting'* within First 5[11] A Whole of Government Strategy for Babies, Young Children and their Families (Department of Children and Youth Affairs, 2018) represented a clear policy window. In addition, a funding opportunity through the '*What Works Sharing Knowledge Fund*' (Department of Children, Equality, Disability, Integration, and Youth, 2023) enabled the HVA to work collaboratively on a study to explore the barriers and enablers to implementing home visiting in Ireland.

The Department of Children Equality, Integration and Youth (DCEDIY), under the First 5 action, has commissioned the UNITES Project, based at Maynooth University, to carry out a National Review of Home Visiting in Ireland. This represents a positive development for home visiting in Ireland. In contrast to the UNITES Project, this feasibility study has a limited scope and focus, and the HVA works collaboratively with the UNITES Project to ensure complementarity.

Methodology & study limitations

Methodology

This feasibility study had a clear and limited scope. It aimed to outline the experiences of the five HVA member organisations of bringing a programme from initial pilot and implementation with efficacy to replication and then implementation at scale. It aims to outline this process's enablers and barriers and identify learnings from international experiences that help shed light on 'what works' in implementation and 'what it takes' to implement at scale. The history, development, and current status of the five home visiting programmes comprising the HVA are the core data used to inform this feasibility. Additionally, a consultation with stakeholders has also been incorporated.

1. Literature review
2. Documenting two international case studies:
    - Jamaican Reach Up and Learn Programme
    - Replicating and scaling Family Nurse Partnership in the UK
3. Exploration of all 5 Irish home visiting programmes to outline the following:
    - background to the origins and development,
    - current capacity and
    - reach of home visiting programmes
    - how they sustain and replicate implementation, programme development and quality assurance of evidence-based home visiting to scale in Ireland.

    This included:

    - gathering essential demographic data
    - completing a scenario approach to how each Programme can respond to varying programme implementation demands and challenges
    - interviews with each Programme site head office
    - focus group with all members of HVA
4. Consultation with stakeholders
    - On the 24th of April 2023, several stakeholders with relevance or interest in home visiting were invited to a presentation and a consultation session.
    - Those invited included policymakers, programme leads and local implementation organisations as outlined below:

[11] Will refer to this strategy as First 5 from here on in.

- DCEDIY Parenting Support Policy Unit & Early Years Unit
- Department of An Taoiseach Child Poverty and Well-being Unit, Department of Health
- Department of Health, including – Sláintecare, Chief Nursing Officer, Chief Medical Officer and other sections
- Department of Education
- HSE – Health & Well-being
- HSE – Women & Infants' Programme
- HSE – National Healthy Childhood Programme
- HSE – Directors of Public Health Nursing
- HSE – Specialist Perinatal Mental Health Programme
- Tusla – Prevention, Partnership & Family Support
- Tulsa – National ABC Programme
- National Forum Family Resource Centres
- Children and Young People's Services Committees
- All local host organisations deliver home visiting programmes at a local level.

Limitations

Methods were primarily qualitative and aimed at a programme level rather than engaging multiple stakeholders across different structural levels. Engaging at these multi-levels was deemed outside the scope of the study and risked duplicating work currently underway as part of the National Review of Home Visiting being carried out by the UNITES Project. It, therefore, excluded interviews or engagement with Parents, Home Visitors, Coordinators or local management, interagency partners and commissioning or policy-making stakeholders.

A limiting factor internationally for many involved in collating data on home visiting is the comparability of data collection across programmes. This is no different in Ireland, where National Programme Support Structures (NPSS) collect data differently. Equally, each NPSS has several demands on their time and availability, limiting the ability to respond to requests for information.

Other limiting factors included time and funding available, which primarily limited the comprehensiveness of the literature review and engagement with international home-visiting peers in terms of international case studies.

Finally, there is a qualitative difference in reviewing international case studies from the literature versus direct contact about the reality and challenges of programme implementation. One Australian Programme with a well-thought-out development process and positive first RCTs was to be included as a home visiting programme case study. Unlike a desk-based analysis of material, engaging with developers directly clarified that many logistical issues challenged large-scale implementation – primarily administrative, funding changes, cuts to local implementation sites, etc. However, time did not allow sufficient engagement with international-peer home visiting programmes, especially across time zones. As such, case studies were limited to a review of published material and website information.

Programme reputation was also raised as a limiting factor with a need to ensure the trust and confidence required of programmes to share information that honestly reflects the challenges faced. In an environment where sustainability is at risk, funding is limited, and there are competitive commissioning processes, it takes considerable courage for Programmes to outline what is not working for them in programme implementation. Even if this is caused by factors beyond their control, e.g., funding and policy infrastructure within which they operate.

Finally, of the five Programmes, only three still employ key individuals who were involved with them from their origins, limiting the accuracy of some of the history of the Programme's origins.

2. Literature Review

Early childhood home visiting –what the research says.

The evidence supporting early childhood home visiting has grown substantially both at a macro level and an individual Programme level. The introduction notes that many home visiting programmes address the critical elements of early intervention essential for positive outcomes. Systematic reviews and evolving neuroscience demonstrate the importance of early life contexts during pregnancy and up to 5/6 years of age, focusing more on the earliest stage represented by the phrase *'first 1000 days'*. We have learnt from this research that responsive caregiving, reducing sources of stress, supporting maternal mental health, and supporting parents to advance and support their child's learning and development are essential for the best outcomes for all children[12].

Longitudinal studies from early preschool programs such as the Perry Preschool Program and the Carolina Abecedarian Project demonstrated that a comprehensive early learning setting and biweekly home visits showed outcomes for children experiencing or at risk of poverty. These sustained outcomes resulted in better life outcomes between 30-40 years later. Of these Programmes, the Carolina Abecedarian Project commenced from birth. Home visiting was one of many components offered, demonstrating the importance of working in partnership with parents in their home (Conti et al., 2016).

After decades of studying the longitudinal impacts of early childhood programmes from the 1960s, Heckman's phrase *'skills beget skills'* exemplifies the multiplying effect of the earliest interventions (Heckman, 2000; García et al., 2017; Zhou et al., 2021).

We also know that early intervention, such as home visiting for those children most at risk of significant early life trauma or Adverse Childhood Experiences (ACEs), can mitigate the worst impacts of these on the mental, physical and social outcomes (Felitti et al., 1998; Lacey et al., 2020). From an economic perspective, research estimated that Ireland's costs attributable to Adverse Childhood Experiences (ACEs) were $7.7 billion or 2% of GDP (Hughes et al., 2021).

It is clear that home visiting has demonstratable impacts[13] on the following:

- healthy babies and children
- child safety and welfare
- socio-emotional development and child behaviour
- early learning and academic achievement
- language and literacy development
- outcomes for parents, too, including confidence and competence in parenting, reduced stress and personal development such as accessing training, education and employment

We also know from the research[14] that when exploring home visiting, many programme elements are shared by those programmes which have demonstrated the most robust evidence. These are:

- working and supporting families before birth
- higher frequency of visits for a longer duration
- a responsive approach to working with families with some level of flexibility whilst also having a core structure and guiding standards of practice or manual

[12] Shonkoff & Phillips, 2000; WHO, 2020; National Scientific Council on the Developing Child, 2020; National Scientific Council on the Developing Child, 2012; Center on the Developing Child Harvard, 2022; Center on the Developing Child at Harvard University, 2021.
[13] Goyal, Teeters, & Ammerman, 2013; Kendrick, et al., 2000; Olds, Sadler, & Kitzman, 2007; Rochford, Doherty, & Owens, 2014; Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013; Michalopoulos, et al., 2019; Kortmacher, Kitzman, & Olds, 1998; Moran, van der Merwe, & Ghate, 2004; Schrader-McMillan, Barnes, & Barlow, 2012; Axford, et al., 2015
[14] Ibid

- comprehensive training and ongoing practice-based support for home visitors
- evidence gathered to date would appear stronger for programmes where the Home Visitor is a nurse or professional. However, there is strong evidence for paraprofessional home visiting once core training and practice supports are in place.

Home visiting outcomes have been robustly analysed using the best available evidence by the Maternal Infant Early Childhood Home Visiting (MIECHV) Programme and are summarised in Figure 4.

- Improve: maternal & child health
- Prevent: child abuse & neglect
- Increase: family education & earning potential
- Promote: children's development & readiness to participate in school
- Connect: families to needed community resources & support.

Figure 4 Home visiting outcomes for children & families (HRSA Maternal & Infant Health Bureau, 2023)

More recently, there has been significant interest in home-visiting programmes from economists. They have demonstrated the various cost benefits of investing in early childhood intervention, including home visiting with the work of James Heckman, frequently referenced as providing a 7-10 % return on investment (Executive Office of the President of the United States, 2014; Heckman, 2000; García, Heckman, et al., 2017). Other sources specifically referenced the benefits of home visiting, demonstrating that lifetime benefits outweighed costs by 5% and 88% depending on the programme (Washington State Institute for Public Policy, 2017).

No other service provision has had to demonstrate its effectiveness and impact more to achieve political and funder buy-in and commitment. Home visiting appears to have gained international recognition regarding what it can offer. The challenge for evidence-based home visiting is to demonstrate now if the positive impacts it has shown can be sustained and maintained at scale.

Evidence-based programmes & practice – contested ground

An analysis of literature to secure a single definition of 'evidence base' can be confusing, and definitions tend to diverge depending on the context and the professional sector or background within which the term is used (Parrish, 2018; Cann, 2019; Greenhalgh, Howick, & Maskrey, 2014).

Evidence-based practice is commonly used in health and social care spheres and originated within medicine and health care. Sackett et al. (1996) originally defined and refined the definition of evidence-based practice, which is "the integration of best research evidence with clinical expertise and [client] values" (Parrish, 2018).

This is the most commonly used definition across the health and social care fields internationally and in Ireland.

A HSE publication, '*Evidence-Based Practice: A Practice Manual',* proposes a definition in line with the original definition above. They emphasise the decision-making process required by each professional in each unique client context. *'Evidence-Based Practice requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources.*' (Leen, Bell, & Mc Quillan, 2014).

The Nursing and Midwifery Board of Ireland outline a similar definition. *'Fundamental to midwifery practice is the provision of safe competent, kind and compassionate care which is informed by the best available evidence, the midwife's own expertise, and the experiences, preferences and values of the woman'* (Nursing and Midwifery Board of Ireland, 2015).

This approach to defining evidence-based practice is frequently represented in Figure 4, demonstrating the integrated nature of decision-making while working with people.

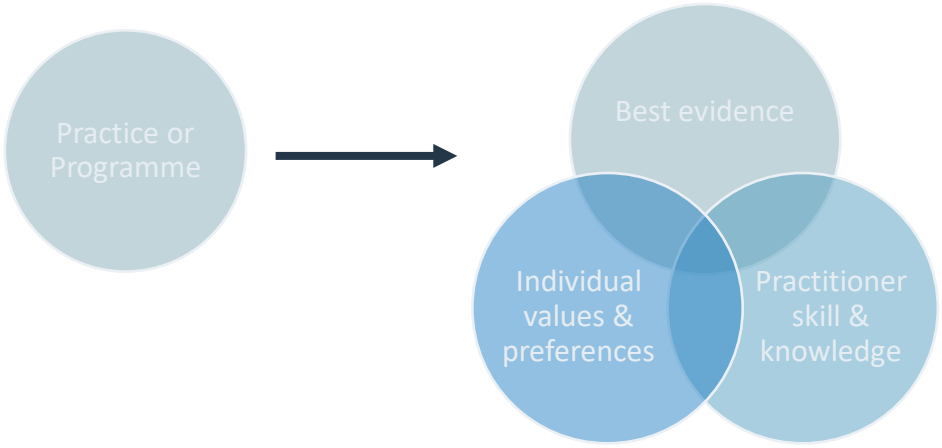

Figure 5 Evidence based practice and evidence-based practise (McLean, 2016 in Cann, 2019)

However, over the last 20 years, the term **evidence-based programme** appears to have taken on a different meaning initially in the US and, more recently, in the UK and Ireland. These definitions dominate those sectors focused on children, child welfare, parenting and Prevention and Early Intervention (PEI) initiatives. These definitions focus on research alone in defining a programme as evidence-based.

Mechanisms[15] to evaluate the research evidence behind many PEI programmes became common in line with a proliferation of high-level impact or efficacy studies. Greater awareness of this scientific lens to evidence in Ireland coincided with significant investment from Atlantic Philanthropies and a focus on ensuring effective services and evidence-based practice.

In exploring this definition of evidence-based programmes, today, two organisations are particularly relevant to the Home Visiting Sector and Ireland.

1. **Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program and Home Visiting Evidence of Effectiveness (HomVee)**

The **Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), which** commenced in 2010, is the new state-funded home visiting national programme established in the US under law. The **Home Visiting Evidence of Effectiveness or HomVee** organisation reviews research information on all home visiting programmes annually, including those that failed to meet the criteria under previous reviews. To be eligible for MIECHV funding, the Health and Human Services (HHS) set out a definition of evidence-based home visiting based on a number of criteria and requirements, which HomVee follows and then assesses home visiting programmes. The standards are extremely rigorous, specifying the number of outcomes to be two or more of eight agreed outcome domains and including criteria for how long effects are sustained and whether the research has been peer-reviewed (HomVee, 2022).

[15] In the US, these became known as 'clearing houses', and only those Programmes with the highest level of research demonstrating effectiveness were listed, e.g. https://www.blueprintsprograms.org/ or https://www.cebc4cw.org/.

2. Early Intervention Foundation (EIF)

Closer to Ireland, the Early Intervention Foundation (EIF) also provides a mechanism for reviewing and assessing evidence.

EIF outlines several evidence levels, indicating more robust evidence at each level. Level 3 is a standard of evidence demonstrating efficacy through statistically significant child outcomes from a single RCT or quasi-experimental design (QED). These are summarised in Figure 6. Recognising implementation challenges across populations, level 4 within the evidence standards requires one or more RCT or QED across different target populations.

EIF define that an evidence base can only be recognised at level 3 and 4, where causal relationships can be categorically proven. Other structures, such as the Cochrane or National Institute for Health and Care Excellence(NICE)in the UK, use multi-analytical methods to assess evidence, which does not allow for programmatic comparisons (EIF, 2023).

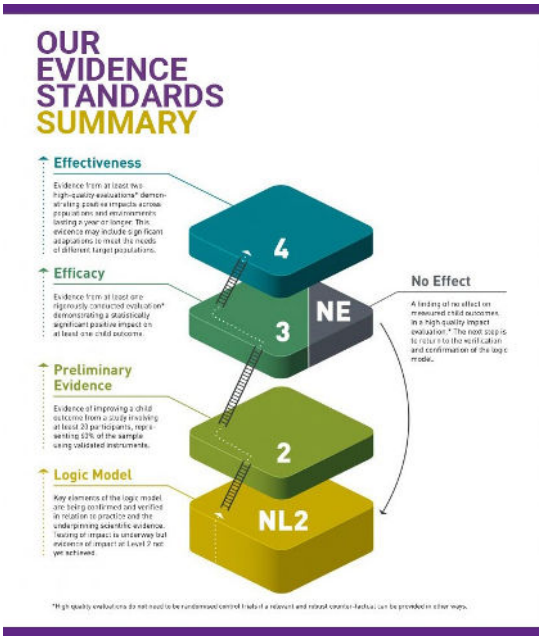

Figure 6 Early Intervention Foundation Levels of Evidence Graphic (EIF, 2023)

More recently, the DCEDIY under 'What Works' announced the development of a 'What Works Ireland Evidence Hub of prevention and early intervention programmes', supported by EIF (DCEDIY, 2023) and this was formerly launched on 31st May 2023 with 5 Irish PEI programmes being included one of which was the home visiting programme, PFL.

Tusla, the Child and Family Agency, comprehensively explored evidence-based programmes within the suite of core documents developed at its inception. In one such document, ' What Works in Family Support, ' evidence-based practice, evidence-based programme and evidence-informed practice are differentiated. This document outlines the ambivalence across sectors about the definition, outlining the *'debate on what constitutes an evidence base in children and families services, is well underway.'* (Tusla, 2013).

Tusla proposes the Veerman & Van Yperen(2007) progressive model to generate an evidence base. Ultimately the RCT remains the highest level of evidence in their model. However, they also propose including robust multiple case studies, which can evidence causal effects when taken together. Veerman and Van Yperen argue that just because a programme doesn't have an RCT, it doesn't mean there is no evidence but just that this evidence isn't at the same causal standard. Veerman and Van Yperen note that practitioners shouldn't stop using programmes where evidence has not yet been demonstrated, especially when there is no alternative. Instead, they argue for a more involved practitioner and progressively exploring evidence gathered from a grassroots level.

Tusla has adopted the Veerman & Van Yperen model within the 2019-2023 Commissioning Strategy (Tusla, 2019). The Tusla Commissioning Toolkit proposes a progressive approach to enhancing evidence generation across all Veerman & Van Yperen's levels. Less than 5% of commissioned services in Ireland can demonstrate a required evidence level. With this in mind, they propose achieving 10% of services demonstrating the highest level of evidence within five years. They recognise their role in supporting capacity building, valuing their community and voluntary partners and, finally, the need for commissioning to move outside the highest levels of evidence if a rapid response or innovative approach is required.

As Ireland is evolving its understanding of evidence-based practice across different sectors, more recently, a reaction to the pure focus on RCTs to generate evidence within children's sectors has emerged in the literature. Many argue that a requirement for evidence to be purely determined by rigorous RCTs is unfeasible across many levels (Cann, 2019; Shonkoff et al., 2017; Greenhalgh et al., 2014). They argue that an RCT programmatic focus:

- is too costly and too limiting in its results
- provides the average effect for a particular population sample, precluding those who didn't engage or those at the margins of the sample where there was less impact
- proves an outcome in one location with unique circumstances and thus cannot be assumed to work in different cultural or administrative settings
- is inherently inflexible and doesn't take on board the needs or wishes of the service users
- generating this type of evidence takes too long.

They propose revisiting the original definition of 'evidence base' whilst building 'continuous practice improvement' and 'an innovative mindset'.

Jack Shonkoff and his team at the Center for the Developing Child at Harvard University state *'the early childhood development agenda would benefit greatly from an expanded definition of evidence that includes but goes beyond cataloguing data from rigorous programme evaluations*' (Shonkoff, Radner, & Foote, 2017). They propose 'the strategic integration of multiple sources of knowledge, an innovation mindset, and the adaptive capacity within existing programmes and systems to use all available evidence productively.'

In launching the 'What Works' Programme in Ireland, Dr Patrick Mc Carthy called for an 'innovative practice mindset' instead of a 'programmatic one' to successfully bring effective prevention and early intervention programmes to scale (Mc Carthy, 2019). He argued for distilling down the *'point of change'* within a programme or the core elements for replication rather than rigid programme replication. In exploring scale, taking a research-only-focus approach to evidence-based programmes/practice '*significantly impacts—and often hinders—the ability to effectively implement, scale up, and sustain any intervention*' (Chambers & Norton, 2021).

Finally, Greenhalgh & Papoutsi (2018) call for a more pragmatic paradigm for demonstrating evidence citing the complexities of current service delivery systems. Programmes and services do not work in isolation but within complex systems, and viewing them in isolation risks omitting 'real world' impacts.

Fidelity and why it is important

The most basic definition of fidelity is the *'precision of reproduction'* (Azzi-Lessing, 2011). In their guide to scaling population health interventions, the New South Wales (NSW) Government proposes that fidelity is '*the extent to which the implementation of the programme or intervention is consistent with programme/intervention protocols previously found to be effective'* (NSW Health, 2014). Caron et al. (2021) propose three elements to fidelity – drawing on the work of others:

- adherence to protocols
- competence in practice refers to the skill sets of practitioners
- context or more structural programmatic requirements such as child – adult ratio or caseload sizes

Caron et al.(2021) review the literature to demonstrate that research in early childhood interventions *'supports the links between practitioner fidelity, parental engagement, dosage of intervention received, and parent and child outcomes*'.

Sustaining fidelity to a programme can be a challenge for all implementation stakeholders. Such challenges increase significantly when a programme is delivered at scale. If a programme suggests a family should have 20 visits, but the family only attends 10, does that impact the outcomes for that family? Similarly, if a family engages later than expected or leaves the programme earlier than expected, how does this impact the family receiving maximum benefits of the Programme? Such elements can be outside the control of the programme. Still, many other factors are within the control of those responsible for local implementation and those providing technical or administrative support.

When exploring scaling up, a critical factor in terms of fidelity is what has been termed by Caron et al. (2021) as '*administration quality*'. In scaling, there is a sense that with increased demands and complexity, there is less oversight or fidelity protection, so administration quality decreases in line with a scale. And so scaling and fidelity are inextricably linked.

Additionally, there is the risk of 'programme drift' where, over time, fidelity is weakened such that the programme implemented is so different from the original model that it can no longer claim to have an evidence base. Caron et al. (2021) and other authors, such as Daro et al. (2014), recommend conducting fidelity assessments and including implementation supports such as training and consultation. As mentioned in an exploration of what 'evidence-based' means, Caron et al. also suggest identifying the core and essential elements of the programme by focusing on these when assessing and supporting fidelity. This more pragmatic approach ensures administration support is maximised to areas with the most significant impact rather than a broad focus on too many moving parts, some of which may not impact outcomes significantly.

A failure to recognise the importance of fidelity from the start can have significant implications for scaling programmes, as Elliot & Mihalic (2004) warn:

'It could easily backfire and undermine public confidence in scientific claims that we have programs that work if these programs prove ineffective when we take them to scale'.

Replication, adaptation & scaling Up - what do we mean?

Replication

An overly simple definition of replication is *' repeating a study's procedure and observing whether the prior finding recurs'* (Jefferys, 1973, as cited in Nosek & Errington, 2020).

Replication is a scientific term that many argue is undervalued and misunderstood. It validates a primary scientific outcome by demonstrating that results do not happen by chance occurrence but are established through systematic and transparent methods, with results that can be independently replicated and findings that are generalisable to at least some target population of interest (Bollen et al., 2015).

Failure to carry out replication studies assumes that communities and the systems that support them are homogenous. However, populations vary in rural/urban, socioeconomic status, housing and ethnicity. The Reach-Up example below outlines the importance and learning inherent in replication studies.

Equally, the systems that individuals live in are different regarding the access and availability of services and support. Some communities experience waiting lists or gaps in service provision. This can either exacerbate or alleviate presenting needs and produce indeterminate results. A single experimental research design cannot account for such differences. Were the outcomes positive because the broader service infrastructure was accessible and well-resourced, or was it solely down to the programme's impact? The cause-and-effect results cannot be treated in 'pure terms' as children and their families do not live isolated in laboratory or controlled conditions.

Adaptation

Adaptation is an evolving field of research with varying definitions and proposed frameworks to guide decision-making. It is the process of decision making which occurs when implementing an evidence-based programme in a new context, necessitating an adjustment of the programme for different target populations, localities and organisational factors whilst retaining fidelity to the core elements of the programme (Escoffery et al., 2018; NSW Health, 2014).

Adaptations are frequently necessary to replicate a programme to a different sample population or new region or country. Two explored in this context will be Reach Up, a Jamaican Home Visiting Programme (Araujo et al., 2021) see Table 1 and the adaptation and replication of the Nurse-Family Partnership in the UK, Family Nurse Partnership reflected in Table 2.

In both of these examples, replication and adaptation occurred in a different country. The original studies demonstrated efficacy following at least 1 RCT (more in the case of Nurse-Family Partnership). During replication, the original 'model' was adapted to the new national context from:

- Jamaica to Colombia and Peru in the first example
- the US to the UK in the second.

Both examples demonstrate unique challenges in matching the impact and results achieved in the original studies to those in the replication studies. As we will see, this and other factors affected how these programmes were brought to scale.

Case Study 1. Lessons in replication and building to scale Jamaican Reach-Up Programme

Originally called the Jamaican Early Childhood Development Intervention or the Jamaican Home Visiting Program, it is now called the Reach-Up Early Childhood Programme. It was developed in Jamaica over 30 years ago by Sally Grantham-McGregor (Grantham-McGregor & Walker, 2015). It was created as an accessible community response to support children in their homes from 0 -3 years of age. In particular, it targeted children in low-income areas who were chronically malnourished. It was delivered by trained local Home Visitors paraprofessionals (community health workers) to provide the programme.

Trained and supervised Home Visitors would visit weekly for 1 hour for 2 years. Home Visitors would bring play materials, introduce and model activities, and responsive caregiving.

This early example of the model was heavily supported by the developer and research team, who were involved in supervising the Home Visitors. As an efficacy study, the numbers of children, Home Visitors and Supervisors were much smaller in the original sample. Three RCTs in Jamaica demonstrated positive outcomes in child development with a strong effect size. A 30-year follow-up indicated that intervention children had more schooling, higher test scores, were more likely to be employed, with wages that were 25% higher and demonstrated improved cognitive, personal and mental health outcomes.

The Programme was replicated in Colombia, Peru, Bangladesh and China with increasing size in terms of scale. Before the impact of the China replication studies emerged, there was a direct relationship between the level of scale and effect sizes seen in statistically significant outcomes. The greater the reach of the Programme, the lower the effects e.g. the Jamaican research saw effect sizes of between 1.18 SD and .88 SD, and effect sizes in Colombia, Peru, and Bangladesh did not reach over .5 SD. However, a recent replication at scale in China would appear to demonstrate effect sizes similar to the

original Jamaican studies.

The learning from the Jamaican 'Reach-Up' Programme, its replications and scaling-up in different countries can be summarised as follows:

1. Replication studies are essential to test the representativeness of the population and the situation/context. An efficacy study can be misleading because it is both a specific population and a unique cultural, political, service structural and administrative context.
2. There is a need for systems and processes to be in place for programme support, including training, supervision, administration, technical support, materials and concrete guidance. In this example, the Programme developers advanced the Programme, terming it 'Reach Up' to provide greater technical and structural support to implementation. This also includes training and mentoring, which needs to be delivered consistently at a local level.
   '*scaling-up of parenting interventions is limited by the technical capacity of organisations to implement them'* (Grantham-McGregor & Smith, 2016).
3. There is a need to focus on the essential 'change elements' or components of the intervention and protect these while adapting the Programme to different contexts – these are referred to as *'non-negotiable key components*', one of which highlighted was training and mentoring.
4. There is a need to evidence a programme's scalability in real-world contexts or build 'scalability' into the research design.
5. The importance of reflecting engagement and attrition rates for a programme – in some contexts, these may be lower for a new initiative but grow in line with a programme's reputation within a community, e.g., the China REACH-Up example.
6. Political and funding support is essential. Much of the literature references the limited political window for advancing a programme. Outside this window, there can be less support for a Programme with pressure to reduce costs and, therefore, reduce 'inputs' to programme delivery, which can impact fidelity. There can also be pressure to deliver outcomes quickly for political wins. For example, should a Programme scale up quickly in line with a political cycle or funding opportunity or do it with quality slowly and iteratively?
7. A programme can't be all things to all children/families. The challenge for commissioners is deciding what programme to fund and, to keep things simple, fund one programme to meet all needs. Lessons from the literature on the Jamaican Reach-Up Programme suggest that programmes can become ineffective if asked to address multiple outcomes. '*Programs can become a victim of their own success: a program that was effective when it focused on child development can become ineffective when it covers too many other aspects of child and household well-being, even if all of these are important in their own right*' (Zhou et al. 2021).

Table 1 Reach Up and Learn, a Jamaican Home Visiting Programme replicated in Colombia, Peru, Bangladesh and China (Araujo et al., 2021; Zhou et al., 2021; Grantham-McGregor & Walker, 2015; Grantham-McGregor & Smith, 2016).

Scaling up

'The early childhood field has faced challenges scaling up programs for decades (Zhou et al., 2021).

Scaling up or bringing a Programme to scale are standard terms in the PEI sector. It is a language borrowed from manufacturing, drawing from 'economies of scale' terminology. It is a term frequently used but often with slight variations on the intended meaning.

There is considerable literature outlining the complexities and challenges of scaling up early childhood interventions (List, 2021; Elliot & Mihalic, 2004; Ammerman et al., 2007; Family Nurse Partnership National Unit & Dartington Service Design Lab, 2020; Gupta et al., 2021; Paulsell et al., 2014). It is also clear that '*evidence on early childhood programs that have been scaled-up has shown mixed results in achieving and sustaining significant outcomes'* (Zhou et al., 2021).

1. **Scaling for who?** : Some of the challenges related to scaling are competing needs.

Everyone is interested in scaling up as it addresses various needs – the need for :

- policymakers to provide widespread solutions to societal challenges
- economists are looking at the cost impact and cost-benefit analysis on a societal level should a programme be brought to scale
- scientists and academics are interested in studying 'what works' for a broader range of individuals
- programme developers would like to bring their intervention to reach more children and families
- local funding commissioners are interested in solutions to local needs which fit well with the systems and services already in place
- families and communities need to access supports proven to work, which also work for them, in their lives and communities.

At times, however, these needs don't align. The development of a particular programme may have a narrow fit or remit and doesn't meet new or emerging needs that local commissioners must address.

A solely research-driven evidence base promotes the best outcomes for the average of a set cohort of families. It promotes a one-size-fits-all approach, which may not meet the needs of some children and families at the margins or outside that specified cohort.

2. **The centrality of context:** In their 'Guide to Implementation', the Centre for Effective Services (2023) stress the importance of 'context' when bringing a Programme to scale. If there are challenges in the context or system at a macro or micro level, then even the most efficacious programme can't deliver or sustain. In launching the DCEDIY initiative ' *What Works*', Patrick Mc Carthy (2019) used the phrase '*bad systems trump good programmes'*.

Such context changes can be at the macro level, for example, unintended consequences of policy change or political change, such as the impact of austerity on the scaling of the Family Nurse Partnership Programme in the UK (Family Nurse Partnership National Unit & Dartington Service Design Lab, 2020). The overview of parenting, prevention, and early intervention development in section 3 demonstrates key areas where Irish home-visiting programmes were vulnerable to the changing policy and economic landscape. Securing funding at the local level became challenging in Ireland during the financial crisis in 2008. The transfer of commissioning and funding from the HSE to Tusla resulted in a change in commissioning priorities, shifting away from the universal and mainstream provision towards a more targeted approach to supporting families with higher levels of need. Throughout these changes, the programmes tried to respond and adapt without impacting fidelity to their core elements.

3. **Getting it right from the start:** Frequently, at the beginning of programme development, piloting and evaluation, little thought is given to 'what it takes' to support the programme's implementation at scale. At this stage in a programme's trajectory, developers only think of demonstrating efficacy rather than considering how to plan for effectiveness at scale.

4. **Readiness of the local site to implement the Programme**: In their study of implementing evidence-based prevention programmes in schools, Elliot & Mihalic (2004) note that many sites that apply to implement programmes have not considered what it takes at a local level to do so. The critical elements in site readiness that were related to successful implementation were:

"(1) a well-connected and respected local champion, (2) strong administrative support, (3) formal organisational commitments and organisational/staffing stability, (4) upfront commitment of necessary resources, (5) program credibility within the community, and (6) some potential for program routinisation, that is, the program being sustained by the existing operational budget " (Elliot & Mihalic, 2004).

Daro et al. (2014) also highlight the need to review the values and ethos of the organisation within which a programme is to be implemented. A programme cannot be delivered locally with fidelity if it does not align with an existing organisational culture. The Hexagon Tool (NIRN, 2023) includes consideration of 'fit', which should extend to organisational culture and values along with alignment to existing service offerings and service delivery context.

Readiness will be explored further in the next section as a necessary NPSS function. However, it is essential to note that at this early stage, for long-term sustainable delivery of a programme with fidelity, Caron et al. recommend the following:

- secure buy-in from practitioners from the start in terms of programme delivery with fidelity
- ensure that workloads are adjusted and allow time for inbuilt fidelity measures
- build in-house support to sustain fidelity long after the initial technical support and training have been completed (Caron et al., 2021).

5. **Readiness and organisational capacity to take a programme to scale:** Throughout the literature, mixed attention is paid to the need for a well-funded, well-resourced and competent infrastructure, specifically programme function, to support the widescale implementation of an evidence-based programme.

'Developing the organisational capacity to effectively deliver programs—published materials, a pool of certified trainers, technical assistance, tested process evaluation measures, a well-designed marketing and delivery capability, and a data management system—is a major task, and we have much to learn about how to do this effectively' (Elliot & Mihalic, 2004).

Much of the literature refers to the need for 'developers' of programmes to provide a whole range of technical assistance, support, training, monitoring, quality assurance and ongoing research, assuming that this is within the resource and funding capacity of those who originally developed the programme. However, limited attention is given to how this should be funded and done to succeed. Elliot & Mihalic (2004), studying the implementation of 'Blueprint' prevention programmes in schools, noted:

'The fact that these programs had completed the necessary efficacy and effectiveness trials and met the rigorous evaluation standards required for certification as Blueprint programs did not necessarily prepare them to deliver these programs on a wide scale'.

Funding tends to focus on the initial stage of programme development and tests of efficacy or proven research of positive outcome change for one sample in one geographic location. At this early stage, little or no consideration is given to how this could be replicated in another area and then brought effectively to scale (as noted above, replication and ongoing evaluation are essential to ensure programme effectiveness rather than local population or area circumstances). This has undoubtedly been the case in Ireland, as we will see later.

The range of functions required to oversee implementation with fidelity, quality assurance, ensuring local translation, sustainability, quality assurance and review and refinement are considerable. The additional support for these functions grows with scaling, especially if they are to be done effectively. The following outlines a range of these functions which emerge from the literature.

5.1. Assessing site readiness/ building local site capacity

Considerable literature exists on what is required in one location to implement a new programme effectively. The work of the National Implementation Research Network (NIRN) has considerably advanced implementation science. In particular, there is a need for the following essential steps: assessing the local needs of the area/population, ensuring programme fit with a local organisation (the Hexagon Tool), and then assessing the capacity of a local organisation to ensure implementation success as outlined in Figure 7.

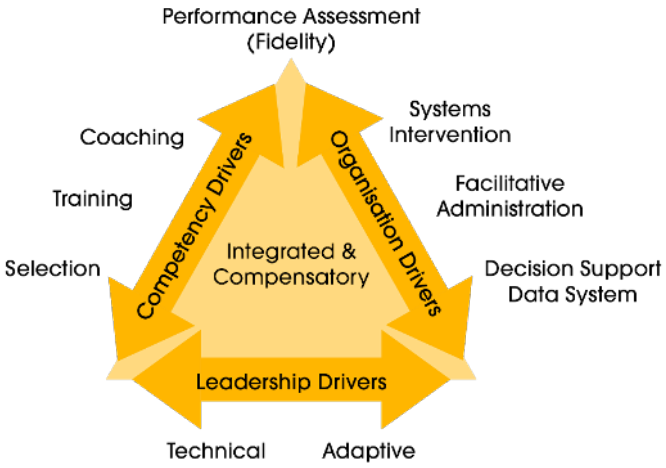

Figure 7 Enabling contexts. Implementation drivers to deliver evidence-based programmes effectively (Fixsen, Blase, Naoom, & Duda, 2015)

NPSS go beyond assessing readiness. They also support local sites to build their capacity to implement a programme. In a study of implementation, Elliot & Mihalic (2004) noted a 6-9 month capacity building stage, continuing throughout implementation. The areas they focused on mirrored those in Figure 7:

- '*a well-connected and respected local champion*
- *strong administrative support*
- *formal organisational commitments and organisational/staffing stability*
- *an upfront commitment of necessary resources*
- *program credibility within the community*
- *some potential for program routinisation, that is, the program being sustained by the existing operational budget'* (Elliot & Mihalic, 2004)

This is a frequently missed step and increases the risk of implementation failure. It must be done in partnership with local funders and commissioners of services, such that if there is a policy commitment to deliver evidence-based programmes, organisations need to be funded and resourced adequately to implement these programmes with fidelity.

5.2. Initial training in Programme implementation

Elliot & Mihalic (2004) outline findings in terms of 'what works' when training local implementation sites. Delivering training to support implementation has many challenges, including the consistency of local staff participating. Elliot & Mihalic note that even when grants have been provided to local implementation services to ensure the feasibility of training, there were still logistical or staff absenteeism challenges in delivering the training as planned(2004).

The feedback from Elliot & Mihalic's study was that practitioners in implementation sites were *'less enthusiastic about how well the training prepared them to implement the program*' (2004). They noted that implementation sites rated the training positively but didn't always feel it supported them to implement the programme, indicating a disconnect between training and the practice. In terms of training, they noted that *'for local implementers, the most useful components of the training were the use of videos, role plays, hands-on exercises, and practice*' (Elliot & Mihalic, 2004). Such findings are not unexpected given the breadth of

science supporting the need for not just training but also more practice-based training or 'coaching' as outlined in Figure 7 above; both are essential implementation drivers (Fixsen et al., 2015; Metz et al., 2015; Synder et al., 2015). While training is critical for 'knowledge acquisition and skill development,' there is always the question of 'what now?' as outlined by Metz, Burke, & Owens in a presentation to children's services in Dublin (2015).

There is a considerable body of evidence outlining 'what works' in coaching and the impact it can have (Joyce & Showers, 2002; Morgan & Rochford, 2017), but a more detailed exploration of best practices in coaching is beyond this paper. Simply put, the purpose of coaching is '*onsite assistance to help with learning to use the innovation in practice settings'* (Metz, Burke, & Owens, 2015). Coaching is seen as' generalising new skills to real-world settings, ensuring *fidelity and implementation and it must include direct observation and feedback'* (Metz et al., 2015).

Training can be designed and developed relatively easily by programme developers supported by reasonable resources and funding. However, this can be jeopardised when a programme goes to scale if costs and limited financing drive the implementation mechanism and high-quality training can be one area that is cut (Zhou, Baulos, Heckman, & Liu, 2021).

5.3. Ongoing training and support during the implementation and sustainment

In cases where a programme is implemented internationally, there will frequently be an international organisation that oversees implementation in the country of origin and beyond. It is likely that there are organisations within each country which are connected to the international Programme office, but who are better placed to adapt and support implementation in another country. Examples are Nurse-Family Partnership, Incredible Years and Parent Child +. These programmes originated in the US with extensive, comprehensive, well-resourced and funded National-International Programme Structures. In translating these to other countries, there is a country NPSS. This is the case for Lifestart below but also now for PFL who are working to support implementation in Chicago, e.g.:

- Family Nurse Partnership National Unit is the structure responsible for translating, implementing and bringing to scale Nurse-Family Partnership in the UK. A statutory office within the UK Government under the Office for Health Improvement and Disparities leads it.
- Archways CLG is an NGO or a community and voluntary organisation in Ireland responsible for advancing Incredible Years Parenting Programme in Ireland regarding adaptation, implementation and research.
- The Early Learning Initiative of the National College of Ireland has a licence to advance Parent Child + in Ireland and support training, implementation and ongoing fidelity and development to those local sites that are implementing the Programme.
- The US publisher licences the Lifestart Foundation to advance the Growing Child Programme and Home Visiting Service worldwide, excluding Asia.

5.4. Collecting and monitoring data - fidelity, quality, innovation & accountability

'Lack of universal data system and scalable measures of quality leaves many flying blind' (Gupta et al., 2021)

Data is necessary for maintaining case notes and client records and aggregating data on what is frequently called 'outputs' or what the service does, how often it does it and with whom it does it. There is a need to report to funders periodically and to collate outcome and programme achievement data to apply for funding. Most importantly, it is essential for ongoing real-time evaluation of the programme and whether it is achieving its outcomes. Ammerman et al. (2007) outline a 'compelling' argument for building data or CRM systems to support internal evaluation and information management.

5.5. Ongoing evaluation

National Programme Support Structures (NPSS) must also secure the mechanisms, research support and funding to maintain and grow a programme's evidence base. Ammerman et al. (2007) note: '*With increasing emphasis on accountability and documenting outcomes in prevention programs, it is essential to conduct ongoing evaluations. Evaluation can be used to improve services, facilitate the evolution of programs towards increased effectiveness, and measure and document changes over time.*'

The rigorous demands for an evidence base as outlined by structures such as MIECHV and EIF necessitate the commissioning of not one but multiple RCTs, including longitudinal RCTs. Securing funding, commissioning, and project managing such complex evaluations requires considerable skill, time and resources. Again, there is little exploration of how this happens within the literature. Consortiums of research entities and philanthropy work closely with programme designers. Still, it appears this requires considerable effort from those responsible for managing the programme.

Ongoing internal evaluation or monitoring of the programme is essential and, as noted above, requires constant review of data and review of how data is to be collected. Again it is unclear from the literature how National Programme Support Structures fund or carry out this task. What is clear from the literature is that this is an essential component in sustaining implementation and overseeing the scale-up of implementation. The risk with scaling up is that "*control over monitoring is lost at a larger scale, which can lead to unmeasured incorrect delivery of a program*" Ali-Ubaydli et al. (2021).

Summary – the big picture context

"Although we have taken giant strides forward in determining 'what works' and promoting the use of science-based programs, we have lagged behind in building the internal capacity of designers to deliver their programs. To move forward with a national prevention initiative, this gap must be addressed by funders and policymakers" (Elliot & Mihalic, 2004).

There are essential factors beyond the control of programme developers and researchers which are fundamental to building an infrastructure to bring sustainable, high-quality home visiting to scale.

1. **Securing political and state 'buy-in' from the start**

All too often, a Programme demonstrates positive impacts and emerges from a well-supported consortium of collaborators. In many cases, this is a collaboration between:

- a local agency and an academic institution that developed a Programme in response to an identified need
- a philanthropic agency
- an external research entity.

The typical development partnership of agency, research entity and funder (primarily philanthropic) frequently disappears when a Programme has achieved positive outcomes from a robust evaluation. Some examples exist where the state was the driving force for implementing a proven programme. In these cases, the programme's administration was aligned within state administration infrastructures, e.g., the Family Nurse Partnership Unit in the UK, the Reach-Up Programme rollout in Chili and Criança Feliz in Brazil. In other examples, the state's role has been described as 'light touch' and this state response continued through the implementation and replication phases, so home visiting programmes remained on the periphery of service delivery infrastructures or as an add-on/supplement to existing services.

In developing a programme, the aim has been to ensure it works, and more than not, it hasn't been built into the original design as to 'what it takes' to make it work both in one location and across many areas. The

incremental approach to design is in response to access to funding, with the goal being that if it can be proven to work, funding can be secured to grow the programme. Having the state informed, on board or even involved in driving the delivery mechanism ensures a greater level of commitment or at least a greater understanding of the resource needs and how the programme can integrate when scaled up.

Pappas (2021) outlines pragmatically the 'real world' experience of securing 'buy-in' from government agencies in terms of the reality of bringing a programme to scale. Pappas argues strongly for building constructive relationships with opportunities for ongoing dialogue and partnership between statutory agencies, program developers and researchers whilst also arguing for the inclusion of the views of parents and families and those directly involved in the delivery. Such relationships are essential to navigate a sustained commitment to a programme, which can provide consistency during transitions in leadership and make a case for the core investment required to ensure programme fidelity and outcomes. Securing early 'buy-in' from government agencies/leaders during the development phase of a programme is strongly advocated.

2. Adequate funding for National Programme Support Structures

'*For those funders investing in program services, the recommendations call for using evidence that meets the scaling criteria and, similar to policymakers, supporting the funding of the necessary infrastructure as much as the specific program.*' (Gupta, Supplee, Suskind, & List, 2021).

Securing adequate funding for home visiting programmes is not unique to any country, and funding is crucial to enable the required 'scale-up' infrastructure. The task of supporting implementation at scale is significant, as outlined above. Frequently, this is called a Programme Head Office or Unit (what we have termed a National Programme Support Structure- NPSS). As noted above, this is embedded into existing statutory infrastructures in some jurisdictions. However, in general, programmes are run and governed by NGOs who explore a range of mechanisms to sustain their funding to enable their work. Many evidence-based home visiting programmes adopt a licencing model and charge local implementation sites for their support, training and materials. It is unclear whether such a model adequately resources the requirements of an NPSS. It can be wrongly perceived as a commercial rather than a social mechanism to fund the support provided, which can conflict with how services and interventions are traditionally funded within jurisdictions. Overall, there is a limited exploration of how these National Programme functions are or should be funded within the literature. As Gupta et al. (2021) outline, *'funding (or the lack thereof) is one of the biggest challenges'.*

Funding and its instability is a primary challenge for home visiting in terms of both growing the scale of a programme and sustaining it at scale. As Moran Finello et al. (2016) outline, *"instability in funding creates challenges for programs and organizations in planning for the ongoing development of existing services and the evolution of creative adaptations that enhance the service system"*. We will explore Irish examples of this.

3. Building a national infrastructure to support, grow and sustain home visiting

Johnson (2009) argues for a multilayered commitment at the federal and state level to advance and support home visiting sustainably, and she made this argument before the establishment of MIECHV. In reviewing Johnson's practical and nuanced proposals, I wonder how she would view the developments from MIECHV. One of her recommendations regarding federal legislation was attained, but MIECHV appears externally as a prescriptive mechanism. While allowing for further research development, its selection of home visiting programmes for funding is based on rigorous criteria. Rather than a prescriptive top-down approach, Johnson argues for collaboration, flexibility and a continuum of service provision for families. At the national or federal level, she calls for:

- multi-state learning collaboratives

- federal leadership to support state and local programmes
- more research on how to effectively deliver different models of service
- federal legislation which supports state home visiting services.

At the state level, she argues for the need to:

- *strengthen mechanisms for interagency and cross-program coordination*
- *help communities and programs align the home visiting intervention with family needs*
- *increase understanding of the role and limits of home visiting in the early childhood agenda*
- *support a continuum of early childhood services that can address a wide range of family needs and achieve results in a cost-effective manner*
- *support research and data systems that expand knowledge of programs and gaps*
- *analyze current spending on home visiting programs and blend (joint-mixed revenue) funding where appropriate*
- *refine and narrow program objectives and outcome measures*
- *promote quality and assure staff training and supervision* (Johnson K., 2009).

4. Workforce development and professionalisation

The issue of staff training and continuous professional development is a constant theme across the literature of 'scaling up' and goes beyond the ability of NPSSs. It involves funding programmes and, more importantly, recognition of staff pay and terms and conditions. As Gupta et al. (2021) put it bluntly, the "*workforce is underpaid, under-trained, and susceptible to high turnover*." Home visiting is not recognised as a profession in its own right, and within the research literature, the term 'paraprofessional' is used frequently. This is contrary to experience, which outlines that Home Visitors develop a significant range of professional skills which necessitate the recognition and development of the profession of home visiting. Sharing many parallels with the Early Childhood Education and Care sector regarding under-recognition, home visiting is an evolving profession requiring support and structural mechanisms beyond any single home visiting programme to advance.

5. Collaboration and partnership of all stakeholders

The necessity for collaborations and partnerships to secure and sustain political will for home visiting is a call made repeatedly throughout List et al.'s (2021) comprehensive discussion on 'the Scale-Up Effect'. From programme development to sustainability, high-quality implementation of evidence-based programmes at scale requires ongoing commitment from a range of partners constantly negotiating as they

- navigate transitions and competing priorities,
- demonstrate flexibility and adaptation to ensure a space for innovation whilst adhering to research evidence and the science of 'what works'
- commit to 'what it takes to work' – funding and resources.

The above elements outline the range of factors to be considered by all involved in the design, development, implementation, scaling and funding of home visiting programmes. However, as we have seen from the Jamaican example, a range of external factors shape a programme's success when first replicated in a different country but then when it is brought to scale in other countries.

There is significant learning from the UK about the Family Nurse Partnership home visiting programme and how it navigated external conditions, such as changes in the broader service funding landscape due to austerity and subsequent administrative changes, which are highly insightful. Such more general systemic issues significantly impacted the findings from the first RCT of Family Nurse Partnership in the UK.

Furthermore, the learning is all the more significant as it was delivered at scale (initially 10 sites, and now up to 130 Local Authorities implement it) from the start. This is an accurate 'scaling-up' assessment, delivered in 'real-world' contexts rather than discrete and isolated projects. Proposing an iterative and co-produced response within their adaptation of the Programme, the initiative is more optimistic about its future and, more importantly, its impact on children and families. Again, collaboration and partnerships were essential in navigating shared external forces in this example of adaptation and sustainability.

Case Study2. Lessons in Adaptation
From Nurse-Family Partnership in the US to Family Nurse Partnership in the UK

Nurse-Family Partnership(NFP) is probably one of the most famous home-visiting programmes internationally. David Olds commenced developing Nurse-Family Partnership in the 1960s. It is a structured programme with the following core practices:

- Preventative health and prenatal practices for the mother
- Health and development education and care for both mother and child
- Life coaching for the mother and her family

Its change mechanism is the relationship between the nurse and the family. It is outcome-focused in its delivery with a robust data collection mechanism supported at a national level.

Research has demonstrated a range of child outcomes, including:

- Improved intellectual functioning
- Improved child receptive language
- Improved infant responsiveness
- Reduced accident and emergency visits & hospitalisations
- Reduced child abuse and neglect
- Reduced child behavioural problems
- Reduced arrests and convictions in adolescence
- Reduced use of substances

Additional parent outcomes were also evident, including:

- Reduced domestic violence
- Reduced smoking
- Increased access to community services
- Increased attempted breastfeeding
- Improved home environment
- Improved maternal involvement
- Reduced use of punishment

This extensive research background is derived primarily from 3 core RCTs which include follow-ups at various time points (4, 13, 10, and 18-year follow-ups) carried out in New York, Tennessee and Colorado. A subsequent RCT in the Netherlands with a 1-year follow-up demonstrated replication outside the US.

In 2007, Nurse-Family Partnership was introduced in the UK in 10 areas under a different name – Family-Nurse Partnership(FNP), led, supported and overseen by a National Unit based in the Office for Health Improvement and Disparities in the Department of Health and Social Care. This national office comprises a mix of clinical, project management, communications and data science capabilities to deliver support to FNP in the UK. It uses best practices, including implementation science, quality improvement, and Agile project management. Today it is being delivered across 130 Local Authorities (Cavallaro et al., 2020).

The FNP website outlines a timeline of developments for the Programme in the UK, which is insightful for all interested in replicating and scaling home visiting programmes.

It outlines the interplay between research, scaling, and implementation supports, such as developing a

data system and reflective and responsive innovation and adaptation. The transparency of learning in published work of FNP outlines the necessity for a Programme to constantly review, learn, adapt, and research as it states: '*FNP doesn't stand still. We respond to evidence and monitor programme data. We adapt and improve the programme carefully, with a clear sense of what is fundamental to FNP*' (Family Nurse Partnership, 2023).

The results of the first UK RCT of 1,645 pregnant teenagers in the UK in 2015 were not in line with the three original NFP findings from RCTs in the US[16] . These findings emerged when there were changes to commissioning arrangements and funding cuts in line with austerity policies implemented.

Learning from implementation science and emerging alternative perspectives of evidence generation (Greenhalgh & Papoutsi, 2018; Rutter et al., 2017), the Accelerated Design and Programme
Testing (ADAPT) project was initiated. In short, this was an iterative and responsive learning process to consider the complexity of delivering a programme in a complex and changing system and to be responsive and flexible to the needs of parents and families. It also set out to improve Programme efficiency by more accurately targeting the Programme to those children and families who would benefit most.

The ADAPT (Family Nurse Partnership National Unit & Dartington Service Design Lab, 2020) project represents and innovative response to 'real world pragmatism' in honouring the core change elements of the NFP Programme by adapting the programme and building in real-time learning. The project also drew on models of co-production to learn more from participants about their needs and what works for them, drawing on this to shape and change essential programme delivery methods.

The inherent opportunity in this project enables considerable 'real-world' evidence development, and one specific project is looking at connecting data across health, social care and education retrospectively and from now on regarding findings. This is a significant population-wide advancement and a real exploration of generating evidence for scaled delivery (Cavallaro, et al., 2020).
Key learnings:

1. State commitment to a home visiting programme was evident in integrating the FNP Unit within a government department. This provided security and the social capital to access the necessary skills and capabilities to implement the Programme to scale. A smaller NGO or CVO would not have been able to withstand the challenges of bringing the Programme to scale.
2. Providing a national Programme infrastructure (FNP Unit) with a multidisciplinary range of skill sets, from research to training to implementation, is essential to replicate, adapt and bring a home visiting programme to scale.
3. Data systems are essential for real-time Programme learning
4. Building in models of ongoing learning and continuously reviewing evidence is vital to ensure the Programme responds to changing service delivery contexts and population needs
5. Incorporating co-production ensured the adaptation of the Programme to the needs of parents and families. Bringing home visiting programmes to scale is a complex process requiring constant learning and re-negotiation with a range of stakeholders, but especially the children, parents and families served.
6. There will be tensions between scale, pace and pressure for results. In a rush to implement at scale and get results, the consideration and planning required to ensure implementation is 'fit for purpose' is often at risk. Similar tensions exist between rigour and pragmatism in terms of data collection.
7. Developing a data-rich service delivery system across sectors can enable more significant learning

[16] It is worth noting that the Mother Infant Home Visiting Programme Evaluation (MIHOPE) study of 4 US home visiting programmes, including Nurse-Family Partnership, failed to replicate the effect sizes of the original RCTs. This has been attributed to the original RCTs being delivered in one location rather than at scale across different locations, as in MIHOPE. There were still positive effects found, but some were not at the level of statistical significance or were smaller effect sizes than in the original research (Michalopoulos et al., 2019).

regarding the role and function of a wide range of services, including home visiting and their impact on the lives of children and families. 8. Delivering at scale is a complex process with multiple moving parts that differ in each location the Programme is provided. Newer models of demonstrating and evidencing Programme efficacy are required, which are innovative, responsive and meet the 'real world pragmatism' needed.

Table 2 Family Nurse Partnership, a UK adaptation of the American Nurse-Family Partnership replicated and brought to scale in the UK

3. Findings: Review of Home Visiting Alliance Members & Stakeholder Consultation

3.1. Development, implementation & scaling of home visiting in an Irish policy landscape

The mechanisms through which home-visiting programmes developed in Ireland are essential findings for several reasons:

1. They outline the policy landscape in which Home Visiting developed and track this from ground-up development to today's policy commitment of creating a national approach to home visiting.
2. The findings outline the role of key stakeholders and the partnerships central to developing such Programmes and how this development was funded. Some such partnerships are context or time-dependent.
3. It tracks how these Programmes were very much a response to needs identified, how this might inform the unique needs of particular communities or families, and how commissioners and policymakers look to ECHV Programmes to address these needs.
4. Finally, and most importantly, it tracks the 'ad hoc' way these Programmes have developed, were funded and resourced and how they were equipped or not equipped to respond to policy and funding landscape changes. These learnings are significant in proposing a sustainable ECHV infrastructure for Ireland.

International context

The international development of home visiting programmes would appear to have commenced from a bottom-up approach. National and international policy is seen to respond to this, especially when presented with considerable evidence of effectiveness. For example, home visiting in the US has been referenced in literature and practice since the 1960s, with home visiting attached to early childhood education and care provision[17] along with the origins of many other programmes such as Nurse-Family Partnership or Parent-Child +. Yet, a federal approach to home visiting is only currently being realised in the US nearly 50 years later.

Legislation and national policy in the US would appear to have merged under the Barack Obama presidency at a federal level. While programmes were funded previously, this legislation and funding outline a national infrastructure for the commissioning and implementing of home visiting (Congressional Research Service, 2018).

In some cases, policymakers look to international evidence for solutions to local problems and then implement these at scale through national structures. This is the case in the Jamaican Reach Up Early Childhood Programme implementation in Peru (see Table 1) and the decision by the Department of Health and Social Care in the UK to implement the Nurse-Family Partnership at scale under the Family Nurse Partnership. However, these programmes were developed initially from the ground up within academia or practice.

Irish context

Such was the case in Ireland with early home visiting programmes such as the Community Mothers Programme and Lifestart. Both Programmes commenced ahead of their time, as it were, many steps ahead of the policy landscape. This section will outline the history of parenting/family support policy drivers, which laid the foundations for today's policy context. Many Programmes developed 'against the odds'; however,

[17] For example, fortnightly home visits as part of the Caroline Abecedarian Project (Sparling, Ramey, & Ramey, 2021)

specific policy windows or supporting policy contexts within which home visiting could grow and thrive will be highlighted. This is outlined under 3-time bands:

1. **The Emergence of parenting support:** The early development of home visiting against the odds between 1980 - 2000.
2. **Effective, outcomes-focused & evidence-based practice in parenting support:** The influence of Atlantic Philanthropies & the foundation of Tusla, the Child and Family Agency between 2000– 2014.
3. **Building infrastructures for quality, sustainability and scale:** The sustainability and scaling up challenges facing home visiting between 2015- 2023.

1. Early stages – 1980s- 2000. The Emergence of Parenting Support

The Irish health system was arranged under Health Boards in 1970, and these structures under the Department of Health were responsible for the health and welfare of children. At a regional level, Health Boards had a specific and sole focus on children in their communities from birth to school commencement. The Early Childhood Care and Education infrastructure was ad hoc, private or run by charities aside from a small number of Health Board preschools in areas of disadvantage.

Children, in their own right, were absent from the policy landscape. Parenting and family support were not a specific policy focus for the state in the 1980s and early 90s. This was partly due to contemporary culture, and at the statutory level, the state had limited intrusion into family life unless in extreme circumstances. Reviewing the policy landscape at the time Carmel Corrigan outlines, '*it could be argued that the traditionally large Irish family did not allow for considerable introspection on children's development by parents who, in the majority of cases, were primarily concerned with the physical well being of their children* (2002).' In other words, focusing on parenting advice, guidance, and support was not a consideration at a family or policy level.

As noted above, some initiatives, such as Health Board Pre-schools, were available to families. However, no support targeted parents specifically or addressed the home environment, and it was in this context in the 1980s that Ireland's first home-visiting programmes were developed.

1983 • **A pilot study of the Community Mothers Programme was carried out:** The Community Mothers Programme was a ground-up response to the disadvantage and marginalisation experienced due to the large-scale relocation of families from inner city Dublin to sprawling social housing estates. Its development in the areas of Finglas, Darndale, Clondalkin, Tallaght, Ballymun, Ringsend, Neilstown-Ballyfermot, and subsequently Loughlinstown, Ballinteer, Bray and Newbridge was in response to the presenting needs in these communities, experienced first-hand by the Public Health Nurses visiting families and frequently two or more generations of the same family. Developed by PHN Brenda Molloy, a regional support structure was put in place to provide low-level implementation support to the coordinators (Family Development Nurses) and the volunteer-led Home Visitors (Community Mothers).

1986 • **The Lifestart Growing Child Programme was developed** by a group of Derry-based educationalists and academics arising from the needs identified by a teacher, Dolores McGuiness. Dolores was a secondary school teacher who was concerned by the fact that many of her brightest students were not doing as well at school as might have been expected. Working with colleagues Dr Aine Downey and Dr Sean O'Connor at Magee College, Derry/Londonderry, they identified the impact of disadvantage, poverty, and parenting on child outcomes. They began to explore responses to mitigate these impacts.

1990 • **UN Convention on the Rights of the Child** was enacted in 1990

1990
- The **National Community Development Programme** was established in 1990. It represented the first variation of an area-based initiative followed by the **Local Development Programme led by local area Partnership Companies**, focusing on social inclusion and removing barriers to exclusion (Lee, 2003).

1993
- The first RCT of the **Community Mothers Programme** was peer-reviewed in the British Medical Journal (Johnson et al., 1993)

1996
- Ireland ratified the UN Convention on the Rights of the Child in 1996.
- **Community Mothers Programme RCT** – extension to the Traveller Community (Fitzpatrick et al., 1997)

1998
- **Strengthening Families for Life:** The changing nature of parenting and a recognition of the need for parenting and family support were first articulated in Strengthening Families for Life (Department of Social, Community and Family Affairs, 1998), arising from the work of the Commission on the family established in 1995. This saw a national plan to develop Family and Community Resource Centres and a more comprehensive range of national and regional policy recommendations.

2000
- Department of Health published the first **National Children's Strategy** (Department of Health and Children, 2000). This strategy outlined three goals, laying the foundation for the many initiatives and service developments that have subsequently occurred, including the increase in research in the lives of children(Growing up in Ireland) and prevention and early intervention. It also commenced a dialogue on quality service delivery for all children's services. It established the Office of the Ombudsman for Children and the National Children's Office. Regarding the protection of children, legislation spanned the start and end of the 1990s with the Child Care Act 1991 and the Children Act 2001.
- **Community Mothers Programme** 7-year follow-up RCT (Johnson Z. et al., 2000)
- By the end of 2000, there were approx.:
  * 19 locations providing the Community Mothers Programme (14 locations in the wider Dublin Eastern Region directly through the Public Health Nurse Service and 5 locations in Limerick, Clonmel, North Tipperary, Louth[18] and Athlone)
  * 21 Lifestart sites (3 in Dublin, 3 in Donegal, 2 in Derry and 11 in locations in Carlow, Drogheda, Kilkenny, Leitrim, Downpatrick, Limavady, Ards, Strabane, Offaly/Kildare, Sligo and Enniskillen and 2 aboard in North Macedonia and Zambia).

Child Poverty
- Child poverty was a primary concern for the UN and the Irish government in the 1990s, as 24% of children lived in consistent poverty in 1994 (Corrigan, 2002). By 2000, the percentage of children living in consistent poverty reduced significantly to 8%, but this didn't drop below 8% again until 2007 and 2008 (Watson, et al., 2012).

2. Evidence-based practice in parenting support: 2001 – 2013. The gradual establishment of a child and family support infrastructure and the influence of Atlantic Philanthropies

After 2000, there were significant changes to how children were seen in Irish society and a gradual, incremental change to the service delivery landscape.

2001
- **Rapid development of Childcare & commencement of City and County Childcare Committees** under the provision of European funding under the Equal Opportunity Childcare Programme - EOCP (2000-2006). EOCP also saw a rapid expansion of ECEC settings with capital development opportunities for community and private settings and staffing grants for community services. There had never been such an intensive period of

[18] We know there was a Community Mothers Programme being delivered in the North Eastern Region Health Board in Louth in 1999 but we have no record as to when this ceased operation (O'Connor, 2001).

scaling up ECEC services in Ireland with the creation of 40,000 childcare places.

- Additional infrastructures supporting children and families grew with the expansion of the Family Resource Centres and the establishment of the Family Support Agency in 2003.
- The Lifestart Foundation was established to support the development of the Lifestart Growing Child Programme and Home Visiting Service throughout the island of Ireland.

2003

- Replication and adaptation of the **Parent-Child + Programme in Ireland:** The National College of Ireland underwent development with a relocation from Ranelagh to new premises in Dublin Docklands. As part of the Dublin Docklands Authority brief to ensure growth and regeneration within the area, a broader initiative to support the local community commissioned a research project to establish community needs. Conducted by the Dartington Social Research Unit, the community research *'found that while local parents had high educational aspirations for their children, they were not confident that they had the skills to help their children achieve in school'* (Dartington Social Research Unit, 2006).

  In response to this, the Early Learning Initiative (ELI) was developed and a process of exploring what evidence-based responses would best meet the local community's needs. This identified the American-developed ParentChild+ Programme. A licence was secured from ELI to implement the Programme in Ireland and support the scaling of this Programme in an Irish context.

  A model of corporate giving and philanthropy played a significant role in the development mechanism for the replication of ParentChild+ in an Irish context and its subsequent scaling.

2004

- Pilot evaluation of the **Lifestart Growing Child Home Visiting Programme**, funded by Atlantic Philanthropies by Queens University, with positive outcomes.

2005

- Establishment of the **Health Services Executive (HSE),** marking the ending of the regionalised Health Boards.
- Establishment of the **Office of the Minister for Children** within the Department of Health.

2006

- **Growing Up in Ireland**, longitudinal research commences, tracking the lives of 18,000 children (one cohort born in 1998 and a second cohort of infants born in 2008).

2007

- **Agenda for Children's Services** laid the foundations for many structures we are now familiar with, such as the Children's Services Committees[19] piloted in 2007.
- **Atlantic Philanthropies** invested in the **Prevention and Early Intervention Programme (PEIP)** in 2007. This saw significant investment in three areas of disadvantage in Dublin, one of which was the Preparing for Life home visiting Programme.

  Commencement of Preparing for Life: As with the origins of Lifestart, Preparing for Life emerged due to concerns for the educational outcomes of children growing up in an area of significant disadvantage in the Darndale-Bellcamp area of North Dublin City. The development mechanism of Preparing for Life will be addressed in more detail. However, the strategic opportunity presented by the presence of Atlantic Philanthropy had a significant role in supporting an interagency consortium to pursue a solution to address the grassroots needs identified. It enabled the commissioning of the Geary Institute to support and evaluate the home visiting programme comprehensively.

2008

- **Lifestart commissioned an RCT**, which commenced in 2008, funded by Atlantic Philanthropies. This significant philanthropic support contributed directly to establishing the solid evidence base of the Lifestart Programme and influenced the landscape of the early childhood home visiting sector. A logic model outlining the theory of change resulting from the Lifestart Growing Child Home Visiting Programme was developed to

[19] Now called Children and Young People's Services Committees

be tested during the RCT.

- 3 Lifestart Programmes also closed in response to the financial crisis in Downpatrick, Offaly/Kildare and Derry.
- The financial crisis had an impact on ParentChild+ also. Original philanthropic donors were unable to continue funding the Programme. As a result, a fundraising strategy was developed, and the Early Learning Initiative employed a development officer to support fundraising to enable the ongoing growth of ParentChild+ across Ireland.
- The **Centre for Effective Services**, established in 2008, focused on developing an evidence-informed approach to policy and practice with those working with children, families and communities.

2009
- Scaling of ParentChild+ through a partnership with Dublin Southside Partnership delivering the Programme in Dublin 6, 8 and 12 funded through philanthropy and supported through the Partnership infrastructure.

2011
- The momentum building during this decade resulted in the establishment of the **Department of Children and Youth Affairs (DCYA)** in 2011. The creation of a Department with a sole focus on Children was significant.
- A funding initiative, the **National Early Years Access Initiative (2011 – 2014),** saw a consortium of philanthropic organisations and the DCYA came together to fund 11 Projects specifically targeting children aged 0-6 years.
  This funding played a significant role in indirectly supporting the National Programme Structure for ParentChild+. This initiative helped the 'parent' organisation, the Early Learning Initiative and enabled cost consolidation to provide a secure structure to support the development of ParentChild+.
- Commencement of Lifestart Services Limited (LSL) – Due to the cessation of funding from the HSE, 3 Lifestart projects in Donegal were developed to form a regional Lifestart county-wide project in Donegal.

2012
- The Community Mothers Programme was listed under the **European Platform for Investing in Children (EPIC)** as a promising evidence-based programme. However, it was beginning to show signs of risks to sustainability within the HSE. The HSE did not replace some Coordinator Public Health Nurses who had retired. Programmes continued with experienced and senior home visitors taking on a Coordinating role.

2013
- Lifestart Foundation supported local organisations to become established in their own right as service delivery agents, or those in existing organizations now sought a licence to deliver Lifestart. In response, Lifestart Foundation established a social franchise approach to licensing, licencing and training organisations and their staff to provide the programme to a high-quality standard.
- By the end of 2013, there were:
  * 17 Community Mothers Programmes across the country [11 were in the former Dublin Eastern region and also in Clonmel, Limerick, Kerry, North-Tipperary, Westmeath-Longford[20], Laois-Offaly Parents First[21]]
  * 12 Lifestart Programmes in Ireland (Dublin, Donegal, Carlow, Kilkenny, Drogheda, Leitrim, Limavady, Ards, Strabane, Sligo, Enniskillen and Derry).
  * 1 Preparing for Life Programme
  * 2 ParentChild+ Programmes delivering to catchment areas within Dublin East Inner City and Dublin City South Side

Child Poverty
- Like many other countries, Ireland experienced a financial crash during this time. Child poverty rates had begun to drop to as low as 6% in 2008, just before the impact of the

[20] In 2008, the Longford Westmeath Community Mothers Programme commenced, and Athlone Community Mothers Programme merged under the governance and management of Westmeath Community Development Company.
[21] While not an original Community Mothers Programme but a Home-Start model, Parents First has been participating under the 2019 Community Mothers Programme Review at the request of Tusla and so has been listed here in that capacity.

financial crash could be ascertained. By the end of the decade, 8% of children lived in consistent poverty, with Irish children 1.6 times more likely to be in consistent poverty than adults. However, by 2013, 11.7% of children lived in consistent poverty. Ireland's challenge to address child poverty through infrastructural change over the previous decade was highlighted in 2014 with the launch of the EU country-specific report under Investing in Children – Breaking the Cycle of Disadvantage (Daly, 2014).

3. Sustainability and scaling up challenges: 2014- 2023. Building infrastructures for sustainability and scale.

In terms of the national policy context, never before have the conditions supported developing and scaling up home-visiting programmes in Ireland. Yet, there is still a considerable journey to ensure that Programmes can be successfully implemented to scale.

2014

- The establishment of **Tusla, the Child and Family Agency.** This represented a significant development for children as the child welfare and family support functions previously governed by the HSE were now extracted to this new statutory agency.
  The establishment of Tusla had an impact on home visiting programmes for both Lifestart and the Community Mothers. Previously, funding provided through the HSE was in line with the universal nature of HSE services such as Public Health Nursing. While home-visiting programmes were delivered to those families with a wide range of needs, the universal nature of their approach was recognised. Over time, with funding changes, home visiting programmes came under increased pressure to respond to families at levels 2 and 3 of the Hardiker model rather than at a universal level.
  For those Community Mothers Programmes in the former Eastern Health Board region, the establishment of Tusla created additional challenges, marking the end of these specific Programmes (see below for exact dates). Funding for the Programme in the former Eastern Health Board areas was split between Tusla and the HSE, and an article in the Irish Times (2014) cautioned against the demise of the Programme in the wider Dublin region. Those Community Mothers Programmes in the rest of the country, while impacted by having their funding move to Tusla, continued and became more engaged in the new local infrastructures being established, such as the expansion of the Children and Young People's Services Committees in 2014.
  Similar challenges were noted by Lifestart services, which, along with the Community Mothers Programme, had to respond to this change in funding source.
- **Better Outcomes Brighter Futures,** Ireland's first National Policy Framework for Children and Young People, was published (DCYA, 2014).

2015

- Building on the learning from the NEYAI and extending the Prevention and Early Intervention Programme, the DCYA and Atlantic Philanthropies contributed to establishing the **Area Based Childhood Programme** in 2013, which expanded to include 13 Projects across Ireland in 2015.
  * Commencement of 0-2 ABC Programme under the ABC Programme initiative in the Dublin Docklands area, modelled on the Community Mothers Programme with input from the Family Development Nurse who had been involved in the Ringsend HSE Community Mothers Programme, which was one of 11 sites closed between 2013-2017
  * Scaling of Preparing for Life to Bray and Finglas under the ABC Programme with continued implementation and ongoing longitudinal research in the original Darndale site. Bray previously had a Community Mothers Programme site, which had ceased operation. Finglas continued to operate a Community Mothers Programme site, which over time was amalgamated under Finglas Preparing for Life.
  * Scaling of ParentChild+ in Clondalkin-Dublin, Louth, Grangegorman-Dublin, and Ballyfermot-Dublin through the ABC Programme initiatives in these areas.

- **Infant Mental Health Home Visiting Programme** commenced as part of an ABC Programme called Let's Grow Together (previously Young Knocknaheany).
- Tusla established **Meitheal, Child and Family Support Networks, Prevention Partnership and Family Support.**
- Department of Children and Youth Affairs published a **High-level policy statement on Parenting Support**, which outlines cross-departmental responsibility for parenting and outlines the considerable role of the HSE in supporting parenting alongside Tusla (Department of Children and Youth Affairs, 2015).
- Atlantic Philanthropies funded the **Nurture Programme**[22] through the Katharine Howard Foundation to advance child health within the HSE.
- Gradual closure of 9 Community Mothers Programme in the Dublin-Eastern region between 2013 and 2015. Only 2 Dublin PHN-led Programmes remain in Finglas and Loughlinstown.

2016
- Parenting Support Champions commenced in 2016 with home visiting programmes, such as Lifestart Donegal and Community Mothers Programme in some areas.

2017
- **A review of the Community Mothers Programme** commenced commissioned by the Katharine Howard Foundation and the Community Foundation for Ireland in response to several Community Mothers Programme Sites closures and concerns regarding the sustainability of the remaining sites across the country. This review was carried out in partnership with Tusla and the HSE, who nominated representatives to a project oversight group.

2018
- Department of Children and Youth Affairs publish Ireland's first early years strategy - **First 5, A Whole of Government Strategy supporting Babies, Young Children and their Families** (Department of Children and Youth Affairs, 2018). First 5 outlines a range of strategic commitments to children and families, specifically bringing together broader policies around parental leave and employment conditions for parents and committing to building the infrastructures to support children's services. For the first time, infant and early childhood mental health is referenced along with a recognition of parental and maternal mental health supports as being essential to support. Significantly it is the first time home visiting is recognised as an effective service delivery strategy for young children and their families. All the home visiting Programmes in Ireland are referenced in the strategy along with a commitment to develop a 'national approach to home visiting'.
- Incorporating the ABC Programme into Tusla as part of the PPFS structure marked a significant change for PFL and the 0-2 ELI Programme. This resulted in a degree of sustainability but also observed substantial differences in reporting under a Service Level Agreement (SLA) with Tusla. This development resulted in 4 out of all 5 home visiting programmes receiving core funding through SLA with local Tusla PPFS regional offices.

2019
- Launch of **'What Works'**, an initiative of the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) to support evidence-informed prevention and early intervention services for children, young people and their families.
- **Sláintecare Integration Funding** supporting the commencement of the **Community Mothers Programme Development Project**
- **Parenting Support Policy Unit** is established in the DCEDIY.

2021
- The establishment of the **Home Visiting Alliance**

2022
- **A national model of Parenting Support** is published by the Department of Children, Equality, Disability, Integration and Youth (2022)
- **Parenting Support Strategy** 2022 – 2027, Tusla (2022)
- What Works Fund the scaling of Preparing for Life home visiting in 4 new local implementation sites in 2023, and pre-development work commences in 2022. This is

[22] This became the HSE National Healthy Childhood Programme

the first national funding which commits to bringing an existing home visiting programme to scale in a planned and strategic way.

- DCEDIY commissioned the UNITES Project Maynooth University to undertake a **National Review of Home Visiting** under the First 5 action – To develop a national approach to home visiting.
- DCEDIY announced the development of the '**What Works Ireland Evidence Hub of prevention and early intervention programmes'** and called for submissions to the Early Intervention Foundation. (Department of Children, Equality, Disability, Integration, and Youth, 2023)
- **Ireland's EU Child Guarantee National Action Plan** (DCEDIY, 2022)
- Announcement of the **Child Poverty and Well-being Programme Office at the Department of the Taoiseach** to provide a whole-of-government response to the many issues facing children

Child Poverty

- Child poverty remained a primary concern throughout this decade. The progressive impact of the recession on consistent poverty rates for children saw them peak in 2013 at 11.7%, and they were slow to reduce, remaining at close to 11% in 2016. By 2017/2018, consistent poverty rates for children reduced to 8.8/7.7% and the child poverty rate was similar to that in 2000.

3.2. Current status of Irish home visiting

Delivery

Members of the Home Visiting Alliance currently deliver **5 different home-visiting programmes.** Figure 8 outlines a map of all the locations within Ireland and Northern Ireland, and Appendix 2 outlines the delivery mechanism of each programme in detail.

- Three of the five programmes have a National Programme Support Structure within Ireland – Lifestart, Preparing for Life and Parent-Child + (Irish partner)
- One Programme is an Irish replication site and accesses support from the US – Infant Mental Health Home Visiting Programme, Let's Grow Together
- One Programme doesn't have a National Programme Support Structure. However, under the Community Mothers Programme Development Project, the newly proposed Community Families has a HSE and Tusla-governed National Support Structure.

There are now **40 Local Programme Sites** across Ireland under the governance and management of various community and voluntary organisations.

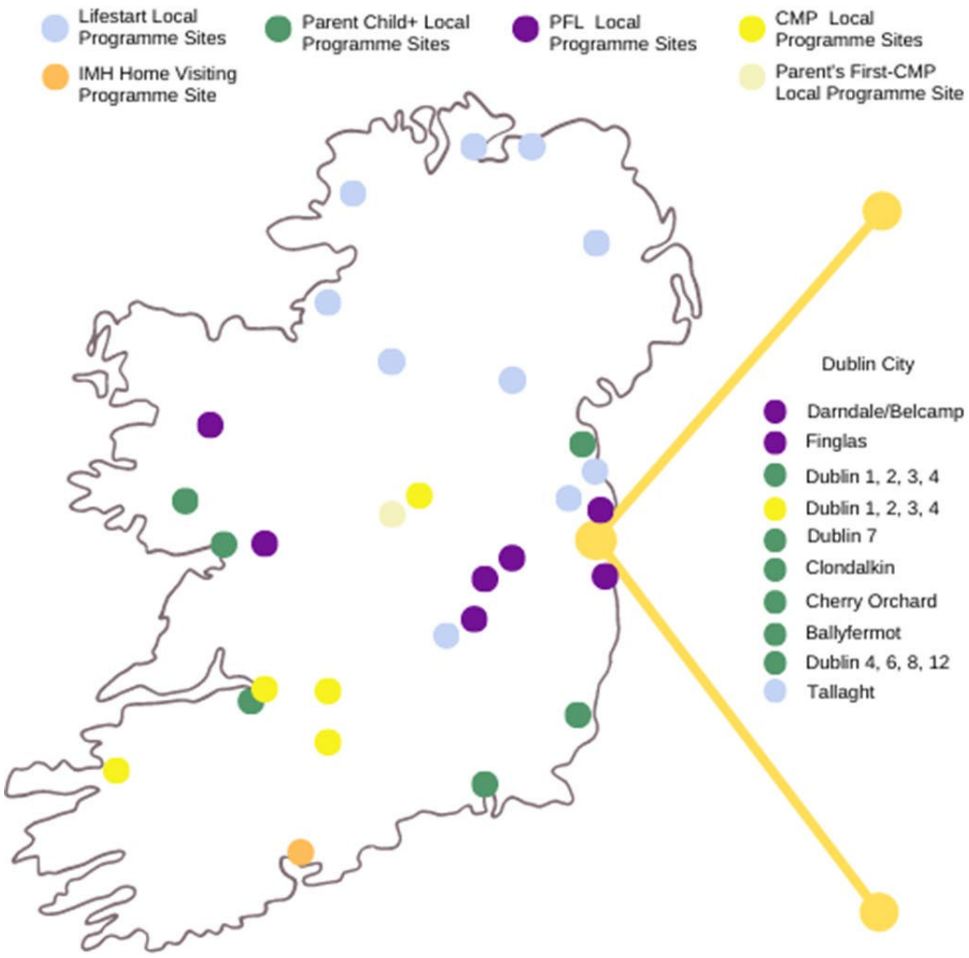

Figure 8 Map outlining evidence-based ECVH in Ireland – 40 existing Local Programme Sites (4 in NI) by Programme

Reach of Home Visiting Programmes

Population: A detailed breakdown of Ireland's population by age has not yet been released by the Central Statistics Office (CSO) from the 2021 Census. However, statistical analysis by the CSO presented a predicated population by age, which combined with an average birth estimate per year to include that avail of home visiting when pregnant is 380,765.

Home visiting programmes in Ireland currently visit 4190 children, or **1% of the total population, from pregnancy to 5.**

Geographic spread: As per Figure 8, there is a geographic spread of Programmes across the country. This is, however, misleading. The staffing level within Local Programme Sites is relatively small and limits the programmes' core element – home visiting. By its very nature, home visiting can be difficult to coordinate at a geographic scale with small staff numbers, given the travel implications.

Many programmes have poorly defined catchment areas as they respond to local referrals and funders' needs and frequently stretch themselves too thinly across multiple geographic regions.

Access: Programme reach is only as good as the programme's accessibility. Again, this can be limited on many fronts. Firstly, the limited local capacity to respond to universal need means that Programmes frequently don't advertise – they fear increasing a demand that cannot be met. This limits the number of families aware of the Programme and, thus, who present themselves or self-refer to access the Programme.

Most families are referred, with the highest percentage of families referred by the Public Health Nurse. If access to the service depends on referral, then most possible referrers must be aware of the Programme. This can be challenging as small local implementation sites must constantly update staff within the Public Health Nurse Service, Tusla Child Protection Social Workers, staff at Maternity Hospitals and all other local referral sources. Staff turnover can be high in many sectors, and informing and updating staff regarding the Programme can take time away from direct delivery.

On average, 3758 families are estimated to benefit from home visiting programmes in one year. Of these, we estimate 82% were referrals. As with the consistent theme of data collection, it is hard to confidently stand over exact figures given that many local sites do not have a robust electronic mechanism to gather this data.

Home visitor training, qualifications and professional development

Over 169 individuals are employed as Home Visitors in full-time (25) and part-time (144) positions throughout the five Irish home visiting programmes. One programme, Infant Mental Health Home Visiting Programme, employs Home Visitors with varying multidisciplinary professional backgrounds, including Nursing and Speech and Language Therapy. While other home visiting programmes don’t specify a professional background, they request a graduate qualification in an aligned area (Lifestart and Preparing for Life). ParentChild+ and the Community Mothers Programme initially didn’t specify a required qualification, but recruitment practices have evolved, and a minimum QQI level 5 in an aligned area is now required as part of their recruitment process.

Home visitors are supported at a local level by Coordinators. Programmes report approx. 44 in a Coordinator or senior support role locally. While for many, this is a singularly focused role and the Coordinator may also take on a small caseload or manage more complex interagency elements, in other settings, the Coordinator is wearing multiple hats within their existing organisation and may also oversee other projects. There is still one remaining HSE Community Mothers Programme; in this scenario, the Coordinator is a Public Health Nurse.

Pre-recruitment qualifications: Appendix 2 outlines the different pre-recruitment qualifications required by ECHV Programmes.

No Programme requires a specific professional background or qualification for recruitment. In this context, professional refers to those who have trained, received qualifications and are registered with a professional body to practice, for example, Nursing, Social Work, Speech and Language Therapy.

However, 3 of the 5 Programmes require a graduate qualification in an aligned profession such as Social Care, Early Childhood Care and Education, Community Development or any of the professional qualifications listed above.

Programme Training:

- **Pre-recruitment Programme Training**

Only one Programme, Parent Child +, outlines a requirement for 5 hours of pre-recruitment training.

- **Initial Home Visitor Programme Training**

All Programmes have an internal Programme Training approach for those implementing the Programme locally. Programmes don't differentiate this training between local Coordinators and local Home Visitors aside from an expectation that Coordinators would have more extensive external training to supervise Home Visitors.

The Community Mothers Programme devolved this training to a local level as Family Development Nurses delivered training when new home visitors were recruited. This has been reviewed under the Community Mothers Programme Development Project, where a revised and centrally developed training model and a mechanism for consistent delivery have been recently finalised and are being piloted in 2023.

Lifestart, Parent Child + and Preparing for Life provide training from the National Programme Support Structure(NPSS). This enables consistency of training but requires considerable time and resources to develop a 'national programme training function'.

The need for training newly recruited Home Visitors is variable annually. Given the low level of staff turnover, the infrequency of changes to local-level funding with Programmes having a static level of staffing and the absence of new developments at a local level results in demand for training for only a small number of Home Visitors in an ad hoc way. Training usually takes place over several sessions ranging from two to five days.

Training requires review, updating and evaluation, again placing demands on the NPSS.

- **Ongoing Professional Training and Development**

All Programmes require Home Visitors to be supported through supervision at a local level. If local support and supervision structures are unavailable, NPSS can provide this professional and programme development level.

All Programmes provide a mechanism for Local Programme Sites to come together at a minimum once a year, with one Programme requiring Sites to come together three times a year. This enables Programme updates, a review of Programme consistency, provides additional training, and, in one case, it is used for case reviews.

Finally, all Programmes outline a range of aligned additional training which supports Home Visitor development. If funding opportunities allow, this training can be provided through the NPSS. However, given the limited resource capacity, such training is ad hoc, and Local Programme Sites are encouraged to pursue

all funding pathways to enhance professional practice. More recently, with the development of the HVA, a range of training opportunities have evolved and are collectively planned and delivered through the HVA executive seeking to respond to the needs and requests of home-visiting practitioners. External training may include training in the following:

- child development
- working with children with disabilities and their families
- supporting families from different ethnic or cultural backgrounds
- trauma-informed practice,
- infant mental health
- domestic violence and
- a range of parenting programmes, e.g., Circle of Security Parenting®.
- All Programmes require Home Visitors to have external training in Child Protection, Data Protection under GDPR and best practice for health and safety and lone working in the community. Generally, this is not delivered through NPSS but is overseen and provided by local governance structures with direct employment responsibility for Home Visitors. It must satisfy local SLAs with its funding agencies.

ICT and data

The literature review identified the significant role of data in implementing and scaling home visiting programmes. Data is crucial to demonstrate:

- programme fidelity
- inform ongoing programme learning and innovation, including how responsive the programme is to the needs of children, parents/families and communities
- demonstrate outputs for commissioners and policymakers
- and to continue to gather evidence of outcomes on an ongoing basis outside the narrow windows when external RCT/QED evaluations occur.

ICT/Data management systems are often called CRM or Customer/Client Relationship Management. They are generally systemic ways to record data on the families availing of the Programme in an electronic format, enabling analysis and anonymised data sharing of Programme outputs and outcomes.

At a local level, funding is not generally itemised within Service Level Agreements (SLAs) but is provided to deliver a local service or programme to a set number of children and families living in a defined catchment area. HVA members note that this funding has not increased with inflation. Local Programme sites have never been funded to develop an ICT/data management system.

While some Programme Sites still operate paper-based records, most input data from paper to Excel Spreadsheets and other electronic databases. However, this is time-consuming, inefficient, and doesn't allow for the range of analysis a CRM system affords. HVA members estimate that approx. 15% of Local Programme Sites have their own ICT/CRM system, and none received dedicated funding from commissioners to develop this. Instead, Sites sourced once-off funding or, in some cases, corporate donations. Some areas are developing, such as Lifestart Services Limited in Donegal. The Community Mothers Programmes are working collectively and are funded by the Katharine Howard Foundation and the Community Foundation for Ireland.

Such systems generally require an upfront investment and ongoing costs to grow and refine systems aligned with the needs of commissioners and the local governing organisation.

NPSSs collect, analyse and report on data collected at a local level. This is essential to review the Programme at a national level, review outcomes, monitor unanticipated changes and identify the need for additional research or developments.

While all three NPSSs have their own CRM systems,[23] these were not designed to enable communication and streamlining with local-level data. This is a funding and resource issue for NPSSs.

Securing the original or Irish evidence base and ongoing research in replication and scaling

Four of the five home visiting programmes secured philanthropic or once-off-state grants to commission evaluations to contribute to their evidence base.

Programme	Source of funding for evaluation
Community Mothers Programme	Bernard Van Leer Foundation and Eastern Health Board. It is unclear how much of the original philanthropy grant went towards the cost of the primary, follow-up and extension to the Traveller community RCTs.
Lifestart	EU Social Funding supported the original pilot study Atlantic Philanthropies – funded a pilot and an RCT. Big Lottery Funded Evaluation of TinyStart, a collaborative project with Tinylife whereby Queens University evaluated the delivery of the Lifestart Programme and Home Visiting Service.
Preparing for Life	Atlantic Philanthropies – funded preliminary research, RCT and follow-up RCT
Parent Child +	Dormant Accounts – funded baseline evaluation following replication in Ireland

There were insufficient records to identify the costs for the Community Mothers Programme's primary research. However, the cost of evaluating the other three programmes was estimated to be €2,300,000.

No NPSS has received funding to evidence replication of programmes to another site location. Equally, no Programme initially developed in the US has received sufficient funding to carry out an RCT or QED to replicate this Programme in an Irish context. Given the cost of RCTs/QEDs, it is unlikely such funding will become available and certainly not on an ongoing basis to enable programmes to test any changes to the delivery model, etc.

This was the case for the Community Mothers Programme. It had secured its evidence base for a model developed in the 1980s. The original model's materials and service delivery mechanism became outdated and subsequently underwent repeated changes, in particular, a move away from volunteer delivery to paid employed home visitors. While the Programme is frequently referenced in systematic reviews given the 3 peer-reviewed RCTs, the tools used to measure causality are not in keeping with contemporary practice, and there has been no subsequent funding to carry out an RCT on the adapated model.

Some would argue that in the former Eastern Health Board area, where the original model was adhered to with fidelity without adaptation, having an evidence base placed constraints on Programme evolution and innovation, resulting in a Programme that commissioning stakeholders saw as being 'out of date'. This is a risk for all the programmes outlined in this document and those with a more current evidence base – how do they ensure it doesn't constrain innovation, responses to new and evolving science at a macro level and the needs and wants of both parents and commissioners?

[23] Two are currently undergoing or exploring review and upgrading of these systems

To date, no Irish home visiting programme has secured funding to evaluate replication and implementation at scale in an Irish context.

Preparing for Life is currently partnering with the Center for the Economics of Human Development at the University of Chicago to implement PFL in the Southside of Chicago led by Professor James Heckman PFL. CEHD is working with Casa Central, a large community service organisation serving a predominantly Latino population, to translate and adapt the PFL programme for use by a Spanish-speaking US population. PFL will also provide ongoing support and supervision to the Casa Central team. CEHD will conduct a longitudinal RCT throughout the implementation process to evaluate the programme in a US environment. The project is funded through a very significant philanthropic donation to the CEHD.

Monitoring quality, fidelity and evidence base

The 3 existing NPSSs provide 'technical support' on a structured and informal process. These National Programme Support Structures receive no funding to provide this support, which will be addressed further.

Lifestart ensures that all home visitors receive support from the National Programme Office and observe and provide feedback by attending a home visit annually. Bringing together all home visitors and local coordinators/managers annually ensures quality and fidelity monitoring.

PFL has established a formal schedule of support, supervision and fidelity support based on the PFL model of strengths-based coaching and mentoring. Home Visitors participate in Peer Support Case Review Sessions three times per year. Supervisors and Managers are also invited to participate in Action Learning Sessions twice yearly. Some sites also contract with PFL for individual support and supervision for Home Visitors depending on local resources.

ParentChild+ provides a range of virtual supports through Sharepoint, offers technical support from the Specialist Coordinator, and visits local sites regularly. Fidelity is also supported through regular training and professional development support – Appendix 2 provides greater detail.

The Community Mothers Programme is in the process of transitioning to a new Community Families model. The mechanism to monitor quality and fidelity and re-establish a contemporary evidence base is developing.

In terms of monitoring the evidence base, this is frequently beyond the capacity of National Programme Units to do so at a robust or external level. Two Programmes have the support of a part-time research assistant to collate internal data to monitor effectiveness and outcomes across all Programme sites.

Scaling up – replication, implementation & supporting multiple local site implementation

The overview of the history of the Programmes outlines the key moments where replication and implementation in new locations occurred.

Today, NPSSs respond within their capacity to requests from local organisations wishing to establish a new Programme site.

NPSSs operate differently regarding their approach to supporting local Sites. Some utilise the tools of *Implementation Science* promoting local organisations to assess *'Programme Fit'*. However, this is challenging in a local context where there can be competition for local funding and challenges in strategically assessing gaps in service provision and commissioners' local priorities.

In many cases, NPSSs work directly with local organisations to assess their capacity to implement a home visiting programme and secure sustainable funding. Capacity building has a considerable role and function and could result in no local implementation.

As outlined above, the steps in adapting local administrative and organisational changes to accommodate a new programme are supported, training of Home Visitors and Coordinators takes place and the manuals, guiding materials and resources are provided.

Technical support is more intensive during the initial implementation phase as local Programme sites commence service delivery.

The challenges in providing this level of support are considerable for NPSSs.

Implementation Funding – Local Programme Sites

It isn't easy to accurately reflect Local Programme Site implementation costs across a range of different Programmes. Local Programme Site costs for implementation are not adequately funded as sites seek to manage these within set funding arrangements with commissioners or through small grant applications.

As such, it was only possible to reflect the total funding received by Local Programme Sites, estimated to be €4,257,416 for 4 of the 5 Programmes.[24]

As expected, costs per child will vary across home-visiting programmes, given programme variation. They are influenced by duration and frequency of intervention, qualifications of Home Visitors and Coordinators, level of in-programme training delivered, level of support, mentoring and technical support provided by National Programme Support Structures, etc.

National Programme Support Structures (NPSSs)

Today, the role of NPSSs are:

1. Governance, development, review and update of the Programme.
2. Responsible for securing and maintaining the evidence-based Programme. However, National Programme Support Structures are limited in their capacity to do this without funding.
3. Supporting interest, Local Programme Sites explore whether the Programme fits them and their community.
4. Supporting local programme sites in readiness to implement / capacity building of Local Programme Sites, including sustainability assessments.
5. Support implementation including :
    a. awareness raising at national and local levels
    b. organisational change to implement the programme and establishment of new systems of working, including using materials/resources/outcome measures
    c. programme training
    d. professional development
    e. ongoing technical and implementation support
    f. support with sustainability and presenting the business case for securing funding
    g. data gathering and internal programme reviews

Staffing the National Implementation Support Structure has been challenging, with all Programmes reporting insufficient staffing levels to deliver the above function adequately. In many cases, staff have a dual role in supporting the implementation in a local site while supporting the National Support Structure tasks. Two Programmes have access to a Research Assistant on a part-time basis. Those Programmes with a National Support Structure have a National Role with a primary function of supporting Implementation full-time with part-time support, as noted above.

[24] Given the integrated nature of service delivery in Let's Grow Together! it was not possible to accurately extract home visiting programme costs in isolation. While this may be possible it would take some time and new financial processes beyond the scope of this project.

3.3. Stakeholder Consultation

A hybrid consultation session was held on the 24th of April at the National College of Ireland with 34 stakeholders in attendance. Following an initial presentation of study findings, there was an opportunity for questions and feedback followed by smaller group discussions answering the following questions:

1. Initial thoughts on presentation – its ability to respond to the needs of children and families across health, welfare and education in an integrated way?
2. What changes, if any, would you make?
3. How can this be achieved, and who needs to help?

While multiple themes were identified through this consultation, they can be summarised under the following broad points:

1. Is Early Childhood Home Visiting a programme or a service, or both?
2. Clarity around the unique role of home visiting and Home Visitors within the current service landscape.
3. Alignment with a range of National Programmes, including the HSE's Women and Infants Programme and National Healthy Childhood Programme, Tusla's Prevention, Partnership and Family Support, ABC Programme and Child Protection Services with specific reference to alignment with the role and function of the Public Health Nurse were central points raised.
4. There was a perspective that other funded roles could incorporate Home Visiting as a tool by adopting particular Programmes.
5. The absence of any dedicated Home Visiting funding lines was strongly articulated. This includes the lack of qualification infrastructure or sustainable remuneration, including pay and employment entitlements (pensions/ paid maternity leave, etc.), with some staff on hourly contracts.
6. Rationalising the need for Early Childhood Home Visiting Infrastructures when there is ongoing pressure to direct funding to delivery instead of national structures. The question of articulating this for a sector with no funded infrastructures was raised. Furthermore, there is a need to argue for advances for the sector to be seen as a service in its own right rather than an 'add-on' programme.
7. Growing evidence for a multitude of needs – the rationale for multiple programmes.
8. How to develop and articulate a 10-year vision for Early Childhood Home Visiting when starting from an unsustainable position – managing growth and scalability expectations when service provision is at risk of closure.

Consultation finding 1: Early childhood home visiting is a service provision not recognised within the range of Irish service delivery offerings. There is a range of different home visiting approaches described as programmes. A home visiting service may deliver one or more programmes.

A Programme or, a Service or Both

During the consultation, some approached home visiting from a programmatic perspective. In this regard, it was seen that if it is a Programme, others already working with children and families could be trained to deliver the programme. This is understandable given the current position of home visiting programmes in Ireland.

However, many organisations delivering these Programmes do not do so in isolation. This is apparent given the importance of integrated working with other services as a Programme feature.

All organisations providing Home Visiting Programmes :

- ✓ participate in the range of local interagency networks
- ✓ they work with families for 2-5 years and are not working in isolation

- ✓ they respond to presenting needs even if they are beyond their scope by advocating or signposting families to the correct service
- ✓ they participate in and sometimes initiate or lead Meitheal[25] Meetings
- ✓ actively participate in Tusla Child Plans, including Child Protection Plans, Family Support Plans or Welfare Plans – in this way, they work collaboratively with Family Support and Tusla to provide an intensive but coordinated layer of support for the family, with each professional operating within their boundaries.

Not all Home Visitors will participate at the level outlined above, and this is frequently the role of the Home Visiting Coordinator or more experienced Home Visitors.

Organisations offering Early Childhood Home Visiting Services may choose to provide one or more Programmes. For example, ELI delivers both ParentChild+ and the 0-2 Programme.

The programmatic element must be delivered with fidelity and outlines programmatic standards such as duration of engagement, frequency of home visits, built-in flexibility, duration of visits, content addressed during visits, outcome measurements and data collection processes.

The organisation or 'service' which delivers these Programmes then provides the additional support provisions which embed these Programmes into the local service delivery landscape.

The duration of home visiting programmes and how they are embedded in local service delivery landscapes result in the creation of 'home visiting services'.

This sets home visiting programmes apart from other parenting programmes. Traditional parenting programmes have limited engagement time with a parent, engagement with only parents and not the whole family, and they are often delivered in isolation from an integrated way of working.

In summary, home visiting programmes, by their very design, present more like a service than a programme. However, this is consolidated by the integrated way in which they are implemented by local service delivery organisations creating home visiting services.

Consultation finding 2: There is a lack of clarity about the role and function of Early Childhood Home Visiting

As noted, Home Visiting Programmes are 'more than' an isolated programme delivery model. In line with this, Home Visiting has a unique role that no other professional has. Although there are overlaps with functions such as those of Family Support Workers or Public Health Nurses, these functions are not duplicated.

Home visiting straddles the child health and child welfare space but is uniquely different in function, delivery mechanism and role to others operating in this space.

1. Function: Home visiting has a unique role, as outlined below in Figure 9.

[25] *Meitheal is used in partnership with parents to help them share their own knowledge, expertise, and concerns about their child and to hear the views of practitioners working with them. The ultimate goal is to enable parents and practitioners to work together to improve the child's life. The Meitheal Process refers to the formal, centrally coordinated process for ensuring that strengths, needs, and desired outcomes are identified and, where necessary, support is planned, delivered, and reviewed in order to meet the identified need, capitalise on the identified strengths, and achieve the desired outcomes* (Tusla, 2022)

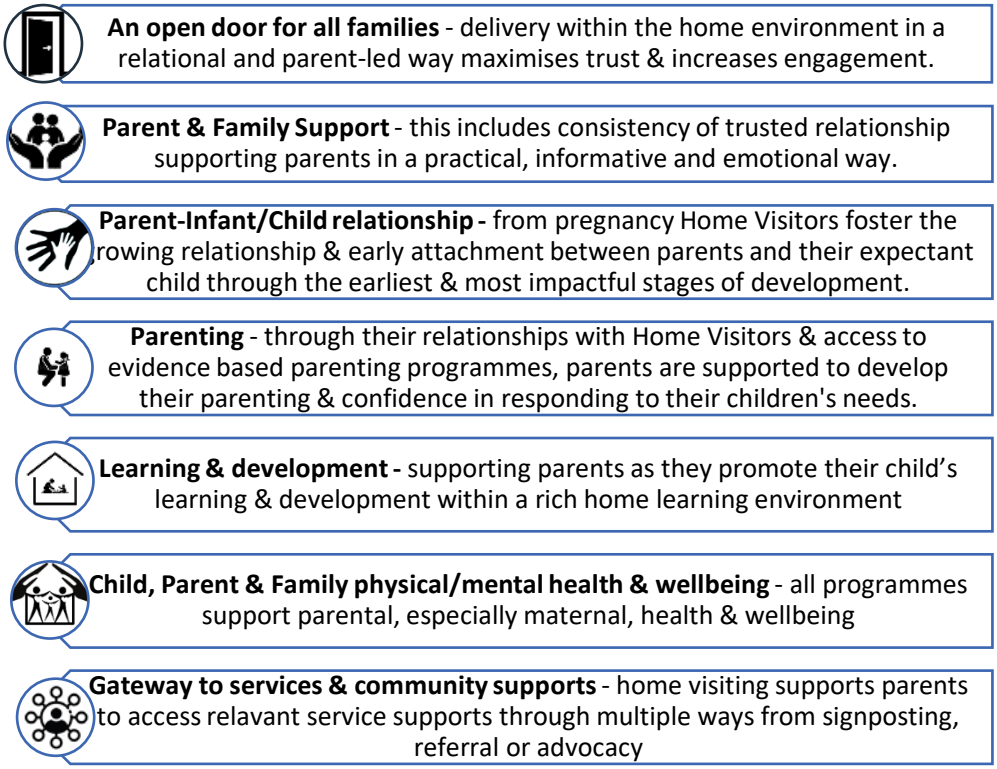

Figure 9 The unique function of Home Visiting

2. The unique delivery mechanism: Unlike other services or programmes, home visiting supports an enduring relationship with families.
    a. Most programmes are delivered for 4-5 years, with a small number provided for shorter 2-year periods.
    b. Programmes visit consistently. This can be monthly for some, and it can be weekly (or biweekly), tapering to monthly.
    c. Some programmes have the flexibility to increase visits in line with needs.
    d. All programmes enable contact with their home visitor beyond the direct visit with home visitors supporting families via text or video calls and engaging families in group work or other community activities, e.g. buggy walks.

    No other service provides the intensity of visits to a family at this unique stage of a child's and a family's development. This delivery mechanism, along with the special role (Figure 9), makes the *'invisible, visible*' – in other words, there is time and space for each family's needs to be explored and identified.

3. The unique role of Home Visitors: While not a recognised profession in terms of an absence of specific home visitor qualifications, professional registration bodies and oversight, Home Visitors deliver a professional service to all families, holding the core professional standards of all working in family support way with families. In this way, there are similarities in terms of the following:
    a. Confidentiality within limits of child and adult safeguarding and data protection
    b. Consistency of engagement with families – same time, same duration, same place with clear and consistent communication
    c. Clear boundaries and explicitly clarify what is and isn't part of their role.
    d. Lines of supervision and support from their Coordinator
    e. Strong and confident practice in child safeguarding, interagency working and participation in all interagency teamwork and service level plans for a child.

In addition to the above core professional standards of practice, which are similar to other roles, Home Visitors work in a unique partnership way which involves:

a. Non-judgemental engagement with parents
b. Respect and a focus on supporting a parent to gain confidence and grow in their role is empowering.
c. They are parent-led and value the parent as the expert in their child and family context.
d. Constantly balancing the parent's needs whilst always keeping the infant/child in mind throughout all interactions.
e. Most home-visiting approaches incorporate best practice in Infant and Early Childhood Mental Health (IECMH), addressing the whole family's needs, providing concrete and emotional support, and advocating for the child, parent and family.
f. They have unique skills in supporting engagement for all families, especially those less likely to engage in universal or statutory services and prioritise establishing trusted relationships with parents.

In this way, home visiting services operate across several Irish service delivery priorities, as Figure 10 below represents. However, the primary funding comes only from Tusla under Prevention, Partnership and Family Support. Again, this makes home visiting uniquely different from other service provisions, given the range of parent and child outcomes and the breadth of age ranges.

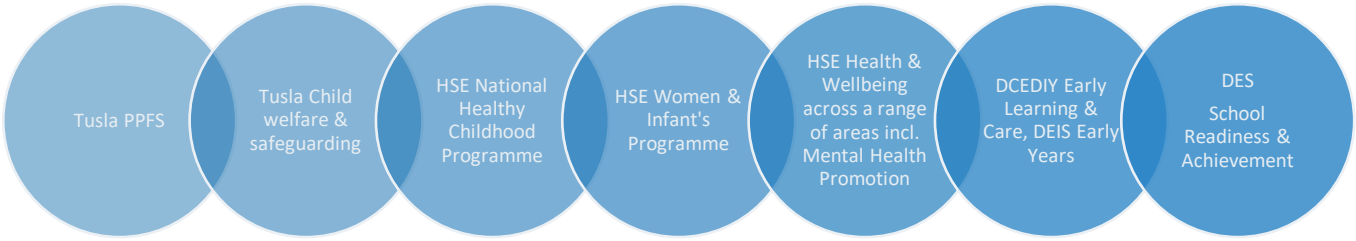

Figure 10 Range of service outcome priorities addressed by Home Visiting services & programmes

Consultation finding 3: Ireland does not have a recognised Early Childhood Home Visiting Sector.

In Ireland, home visiting does not have a qualification pathway, recognised salary scale, professional registration, standards organisation, or statutory oversight[26]. The absence of this against the visibility of Early Childhood Home Visiting Programmes perpetuates the perception that they are Programmes which other professionals or paraprofessionals can deliver as a supplementary tool to their existing roles.

The absence of an infrastructure for home visiting in Ireland creates a reliance on NPSSs to ensure training, accountability, and quality oversight to deliver specific home visiting programmes. Similarly, NPSSs must ensure their Programme's causal evidence is current and maintains contemporary standards outlined by commissioning bodies (a challenging task given the cost and time implications involved in RCTs). Given advances in Ireland's PEI sector and the launch of the '*What Works Evidence Hub*', this function will be essential to advancing home visiting in the future.

[26] The Community Families Programme does have a statutory-led National Support and Oversight Group

Finally, the absence of a sector has resulted in inconsistencies in the pay and terms and conditions of those working as Home Visitors. Additionally, the changing request from commissioners is significantly demanding, often beyond what the Programme originally intended to address. Supporting higher-need families is more time-consuming in terms of the intensity of provision and the consequential interagency work. This is a significant area to be addressed and was strongly raised throughout the consultation process in line with concerns around how local Programme Implementation Sites are funded (annual funding, absence of any developmental funding for advancing/capital/staff pay increases, etc.).

While the state may have reservations about funding multiple National Programme Support Structures, contrary to this is the absence of any infrastructure, which would be naturally seen in other sectors such as Early Learning and Care, Nursing, Education, or Social Work and Care.

While the ELC sector is far more extensive, with a workforce of over 25,000, and so warrants significant layers of infrastructure with associated costs, it is also a sector that has grown exponentially since the 2000s. Figure 10 below outlines some infrastructure layers supporting the Early Learning and Care sector, excluding third-level or post-leaving-cert education. Home visiting shares a similar history to the ELC sector regarding its origins and subsequent advancement towards professionalisation(or an absence of this in the case of home visiting), including the area of pay and terms and conditions or layers of professional development. Preventing an overly complex and layered infrastructure to advance home visiting is essential. Lessons from the expansion of ELC should be considered such that the growth of home visiting as a sector is planned and strategic.

What is clear from the findings is that there is no funded infrastructure to deliver the current level of home visiting provision and no recognised salary scales. In this context, home visiting will not be able to scale up. More significantly, without such infrastructures, the sustainability of home visiting is at risk.

Table 4.2: Overall Cost of Operating Model of the Sector

	Total Cost (€m)	Main Role
DCEDIY (2020)	6.67	Policy, Oversight, Budget sanction
DE (including DE EY Inspectorate)	1.36	Policy, Inspection
Tusla	8.34	Registration and Inspection
Pobal (Admin Costs)*	19.54	Funding administration, compliance
Better Start	10.70	Advice & Training on Quality standards
CCC (2020)	10.19	Advice, Information, Support & Training
NVCO	2.96	Training & Information
Total Cost (€m)**	**59.76**	

Source: Indecon
Note: *Only relates to admin costs for EY programmes. Does not include admin costs for programmes funded by other departments (e.g., DSP).
****** This does not include programme supports***

Figure 11 Cost of supporting infrastructure for Early Learning and Care and School Age Childcare (Indecon, 2021)

Consultation finding 4: Avoiding a 'one size fits all' approach is necessary to meet commissioner's needs.

Ireland needs to support various evidence-based home visiting programmes to advance ongoing learning and programmes that can respond to multiple needs and diverse communities.

From a commissioner's perspective, a one-size-fits-all approach will not meet the multitude of needs faced by Irish children and parents. Programmes developed have done so within specific communities with children and families with unique life contexts, ages, nationality and stages of their development as a child, parent and family.

The learning from the different programmes can be shared at a systematic review level to demonstrate explicit knowledge of 'what works' comprehensively for all families, thereby advancing an evidence base for home visiting in general and individual evidence from specific programmes.

Consultation finding 5: A 25-year vision for early childhood home visiting in Ireland.

The consultation process raised several points around costs and a vision for home visiting. One aspiration raised through the consultation was ensuring all children are offered a home visit.

While a comprehensive cost-benefit analysis is out of scope for this paper, a broad assessment of potential costs and scaling has been considered. However, this exercise is not informed from an economic perspective, and it has not been possible to adequately account for inflation, cost increases and pay/salary increases. In this regard, this is purely a theoretical exercise to outline:

1. The considerable journey to be undertaken to move from reaching 1% of the child population and securing this foundational base through sustainable investment.
2. The necessity for increased national support in line with scaling – while economies of scale can be realised over time, there is a need for initial and, at crucial times, enhanced investment in NPSSs.
3. Areas which are beyond the scope of this report. For example, the cost implications of growing an Early Childhood Home Visiting education and qualification process at post-leaving-certificate and tertiary levels and the necessary professional supports required to enhance ongoing professional development.
4. As we noted in the findings above, a limited number of sites have a database, and investment in such infrastructure is beyond direct delivery with no provision made in current SLAs.

Table 3 below outlines some cost considerations if moving to scale proportionately to ensure every child in Ireland is offered a home visiting Programme by 2048.

Duration	Aspiration % of child population	No. of Children	Local Site Implementation	Per Programme National Site Support	Total National Programme Site Support	Total
Year 1	Secure existing services	5000	€14,740,000	100,000	500,000	€15,240,000
Year 3	5%	19038	€56,124,024	175,000	875,000	€56,999,024
Year 5	10%	38077	€112,250,996	250,000	1,250,000	€113,500,996
Year 7	15%	57115	€168,375,020	375,000	1,875,000	€170,250,020
Year 10	30%	114229	€336,747,092	500,000	2,500,000	€339,247,092
Year 15	50%	190383	€561,247,610	500,000	2,500,000	€563,747,610
Year 20	70%	266536	€785,746,654	650,000	3,250,000	€788,996,654
Year 25	100%	380765	€1,122,495,220	700,000	3,500,000	€1,125,995,220

Table 3 An estimate of the cost of bringing home visiting to scale in Ireland over 25 years

Summary of findings: The feasibility of current Home Visiting Programmes in Ireland

1. **There is a clear need for greater clarity about what Early Childhood Home Visiting is.**
   It has been clear from the consultation and engagement with wider stakeholders that there is a lack of clarity about what home visiting is, its role as a unique service offering and a need to clearly articulate how Home Visitor roles are differentiated from other functions across the health and social care landscape.
   We have seen from history that ad hoc development and its small scale have perpetuated a lack of clarity. While the coming together of the Home Visiting Alliance has made considerable gains in promoting home visiting as a distinct sector, there is still a long way to go for national recognition for the need to advance and grow the necessary infrastructures for such a sector to sustain and grow. Such an infrastructure straddles three areas:
   - National policy, strategy and service delivery alignments and priorities
   - National support structures
   - Local implementation sites
   - Data and research
2. **A national support structure for each home visiting programme is essential**.
   This report outlines the centrality of a 'head office' or National Programme Support Structure to home visiting programmes. This structure is often developed from the original programme development structure or a newly formed organisation established once a Programme demonstrates efficacy with demands to replicate. From a review of international programmes, this Programme Support Structure is generally led by a Non-Governmental Organisation(NGO), however, there are examples included where this function is led by a state agency (Family Nurse Partnership or Reach Up adaptation in Peru).

   These structures are crucial to supporting replication, adaptation, and ongoing implementation of home visiting programmes.

   The history and development of Irish home visiting demonstrate the necessity for a National Programme Support Structure. Where a Programme has national support, they are more likely to be sustained. It is a complex role necessary to support home-visiting programmes, including collecting and monitoring local data, assessing the readiness of and training and mentoring new sites, providing ongoing training, practice development, ensuring fidelity and growing the programme's evidence-base. The experience of the Community Mothers Programme demonstrates that without such a structure, the Programme can be placed at risk. These structures will require adequate resourcing if the delivery of high-quality home visiting programmes are to:
   - sustain
   - grow, develop and respond flexibly to emerging research evidence and national policy
   - have a strong and ongoing contemporary evidence base.

   Given the absence of funding for these structures in Ireland, it is reasonable to say that all National Programme Support Structures are unsustainable in the long term. In Ireland, these structures have had to pivot and change, and they demonstrated constant innovation as they sustained against the odds.

3. **Current funding models for home visiting are insufficient to cover the 'real costs' and are unsustainable.** Current funding models do not reflect the total implementation costs nor recognise the need for adequate remuneration for home visiting staff, programme development costs, training

and ongoing professional development supports and ICT/database costs. Funding is negotiated on an annual basis, creating uncertainty for all programmes.

4. **There is no dedicated or sustainable funding for National Programme Support Structures.**
As funding for Programme delivery is administered locally, there are limited mechanisms for the National Programme Support Structures to have their role recognised and, more importantly, funded. Local commissioners have the remit to manage a tight budget within a set geographic area with competing priorities. It is beyond their remit to consider the need to fund a national structure.

None of the participating programmes receives dedicated funding for a National Programme Support Structure. For those Irish home visiting programmes with a National Programme Support Structure, funding is from the following sources:

- Philanthropy or Corporate donations
- Fundraising
- Cross subsidisation of core head office functions, e.g. Northside Partnership and National College of Ireland, provide governance, finance, HR and payroll functions for Preparing for Life National Office and ParentChild+, respectively.
- Social franchise model, e.g. Lifestart Foundation
- Charging new or existing Programme Sites for nationally delivered supports such as training, materials and mentoring/coaching, e.g. Preparing for Life

2.1. Readiness to scale – the pressure to scale too fast without additional resources or support.
Frequently, after a Programme has demonstrated efficacy, there is an eagerness to replicate implementation in many new sites. The learning from Preparing for Life is that responding to scaling up can not be underestimated and requires significant funding to ensure all the mechanisms are in place to support new replication sites and ensure fidelity, ongoing learning and data collection.

2.2. To licence or not to licence – how have Programmes funded a national office function, and how does it fall short?
One model of funding a National Programme Support Structure is to charge for the licence to implement the Programme. This model has been adopted from the US and is used to fund National (or International) Programme Support Offices.

This model asks Local Implementation Sites to factor in the charge for a licence as part of their ongoing implementation costs. Securing funding for Local Implementation Sites in Ireland is challenging; additional charges to their day-to-day costs increase unsustainability.

5. **The 'development mechanism' for programmes is not sustained once efficacy is proven.**
Development mechanisms for home visiting programmes frequently include a range of partners working together, such as implementation organisations, philanthropy or funders and research or academic institutions. Such partnerships are essential for programme development but also for ongoing programme support. In reviewing the literature, a considerable focus is placed on this interplay of partners to scale up programmes. It is unclear from the literature how this initial support translates into a sustainable Programme infrastructure to enable ongoing development, research, monitoring fidelity and sustaining quality.

In many cases, philanthropy plays a central role. Philanthropic funding does not sustain ongoing core costs, and viability is a constant challenge for home visiting programmes. Most Irish home-visiting

programmes had both philanthropic and research partners at crucial developmental stages during their history. However, this was short-term and unavailable to provide the support required for ongoing Programme development, replication, adaptation and scaling up.

6. **Securing an evidence base for programmes is challenging and expensive, making it unfeasible and out of reach for many programmes.** Securing the necessary funding for research relies heavily on philanthropy or ad hoc funding through chance opportunities. This becomes more challenging when the research is more complex and spread over a longer duration.

   Home visiting creates many methodological challenges for those designing research methodologies.

   - Home visiting as an intervention engages with families for two to five years, so a pre-post test methodology could take 6-8 years.
   - Adjusting for 'spill over effects' can make securing a control sample in a like-for-like community difficult.
   - Given its long intervention duration and how it integrates within child and family services, home visiting can be disproportionately affected by changes to broader systems and service delivery mechanisms. Uncontrolled variables such as waiting lists for other early years services or, alternatively, a well-integrated early years wraparound service structure can impact outcomes, giving either false positives or negatives.
   - Home visiting looks at various child outcomes, including child development. Objective and standardised measures of child development are complex and costly to administer.

   This makes RCTs for home visiting more expensive than for other shorter-duration parent support initiatives.

7. **There is a lack of clarity on what evidence-based means across sectors and government departments.** The term is used frequently but sometimes differently in Health, Children and Families, Child Welfare and Prevention and Early Intervention sectors. This can result in differing expectations from different government departments and agencies.

   Narrow definitions of what we mean by evidence-based practice, especially those derived from an analysis of evidence at a Programmatic level, result in:

   - competitive commissioning processes
   - the need for extensive research funding
   - extensive research expertise.

   Focusing on programmatic evidence limits the range of evidence-based practice options for commissioners. While many evidence-based programmes are available, one may not meet a specific population's needs. Some programmes demonstrate outcomes in one area but not in others – does this mean you need two or three different programmes to meet a child's needs? Furthermore, efficacy studies show an intervention has worked for a majority cohort of the population but not the whole population. They frequently don't identify those families who don't engage initially or who drop out of the programme. These are often a cohort of families that commissioners are most interested in supporting (Hackworth et al., 2018; Moran et al., 2004; Smokowski et al., 2018). Discovering how to interpret what each Programme's evidence base means can become a logistical challenge for a commissioner. It makes implementation-at-scale a challenge for policy-makers and funders for the following reasons:

8. **Investing in newer programmes at the risk of pre-existing programmes in the same area has led to the closure of some local sites.** Some programmes experienced poor long-term ongoing or development investment. The absence of a strategic approach connecting national policy priorities to local and national commissioning has resulted in overlooking these programmes in favour of newer initiatives. Instead of building on existing programmes, there are examples where they have been displaced, leaving some areas without access to a home visiting programme; the older programmes, Lifestart and the Community Mothers Programme, both reference this. While the timing and underpinning rationale for closures are unclear, these Programmes closed after newer initiatives emerged. One example is the HSE-governed Community Mothers Programme in the Dublin region. It saw 13 closures from 2013 to 2019. The many factors which underpinned these could be the following:
    a. retirement and non-replacement of Coordinators
    b. moving all child and family services from the HSE to Tusla
    c. commencement of the PEI Programme followed by the ABC Programmes, which showcased new approaches to effective service delivery
    d. consistent lack of investment in Programme development, review and national support.

9. **Collating data across and within home visiting programmes is difficult due to an absence of data collection mechanisms/ ICT/ databases at a local and national level.** Funding at a local level is directed to day-to-day costs, predominantly staffing costs, rather than once-off or ongoing development investments. The initial and ongoing cost of having an adequate ICT system is beyond the reach of many local and national programme structures.

5. Recommendations

The findings outline that evidence-based home visiting has developed and grown in Ireland in many ways against the odds. Each Programme has had an ad hoc journey as they navigated windows of policy or funding opportunities for their development and expansion to deliver programmes across the country. This has been done on limited resources, with many Local Programme Sites and all National Programme Support Structures facing precarious sustainability.

Additionally, for National Programme Support Structures, there is an inability to implement to scale as required to adhere to best practice to protect fidelity as is set out by the literature. The ad hoc nature of developing such national structures depends on small local or national once-off funding opportunities. Alternatively, they solely depend on philanthropy, corporate social responsibility, or licensing/charging arrangements with local Programme Sites.

The model of 'licencing' or charging local Programme Sites is double-edged. This model is insufficient to adequately fund the National Programme Support Structures. It also places additional funding burdens on Local Programme Sites that are insecure and insufficiently funded to deliver the programme.

This is an infrastructure that, in its current processes and mechanisms, cannot adequately develop, implement or bring to scale evidence-based home visiting across Ireland. It is not presently feasible.

From implementation science and extensive research into 'what works' in prevention and early intervention, the research literature tells what is necessary to advance the development, implementation, replication and scaling of evidence-based programmes:

- Collaboration between policymakers, research, philanthropy, NGOs and local implementation sites
- Local and national buy-in from statutory partners
- Ongoing research at the RCT/quasi-experimental level at replication, adaptation, and scaling
- Consistency of funding – multiannual funding and joint commissioning of funding across sectors recognising all programme outcomes
- Programme supports across jurisdictions or nationally for local implementation sites to support:
    - readiness to implement assessments
    - training
    - ongoing technical implementation supports
    - data gathering using ICT/CRM systems
    - data and programmatic monitoring for quality and fidelity
    - ongoing professional development to maintain and grow standards of implementation (including supervision, communities of practice/learning, and additional training)
    - and bottom-up adaptations or programmatic innovation so that programmes do not become static or 'stuck in time.'

There is significant learning from the Family Nurse Partnership- ADAPT report (Family Nurse Partnership National Unit & Dartington Service Design Lab, 2020). It highlights the high level of support and funding the National FNP Unit had, including the backing of the Department of Health and Social Care. This enabled an ongoing and iterative process co-produced with local stakeholders, children, and families, ensuring adequate Programme fit meeting a range of stakeholder needs. Similarly, the learning from the Jamaican 'Reach Up' Programme outlines that the scale of impact of a programme is directly related to the context in which it is delivered. The effect of the original research was far greater than that of subsequent translations into other countries. In this case, the systems can be the host organisation delivering the programme locally or the funding, policy, service integration and more comprehensive national service infrastructure, which can

impact a programme's development as was the case with the Family-Nurse Partnership Programme and the impact of austerity.

So, what can be done in Ireland to advance home visiting, recognising its potential for advancing better outcomes in the short and long term for children, their parents, families and communities?

1. A national four-layered infrastructure with targeted actions at each level is required to sustain, implement and bring home visiting programmes to scale. This is outlined within the document (figure 6). Such a structure could be considered under the First 5 reference to agree on '*a national approach to home visiting'* coordinated by the Parent Support Policy Unit. It aims to build on existing structures, ensuring integration across Government departments at a national level and sectors, agencies and structures at a local level, ensuring top-down and bottom-up connectivity. It aims to address the following:

    a. national strategic planning and coordination,
    b. access to national and local research,
    c. strategic inter-agency/departmental approach to funding and commissioning, and aligned data gathering
    d. the growth of National Programme Support Structures to support and grow home visiting to scale in Ireland.

2. Build on the First 5 action to 'agree on a national approach to home visiting' through the creation of a centralised national office within the Parenting Support Policy Unit with responsibility for home visiting in Ireland, reporting to a cross-departmental policy structure to:

    a. strategically lay the foundations for the implementation of home visiting to meet a range of child outcomes through a joined-up Government approach ensuring cross-departmental funding for home visiting from Children, Health, Education, Community and Rural Affairs and Justice
    b. collects and collates national data on home visiting and enables a bottom-up influencing of national policy, aligning it to national data on outcomes for children and families
    c. coordinates the gap between national funding for Programme Support Structures and collaborates with local commissioners to align this with implementation site funding at the local level.

3. Adequately fund the implementation of home visiting programmes at a local level through a multiannual cross-sectoral mechanism. Additionally, fund the national programme support structures required to oversee, support, develop and scale home visiting.

4. Agree on a national definition of 'evidence-based', which enables innovation and is practice rather than programme-focused. This should be a pragmatic definition which does not stifle innovation and needs to be 'feasible' with accessible mechanisms for all programmes to secure the necessary efficacy research. Such an approach must reflect the complex way services and programmes are implemented and enable ongoing learning, innovation and adaptation rather than relying on single RCTs that may no longer reflect the complex context and changing needs of populations.

5. Develop and fund national and reciprocal local data collection methodologies:
    a. define key national metrics for all home visiting programmes
    b. as part of local commissioning, provide funding for the design and implementation of CRM/data gathering mechanism to ensure accurate real-time data collection at a local level
6. Support Programmes to achieve, grow and sustain an evidence base by establishing a national research function as outlined above. Programmes should be supported either directly or through the provision of funding to carry out the following:

a. initial and longitudinal research
b. innovative supports to ensure adaptations or programme changes can also be reflected in the evidence base to ensure home visiting programmes are innovative and responsive to new emerging research and population-level needs.
c. carry out replication evaluations of international programmes in Ireland and replications of Irish programmes in different contexts in Ireland, e.g. urban areas of disadvantage to rural areas

7. The professionalisation of the home visiting sector is required to advance and support home visiting in Ireland. Invest in the sector's professional development through home visiting qualifications, training and professional development across all levels of practice.
8. Recognise the full potential of home visiting in engaging and supporting all parents across the continuum of need to reach those families less likely to engage in centre-based or more structured external supports. HVA members outline their programmes are supporting many families with higher levels of need whilst also providing preventative, early intervention and universal support. Acknowledge the wider role of home visiting in health and education, e.g., child, parent and family mental and physical health and early home learning, language and building the foundations for literacy and positive school engagements.

A Vision for Early Childhood Home Visiting in Ireland: The recommendations above set the stage to advance home visiting in Ireland in a gradual and sustained way. Ultimately, the vision for Ireland is that every child in Ireland would be offered a home visiting programme. This vision requires considerable scaling, and the overarching principle should be **'sustainable strategic scaling'** rather than an unplanned race to scale; as Araujo et al. (2021) note, *"one clear trade-off is between scaling up quickly and doing it with quality"*. There is much to learn from the literature regarding scaling too fast. In an Irish context, learning can again be drawn from the development of the Early Childhood Education and Care/Early Learning and Care (ELC) sector. The impetus to scale the development of the ECEC/ELC sector was European Funding, which prompted extensive capital development and workforce expansion. Today, there are ongoing challenges with how ECEC can deliver for children and parents, commissioners and the essential workforce. Learning from the complex scaling of services and projects will be crucial, and a sustainable and strategic approach to the scalability should be a priority if we are to achieve a vision of providing a service to all children in Ireland in 25 years.

This document outlines estimated costs for direct implementation and the essential investment in supporting infrastructure to ensure scaling is effective, quality assured and meets the needs of children, families, communities and commissioners. The starting point is to secure sustainability whilst delivering to nearly 5,000 children, costing €15,240,000[27]. Table 3 outlines a 25-year approach to sustainable scaling, ensuring all children who need the programme (30% of the population) should have access to a programme within 10 years at a total cost of €339,247,092. There are multiple caveats about these cost estimations, as outlined in detail within the document. However, they provide broad indicators of cost requirements for a sustainable ECHV sector. Securing a solid foundation for this ambition is required, as outlined in Figure 12 below.

[27] Cost for local implementation €14,740,000 in addition to infrstructure costs of €500,000.

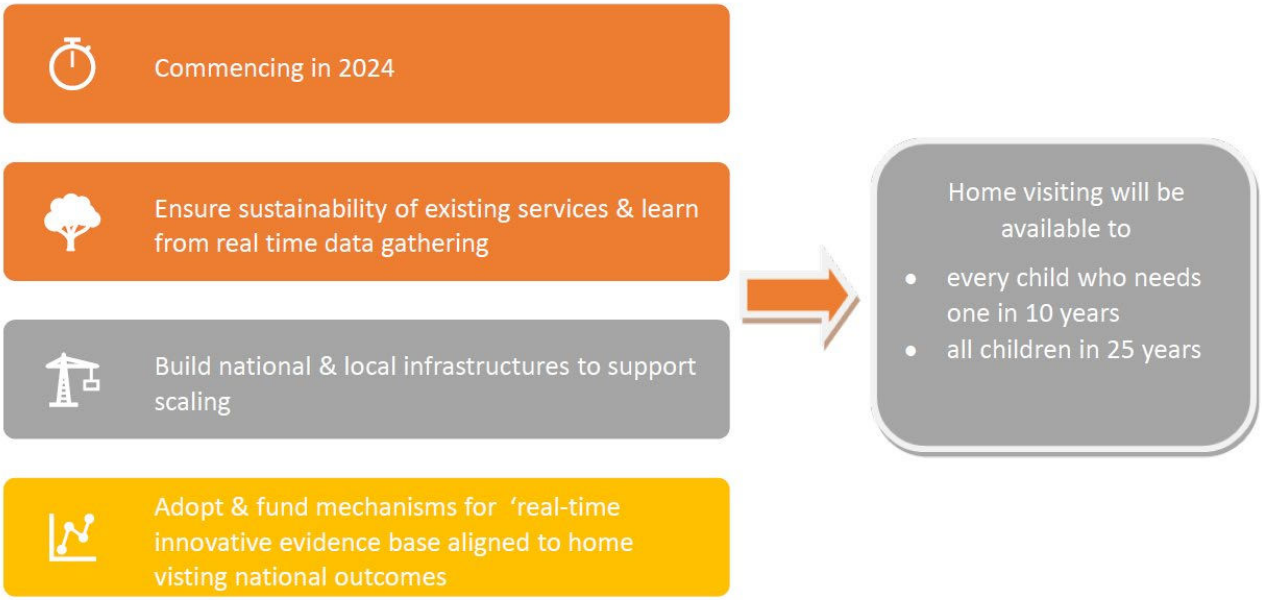

Figure 12 Laying solid foundations: Three core principles for sustainable strategic scaling of home visiting by 2033-2049

Figure 13: Relevant stakeholders across four levels of support infrastructure required to ensure the feasibility of Home Visiting in Ireland

Summary and conclusion

The current policy context in Ireland allows a unique opportunity to develop an integrated strategic approach to early childhood home visiting in Ireland. The recommendations outlined herein align with the wider aspirations of First 5 across all Goals and, particularly:

- Goal A Action 2.2 specifically outlines that '*an approach to home visiting will be agreed*' as part of a wider tiered model of parenting services supporting a continuum of need
- Goal 4, building blocks 3 and 4 as foundational steps towards an effective early childhood system.

Irish home-visiting programmes are listed across three catchment areas as valued parental support before and after a baby is born within the HSE response to the Maternity Experiences Survey, Listening, Responding and Improving (HSE, 2020). A final policy window is within the HSE Mental Health Promotion Plan as a 'Starting Well' action is to :

'Increase coverage of home-visiting programmes nationally in line with the goals of Supporting Parents, the national model of parenting support services'.

Home visiting is not adequately funded at a local level as it delivers a service to 1% of the current eligible child population. It is clear from this report that a strategically funded approach supporting these programmes at a national level is required. A top-down – bottom-up integrated national and local level infrastructure is needed to equip home visiting programmes to implement high-quality, evidence-based services and grow sustainably in response to national policy and local needs. An aspiration to ensure all children and families have access to a home visiting programme from pregnancy to 5 years of age seems dauntingly ambitious. However, by building a viable infrastructure to support the sustainable growth of home-visiting incrementally over the next ten years, it would be hoped that access to such invaluable parental support could grow from its current 1% reach to 30% of the eligible population with clear benchmarks of how to ensure the whole child population would be offered a programme within 25 years.

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Appendix 1: Background to home visiting programmes in Ireland

Community Mothers Programme

The Community Mothers Programme was the first home visiting Programme developed and delivered in Ireland. Developed in the 1980s, it was initially a replication of a UK Programme called the Early Childhood Development Programme developed at Bristol University. The original rationale was to impact the home environment of children. *'To change parents' behaviour patterns in the rearing of their children by fostering self-reliance in parents from disadvantaged areas and assisting them to gain more control in this area of their lives and thus give their children better chances in life'* (Eastern Health Board, 1989). It is clear that from the start, the Programme focused on parents to improve health, learning, development and broader outcomes for children.

Delivered by trained volunteer mothers living in the local community who were reimbursed for expenses. Qualified Public Health Nurses or Family Development Nurses supported and coordinated home visitors or' Community Mothers'. As the Health Board solely funded the Programme at the time, the Family Development Nurses could traverse their role as PHN and FDN and were the first point of contact for all parents as they entered the Programme. It was delivered at a relatively low cost.

The Programme at the time gained significant Irish and international attention. It supported a holistic approach to health, was delivered at the primary health level and promoted the full participation of individuals by empowering them through a community development model and not a medical model. It tapped into a policy 'mood' outlined by the World Health Organisation declaration at Alma Ata.

Development Mechanism: The Community Mothers Programme was a response led by Ireland's Public Health Nurse Service. It had its first pilot Programme delivered in 1983. A partnership between a regional statutory response, the Eastern Health Board, Philanthropy (the Bernard Van Leer Foundation) and the research support was initially the University of Bristol and Public Health Specialists from Ireland's Health Service and the Eastern Health Board Information Unit.

Evidence-base: The Programme carried out three RCTs, including one replication of the Programme to the Traveller Community and one longitudinal Programme following the original cohort after seven years (Johnson et al., 1993; Fitzpatrick et al., 1997; Johnson Z. et al., 2000). With peer-reviewed statistically significant positive outcomes demonstrated in:

- the level of uptake of immunisations
- an increase in nutritious diets
- increased engagement of parents in early learning and development activities with their child
- increased self-esteem and positive mental outlook for parents.

The Programme is a promising practice on the European Platform for Investing in Children (EPIC).

Implementation, replication, and scaling supports – national Programme structure: While there was a well-researched and supported replication of the Programme to the Traveller Community published in 1997, there were no other replication studies at the level of RCT in Ireland.

There was, however, considerable interest in delivering the Programme across the country. In the Eastern Health Board area, a level of implementation support was provided by a single staff member and Programme lead. Implementation support was provided at the Family Development Nurse level and the individual Community Mother level. Across the Eastern Health Board region, Community Mothers were brought together at least once a year for training and development. With limited budgets and competing demands on the role of Family Development Nurses who were also Public Health Nurses, it was a Programme that did not have the core and protected resources and capacity solely dedicated to Programme review and development for sustained implementation.

This structure in the Eastern Health Board could not oversee and support the scaling up the Programme across the country.

This resulted in a parallel Programme development led by regional Health Boards, which veered from the original model of having a Public Health Nurse in the coordinating role. Given the regional nature of Health Boards, there was no national oversight of this new development and no national funding available to support such a support mechanism. Instead, the Programmes were implemented by Community and Voluntary Organisations and coordinated by a senior and experienced family support or community development worker. This has been referred to as the community-governed model instead of the original health-governed one. This was the case in Limerick, Athlone and Louth, and this approach was subsequently replicated in Clonmel and North Tipperary.

Even though Kerry established a Health Board model in 2001, it could not avail of the limited support in the Eastern Health Board area.

No further experimental or quasi-experimental research was funded or carried out on any replication sites or those sites delivering a community model. While evaluations and research took place, this was predominantly qualitative and evaluative rather than outcome-focused or experimental/quasi-experimental design.

Sustainability and Programme challenges: By 2004, things began to change for the Community Mothers Programme in the original Dublin sites. The core materials of the Community Mothers Programme have not been updated since 1983. The original Programme sites in Dublin stuck rigidly to the original evidence base, thereby delivering a Programme that was beginning to become 'out of date'. While the other 'community' model sites continued to sustain embedding themselves into the local interagency infrastructure, they began to adapt the materials. They no longer used the original forms and manual.

Without a National Programme Support Structure, the regional support structure and original programme development unit had minimal administration, research and development support resources. Data collected within the Eastern Health Board region was minimal, focusing on outputs – however, annual reports were produced yearly.

Because of the limited capacity of the Programme's regional support, it didn't advance the promising outcomes from the original research by promoting the early childhood development, early learning and parenting components. This meant the Programme was seen as a predominantly 'health' Programme in some areas and was no longer meeting broader needs that emerged from the local community, such as the educational and child and family support outcomes. Finally, for the Dublin sites, the volunteer nature of the Programme meant that only those in the FDN role could represent the Programme at local interagency developments or meetings. This led to the Programme being seen as insular. They could not partake in more interagency work, which was now expected given

advances in parenting, early childhood outcomes and wider prevention and early intervention, e.g. Children's and Young People's Services Committees and Child and Family Support Networks.

By 2017, only two catchment areas delivering the original programme model remained in the Dublin region. Six programmes adapted and changed from the original model. They continued to operate with considerable funding and resource challenges. Each Programme site adapted to meet local commissioners' needs, resulting in a mixed model delivery without standardisation. A Review of the Community Mothers Programmes in 2017 identified core commonalities such as how these programmes worked. They all place the centrality of the relationship between the home visitor and parent as the agent of change for participating families. They could work flexibly with families across the universal-targeted spectrum and successfully engage and build relationships with families traditionally seen as 'hard to engage'. Finally, the review outlined how families valued the programme. Recommendations were made for the Programmes to come together and work towards greater standardisation without losing the flexibility that had served them and their families well to date. A central recommendation was to bring the two core funders together to review, develop and support the Programme to meet the needs of children and families of today and to secure the future sustainability of the Programme.

This work has been funded under Sláintecare, and a model for future delivery has been developed collaboratively with the Programme sites and various stakeholders, including parents. A joint governance structure led by the HSE National Healthy Childhood Programme and Tusla's Parenting Lead was established in 2022. Work is underway supporting local programme sites to transition to the new delivery model.

Lifestart

Lifestart was developed by Derry-based educationalists and academics, including Dolores McGuiness, Dr Aine Downey and Dr Sean O'Connor, who brought the Growing Child programme to Ireland. The Growing Child was devised by a parent, Denis Dunn, a publisher who commissioned its development by child development experts at the University of Purdue and delivered the programme to parents in the US. An independent evaluation of two pilot projects in Derry and Connemara in the late 1980s indicated that the most effective delivery mechanism for the Growing Child programme was through a home visiting service. This was the first home visiting programme to be developed and delivered across both jurisdictions on the island of Ireland.

The Lifestart Growing Child programme for parents is a structured month-by-month curriculum of information, knowledge and practical learning activities for parents of young children. The programme offers age-specific information on child development and is tailored to each child and family.

Specially trained family visitors deliver the programme in the parent's own home. The primary aim is to support parents as they support their infant's physical, intellectual, emotional and social development through monthly home visits.

The programme, at its core, is universal for all families. The underpinning principle of the programme is that the home is the primary environment for child development and early learning.

The Lifestart Programme recognises that all parents need some parenting support and that the most effective form of prevention and early intervention is to provide universal support for all families. Because the Lifestart programme is adaptable at the point of delivery, it can cover the full range of parenting needs. In most cases, Lifestart service providers, including the Foundation itself, are funded to deliver a targeted and referred service, which in some instances also retains an element of universalism by targeting first-time parents.

Development mechanism: The actual trigger for the development of the programme and service was Dolores McGuiness, a secondary school teacher, who was concerned that many of her brightest students were not doing as well at school as expected. With colleagues at Magee College, including Dr Sean O'Connor, she researched children's backgrounds and ascertained that disadvantage, poverty, and the quality of parenting children received affected outcomes. They found good parenting was a protective factor that could improve outcomes even among the most disadvantaged of children.

EU Social funding was secured for three years to pilot the Lifestart Growing Child Programme. A pilot was initiated in two original sites in the Dunluce Family Centre, Ballymagroarty in Derry and an Early Years Project, Oiliunt Baile, Connemara. The Ballymagroarty site was selected because it was in a relatively new housing estate housing many first-time parents experiencing poverty and trauma due to the Northern Ireland conflict. The Connemara site was chosen because its community was also experiencing poverty and rural isolation. This funding extended to an initial evaluation, which showed that despite the different contexts, home visiting was the most effective mechanism to deliver the Growing Child Programme (Mc Nelis & Kelleher, 1994)

The Programme grew and responded to the changing service delivery landscape. The Lifestart programme incorporated a logic model, which depicts how the programme is thought to work. The initial impact of the Lifestart Programme is on parenting outcomes, which positively impact child development outcomes.

National Programme Support Structure: The Lifestart Foundation is responsible for developing the Lifestart Growing Child Programme and Home Visiting Service. The Foundation is a charitable body registered in Northern Ireland but works on an all-Ireland basis. The Lifestart Foundation delivers the Lifestart Programme and Home Visiting Service under contract with Health and Social Care Trusts in Northern Ireland, and licences, trains and quality assures programme implementation throughout Ireland. A national office in Sligo funded nationally for some years, but this funding was diverted into local service delivery in 2015. A more limited Sligo office was funded for a further three years to work on developing Tusla's parenting strategy.

Evidence base: In 2004, Lifestart Foundation secured funding through Atlantic Philanthropies to commission their first RCT. A research team from Queens University (comprising the Centre for Effective Education and the Institute of Child Care Research) were commissioned to evaluate the Programme.

The evaluative pilot indicated the appropriateness of undertaking a scientific RCT again conducted by Queens University 2008-2015. The results, published in 2015, confirmed that the Lifestart Programme and service aligned with its logic model. The evaluation demonstrated statistically significant effects in reduced parenting-related stress, increased knowledge of their child's development, and improved confidence in their parenting role using three outcome measures:

- *Tool to Measure Parental Self-Efficacy (TOPSE)* (Kendall and Bloomfield, 2005)
- *Parenting Stress Index (PSI)*
- *Knowledge of Infant Development (KIDI)* (Macphee, 1983)

At a component level, this demonstrated statistically significant impacts across the following parenting domains:

- parental efficacy
- knowledge of child development
- parent/child attachment
- parent confidence re discipline and boundaries
- reduced parenting-related stress.
- improved parenting mood.

The outcomes for children, while not statistically significant, were also positive, indicating improvements in cognitive development, social and emotional development, and behaviour and a significant reduction in speech and language referrals. Since the intervention improves parent attitudes, behaviours and practices, the effects on children will likely be longer-term and accumulative. The researchers concluded that the benefits for both parents and children were directly the result of the Lifestart intervention, and the role of the Family Visitor was crucial for outcomes.

Implementation, replication and scaling supports – national Programme structure:

Community-based organisations approached the original Lifestart Project in Derry in Sligo and Donegal, interested in replicating the Lifestart service in their areas. To facilitate replication, the Lifestart Foundation was set up in 2001 to manage the licensing of organisations and training and quality assurance of programme delivery staff. The Foundation acquired cross-border funding that allowed it to :

- manualise the programme and service

- formalise and professionalise training and quality assurance systems and procedures
- promote the service more widely.

As a result, many other communities in NI and Ireland began to seek local funds to deliver the Lifestart programme and service. The Growing Child programme was reviewed by experts and redesigned in 2012 and is currently under review by a panel of experts to incorporate findings from the latest neuroscience research and reflect current thinking on gender and diversity.

Currently, thirteen organisations deliver the Lifestart Growing Children programme and home visiting service, eleven in Ireland (seven in the ROI and four in NI) and two abroad in Macedonia and Zambia. In the past, nineteen organisations delivered the service. In response to the 2008 financial crisis, three organisations in communities in Donegal merged into a regional vehicle for service delivery, Lifestart Services CLG. As a result, three others closed down and ceased delivering the Lifestart Programme, including one of the original piloting organisations in Connemara. The main challenge for organisations providing the Lifestart service is acquiring the funds to sustain that funding over time.

The organisations that closed down were all in receipt of funding not specifically dedicated to family support or children's services, making them vulnerable to changes in funder priorities. The more significant majority of organisations that are or were in the past delivering the Lifestart service are set in communities with a high level of poverty and disadvantage and/or rural isolation and where many children are at risk of poor outcomes. To address these needs, discrete organisations were set up in some communities as service delivery agents, while in others, existing organisations sought a licence to deliver the Lifestart service. Given that this latter approach was becoming more common, in 2013, the Foundation developed a social franchising approach to licencing, making it much easier and simpler to licence and train existing organisations and their staff to deliver the programme and service to a high-quality standard.

Preparing for Life

Preparing for Life grew from the experience of Noel Kelly, a teacher in Darndale who was seeing children start school without achieving the essential milestones that would enable them to actively participate and engage in education. Noel brought a group of local stakeholders together to research the problem and develop a solution. It became clear that any intervention had to happen as early as possible if children were to develop the physical health, problem-solving skills and concentration needed for school and the ability to manage their relationships with peers and teachers.

Development mechanism: The proposal developed by PFL was selected for funding by Atlantic Philanthropies. Following extensive local consultation and with the support of international experts, a team was assembled, and a formal, manualised programme was developed and implemented. The PFL Programme aimed to improve levels of school readiness of young children living in several disadvantaged areas of North Dublin by engaging with mothers during pregnancy and working with families until the children start school.

The purpose of the PFL Programme was to improve low levels of school readiness by assisting parents in developing skills to help prepare their children for school. Dr Orla Doyle of the Geary Institute, UCD, was selected to oversee a rigorous, Randomised Controlled Trial (RCT) to assess the programme's effectiveness. Collaboration with local families was vital from the outset and continued throughout the process. In addition to the consultations with families, there were extensive efforts to involve local agencies in mapping and shaping the vision of PFL to meet the needs of local families. The development of PFL was a bottom-up initiative involving 28 local agencies and community groups who worked collaboratively to develop a programme tailored to meet the local community's needs and was grounded in empirical evidence. It also supported PFL to complement other agencies in the area.

Preparing for Life was specifically designed to support families to take control of their lives and better support the development of their children. By building on strengths and the resources within the family, PFL encourages self-sufficiency and independence, working with families to support them to make well-informed decisions for themselves and their families and to intervene before problems arise. More recently, this has transformed into the idea of family capabilities and exploring possibilities with families and support with problems where required.

It should also be noted that PFL was established under the Northside Partnership in 2007. Northside Partnership is a Local Development Company based on the North side of Dublin City in Ireland. The Government established Local Development companies to provide an area-based response to communities with high long-term unemployment and social exclusion levels. It provides several offerings in response to local needs through its Employment, Enterprise, Education, Health and well-being and Community Development programmes. The organisation works closely with local community groups, training schemes, employers and businesses, government departments, and local government. This connection continues to provide many connections to additional services for families.

School readiness was a vital aim of the PFL programme. This was conceptualised in terms of the joint responsibilities of home, schools, and communities in providing caring environments that promote children's learning (Piotrkowski, 2000). The team also expanded the delivery of parenting supports and formalising the delivery of ante-natal education, baby massage, breastfeeding education, and formal parenting supports such as Triple P and Circle of Security. The Home Visiting Programme integrates with many of these elements formally to enhance the support offered to families.

Evidence Base:

In March 2023, Preparing for Life Home Visiting was selected for inclusion in the Early Intervention Foundation (EIF) Guidebook and is currently being assessed for under the Home Visiting Evidence of Effectiveness (HomVEE) programme in the US.

The primary evidence for the PFL Programme is from the original evaluation commissioned, as noted above, from the start of the Programme overseen by Orla Doyle under the UCD Geary Institute. The primary outcomes for children as recognised by the EIF Guidebook :

- Improved Cognitive Abilities
- Improved Naming Vocabularies
- Improved Communication
- Improved Autonomy (Doyle, O., & PFL Evaluation Team, UCD Geary Institue for Public Policy, 2016; Doyle, O, 2020)

Additional findings noted were:

- Children's health and wellbeing, with a focus on children's nutrition, sleep, and mental wellbeing
- Children's development, including their physical, cognitive, language, and social and emotional development.
- Parents' knowledge, skills and Interactions between parent and child, with a specific focus on improving attachment and positive interactions within the parent-child relationship and on general parenting practices and behaviours.
- Parental health and well-being, recognising and developing parents' strengths and capabilities, supporting their well-being, and reducing parental stress.
- Home environment, focusing on home safety and family-child interactions that support a positive learning environment.

There was a process of ongoing data collection and a follow-up at age 9 years with work underway for a year 12-13 year follow up with effects sustained at follow-up. It is considered Europe's longest-running RCT of an early intervention programme.

Implementation, replication and scaling supports – national Programme structure:

Funding from the ABC programme allowed for implementing PFL Home Visiting in Bray, Co. Wicklow and Finglas, North Dublin. Additional funding was also provided for a smaller implementation in Newbridge, Co. Kildare and Athy, Co. Kildare followed this.

In 2020, PFL worked with the Centre for Effective Services to review the programme through extensive consultation with programme sites. This identified the need for more formal implementation support and structured support and supervision to ensure fidelity. The PFL Implementation Team updated the Programme Manual, resulting in an updated logic model, and theories and it also clearly defined the PFL approach, including learning and adaptation from the previous 13 years of operation. The manual also defined the Programme Practice Principles and described a formal implementation support process.

In 2022, Tusla committed to implementing evidence-based programmes which the ABC Programmes, including PFL Home Visiting, were delivering. Four sites were selected: Bagnelstown, Co. Carlow; Ballinasloe, Co. Galway; Castlebar, Co. Mayo; and Balbriggan, Co. Dublin. Programme hosts were a mix of Family Resource Centres and Tusla PPFS Offices. Funding was provided for the programme through the Tusla What Works Programme. Local Tusla offices also reassigned staff and provided

additional funding. The sites worked closely with the PFL Implementation Team on planning, recruitment and training, and ongoing support and supervision are in place. Recruitment of families is currently underway in each site.

Parent-Child +

In 2002, NCI relocated from its original site on Sandford Road, Ranelagh, to its current, purpose-built facilities at the IFSC on Mayor Square. With the development of the IFSC and the Dublin Docklands, the Dublin Docklands Development Authority (DDDA) wanted an academic institution that would develop strong links with the local community and help to address educational disadvantage. The DDDA selected NCI to fulfil this brief due to its history and ethos, which remain core to its mission today.

When NCI relocated to the Dublin Docklands, Early Learning Initiative (ELI) was established at the request of the local community to address the generational, long-term problems of social deprivation, poverty, poor educational attainment and mass unemployment in the area. The aim was to 'change lives through education' through the provision from birth, an integrated programme of activities, training and support for children, parents and educators.

This was a natural fit as NCI took on a community development and 'ecosystems' approach to education, realising that to increase attendance and participation in higher level education, supports needed to be grassroots and embedded in a community wraparound approach. More importantly, support must commence early in a child's life.

Given the above needs and proposed approach, a review of potential evidence-based programmes took place in 2006 to explore the best way to support the children and families within the Dublin Docklands region. Arising from this, a proposal was developed to replicate the ParentChild Home Programme as it was called then, from here on referred to as ParentChild+.

It was developed in the mid-1960s by an educational psychologist, Phyllis Levenstein, who was motivated to reduce high school dropouts by focusing on the early development of language and literacy skills and parent-child interactions.

The Programme was developed with the following aims;

1. *Increases school readiness and school success*
2. *Supporting reading and play activities in the home*
3. *Building language, literacy, and learning-rich home environments*
4. *Supporting the development of social-emotional skills, children enter school ready to be successful students* (ParentChild +, 2023).

Today ParentChild + is delivered through 142 organisations. In the US, it is delivered across 15 states, and internationally, it is offered in 6 countries: the UK, Ireland, Bermuda, Chili, Israel, and Singapore, reaching over 7,000 families annually.

Development mechanism:

As noted above, the Programme originated from academic and educational psychologist Phyllis Levenstein. Its history outlines the many stages of development from theory to design to piloting. Once an established research base demonstrated positive impacts, the Programme developed an independent and not-for-profit organisation to oversee the replication and implementation of the

Programme. The Programme origins were considerably supported through philanthropy and corporate and research partnerships. Today, it is supported across national and local implementation levels through many philanthropic and corporate funding supports and some US statutory funding within specific areas. Its research partners are New York University, ORIS Impact and Lehigh University.

To implement the Programme internationally, it engages national implementation support partners. The National College of Ireland is the Irish implementation partner for ParentChild+ in Ireland.

In 2009, ELI partnered with Dublin South City Partnership (Dublin South City Partnership) to expand the programme to the wider Dublin city area of Dublin 6, 8 and 12. It continued partnering with more sites in Dublin and other counties around Ireland over the next few years.

By 2020, ELI had established ParentChild+ in eight other sites and in line with the Strategic Plan 2020-2025, a national centre was established. This national centre's main aim was to replicate ParentChild+ nationwide. There was also a focus on research with the steps to bring the ParentChild+ longitude study back to the forefront of ELI's key activities and a continued focus on community action research and evaluation. To ensure fidelity to the programme and high quality and assurance from every ParentChild+ site throughout Ireland, a senior specialist position was dedicated to supporting the delivery and growth of ParentChild+ on a national level, with a job specification of onboarding new sites, training staff and maintaining quality throughout.

Evidence base:

The evidence base for the Programme was developed in the US with supporting studies in Bermuda and Canada. It has an extensive evidence base, including three significant RCTs in the US (Madden et al., 1984 -peer-reviewed; Astuto & Allen, 2016; (Astuto & Allen, 2018). The research extends to five further RCTs in Bermuda & the US, six quasi-experimental evaluations in the US, and three studies in Canada & Ireland, including the baseline study, noted below.

The research demonstrates an evidence base for delivering the Programme to toddlers and their families in low-income communities, including those where English is a second language (Spanish-speaking migrant families in the US), with the following statistically significant child outcomes:

- improved cognitive ability
- improved language
- improved social-emotional competence
- improved self-regulation.

The Irish evidence base for ParentChild+ is evolving. In 2011 a baseline study of the pilot ParentChild+ Programme was completed. It identified areas for exploration as the Programme would refine its adaptation as it replicated delivery in an Irish context (Share et al., 2011). Factors to be explored include how children and families were recruited to the Programme and supporting children and families where English is a second language. The baseline study was funded through Pobal Dormant Accounts.

A further qualitative evaluation will be published in 2023 and outlines qualitative evidence from case studies of 13 mother and child graduates of the ParentChild+ programme (O'Neill, 2023).

These case studies indicate that post Programme completion:

- children were doing well in school academically, with a minority requiring additional supports
- STen scores received in the average range for English
- majority of children also exhibited positive socio-emotional development and participated in extra-curricular activities.

Feedback from the school indicated:

- children's willingness to engage in the classroom
- positive engagement with their peer
- a high level of socioemotional development with the children concerned.

Mothers reported being well-equipped to support their children with learning and developmental outcomes attributed to the skills developed in the ParentChild+ programme. Still, they did outline some challenges in helping their children with Irish and Maths.

Mothers stated that the ParentChild+ programme helped them to have "a little more patience and open mind about parenting".

The mothers mentioned the "warm and affectionate" relationships fostered by the Home Visitors and that they were "just so brilliant" and they "really enriched our lives". Mothers also mentioned that they continued to employ the skills they learned with their "other children".

These findings support the previous evaluations (2014-2017) of the ParentChild+ programme and the baseline study completed in 2011 (Share et al., 2011).

Implementation, replication and scaling supports – National Programme structure:

Supporting other ParentChild+ sites has always been a priority of ELI. As more sites boarded, the need for a dedicated person to onboard, support and ensure quality practices throughout the programme became evident.

Readiness for implementation: Some systems are set in place and followed through from the beginning of a potential new site expressing interest. Initial meetings between ELI and potential sites are started, with in-depth discussions.

- Costs of Programme Implementation
- Funding
- The contract between ELI/ParentChild+ and the site and responsibilities
- Site resources to implement ParentChild+
- Timeline of startup of the Programme
- ELI at hand to present for Board members or other consortiums of interest.

These discussions can take several meetings, and contracts are signed once all parties are happy with the outcomes. Senior specialists liaise with the manager in setting up a strategy to support the site with the programme's rollout.

Supporting implementation at the local programme site level: Timelines for training, recruitment and the start of the Programme can vary depending on the site's needs. It can be rolled over within 9-10 weeks from the Coordinator position being filled. Once contracts are signed, a typical startup consists of the following:

- Access to:

    - SharePoint site for ParentChild+ manuals
    - Training PowerPoints
    - Templates and Monthly Report Excel sheet.
- Access to
    - American ParentChild+ site for materials
    - Elevate, the ParentChild+ America training site.
- ParentChild+ Senior Specialist on hand for questions and support.
- Training for site staff on financial procedures and quarterly reporting by ELI Finance Officer.
- ParentChild+ Senior Specialist is available for the interview panel for the Coordinator position.
- ParentChild+ Senior Specialist will train Coordinator and support them in setting up Programme.
- ParentChild+ Senior Specialist will support Coordinator with 'Potential Home Visitor Information session' – from advertising the session to implementation. After the session, sites give out application forms for Home Visitor positions.
- ParentChild+ Senior Specialist is available for interview panel for Home Visitors positions.

The National Programme Support Structure provides implementation support once local home visitors have been employed and inducted by local organisations. These supports include the following:

- Senior Specialist gives support in recruiting families for Programme.
- ParentChild+ Senior Specialist trains Home Visitors and Coordinators in Home Visiting training.
- Home Visitors start in supervision and are introduced to families.
- ParentChild+ Senior Specialist trains staff in assessment and data collection training.
- On-going support and training from ParentChild+ Senior Specialist.

The supports have been tweaked over the years through a reflective practice process. ELI seek out community organisations with good governance in place, and their core ethos and values would align with ELI's.

As the Programme is scaled up, an iterative process is responsive to each site's needs. A primary obstacle to scaling is securing local-level funding. To date, all local site implementation is supported by funding secured through the National Programme Support Structure, which applies for funding and connects philanthropy and corporate donations to implement the Programme. Recognising this is not a viable or sustainable approach, and the National Programme Support Structure works with local sites to build their capacity, secure funding, and become sustainable.

In addition to providing a range of Programme specific supports required for scaling with fidelity, the National Programme Support Structure also promotes the educational development of the home visitors.

ParentChild+ supports all home visitors delivering the Programme across the country to become lifelong learners and understands the significant impact of continuous professional development on work practices and the quality of service. ParentChild+ ensures home visitors gain a minimum Early Learning and Care award at Level 5 on the NFQ and higher. National Programme Support Structure links with community organisations and the Educational Training Board to provide training opportunities. Also, in consultation with the National College of Ireland Centre for Education and Lifelong Learning, two new micro-credential courses for home visiting have been rolled out with a

high uptake from not only ParentChild+ staff but also staff from home-visiting programmes across Ireland.

As well as QQI training opportunities, ParentChild+ staff are encouraged to continue with CPD non-accredited courses for upskilling their pedagogy. The ParentChild+ CPD booklet is a training resource with 1000s of free online courses for the lifelong learner.

Let's Grow Together! Infant and Childhood Partnership – Infant Mental Health Home Visiting

Let's Grow Together! (Previously known as Young Knocknaheeny, established in 2015) is a registered charity based in Cork City Northwest and one the twelve ABC Programmes operating nationally.

Let's Grow Together! aims to provide area-based prevention and early intervention programming and approaches that support early childhood development, relationships, and environments for the benefit of children, families, caregivers, and communities. We achieve this by:

- Respectfully enhancing skills and early childhood development knowledge of all parents, practitioners, and services.
- Strengthening and supporting all relationships and environments that are important to every child's early development.
- Embedding systems and community change to support early childhood development.
- Undertaking participatory learning and evaluation to influence practice and policy.

The Let's Grow Together programme, consists of four interconnected Strategies, supported by a research and evaluation process and underpinned by an Infant Mental Health Framework. The strategies are connected by their common capacity-building, integration, and quality improvement approaches.

Development mechanism: Before receiving funding under the ABC Programme Infant Mental Health was a strategic focus for Young Knocknaheeny. It is a core element of the wider supports offered by Let's Grow Together! and as such is difficult to extract and review in isolation.

It derives from the Michigan Infant Mental Health Home Visiting Programme- Supporting Competencies/Reducing Risk. This is a manualised programme under Early Attachments: MH Home Vsiting® (Weatherston & Tableman, Infant Mental Health Home Visiting. Supporting Competencies/Reducing Risk. Manual for Early Attachments: IMH Home Visiting, 2015). The Programme implementation was supported and adapted by recruiting an IMH-endorsed specialist. It draws on the 6 core components of:

1. Concrete assistance
2. Emotional support.
3. Developmental Guidance.
4. Early relationship assessment and support.
5. Advocacy.
6. Infant-parent Psychotherapy (provided by IMH Specialist IMH-E® only).

Evidence base: The MI-AIMH IMH Home Visiting® has

- 1 RCT – US peer-reviewed
- 5 Quasi-experimental design – US peer-reviewed

It has been included in an evaluation of the broader Let's Grow Together! Programme process evaluation (Buckley & Curtin, 2018).

Implementation: The Infant Health and Well-being Strategy aimed to develop knowledge, skills, practice and services for the pre-birth to three-year development period. This is essentially a capacity-building strategy utilising a relationship-based approach, which was cognisant of the inter-generational impact of adversity on individual families and communities. IMH Masterclasses and Network Groups aim to enhance the **capacity of practitioners** to engage with vulnerable families, particularly regarding early social and emotional development. The home visiting and parental support programmes aim to strengthen the **capacity of families** to support their child's early development and enhance engagement between vulnerable families and appropriate services.

The Infant Mental Health strategy is delivered by the Let's Grow Together Inter-disciplinary Team with recognised qualifications in Social Care/Work, Speech and Language, Nursing, Community Development, Family Support, Early Childhood Education, or a related field.

- 4 Infant Parent Support practitioners (IPS)
- 2 Speech and Language Therapists (SLT's),
- 1 Public Health Nurse with a focus on Child Health & Development
- 1 Infant Mental health and wellbeing Coordinator who is also the Strand Lead.

The IMH strategy incorporates the Interdisciplinary IMH Home Visiting Programme. This relationship-based home visiting service, provided by the Let's Grow Together inter-disciplinary team, is available to all families who require additional support.

Relationship-building programmes that are integrated into home visiting practice:

- **Ante-natal Programme** This is a holistic and relational-based programme offered in the pregnancy stage to create time for parents-to-be to reflect on their emerging relationship with their baby, and their new roles as parents, with an assigned member of the IMH Inter-disciplinary team.

- **The New-born Behavioural Observations (NBO) system** (for babies (0-3mths)is a relationship-based tool that offers individualized information to parents about their baby's communication strategies and overall development to strengthen the parent-infant relationship. This is done in the family home and can act as a gateway to other services in the postnatal period.

Group Programmes offered by Let's Grow Together support the caregiver-child relationship and can be adapted for home visiting.

- **Infant Massage** Offered to parents and their babies up to the seven to the nine-month developmental stage to promote understanding of their baby's non-verbal cues and signals. It supported parent's attunement and capacity to bond with their baby. (Offered 1:1 in HV or group).

- **Circle of Security Parenting-** Circle of Security is an 8-week training programs for caregivers that make it easier for them to understand and meet the emotional needs of their children. (Offered 1:1 In HV or group format).

- **ELKLAN Let's Talk with your Baby Programme (3-12 months)** Delivered by IPS, this was an eight-week programme for caregivers and their baby. It promoted parent-infant interaction, development of attachment, and early communication skills.

- **Babbling Babies-(7-9mths)** caregivers can meet with a Speech and Language Therapist to talk about how their relationship with their baby can support their baby's communication skills and confidence

- **Peep Early Education Partnership (PEEP) (0-2 and 2-4 years)** This six-week programme, delivered by IDT, promotes parent's awareness of their infant and toddler's very early learning and development capacities through everyday interactions and activities.

- **The Peep Getting to Know Your Baby programme (1:1 in HV or group format) is offered antenatally**.

Capacity Building for IMH Interdisciplinary Team to support home vising practice.

- **Ongoing professional training** All staff are offered facilitator training in Circle of security, NBO, Peep learning together, Peep Getting to know your Baby, Hanen, learning language and loving it, Elkan, Let's talk with your baby, Baby massage.

- **IMH Practitioner Training and Network Groups**

This involves providing a two-day inter-disciplinary IMH Masterclass followed up with the facilitation of two ongoing Infant Mental Health Network Groups (IMH-NGs) for frontline practitioners working in statutory and voluntary agencies within the Let's Grow Together catchment area. IMH-NG's provided a mentoring and coaching facility following the IMH Masterclass. These were developed to support the consolidation of IMH core competencies and skills and facilitate their integration into frontline service delivery, i.e., Home visiting or the evidence-based caregiver-only or caregiver and child groups offered by Let's Grow Together!

- **Reflective Practice Supervision**

All the IMH interdisciplinary team have access to monthly 1:1 supervision and monthly group reflective practice supervision to support practitioners to reflect on themselves and how they are, deepen and broaden their knowledge, develop their professional practice, and explore the challenges of working with families and individuals with complex needs.

Appendix 2: Overview of programmatic components Irish home visiting programmes

Programme	ParentChild +	Lifestart Growing Child	Preparing for Life	Community Mothers Programme	IMH Home Visiting
Number of Programme Sites Supported on the Island of Ireland	12	11 (7 in ROI; 4 in NI)	9	7[28]	1
Number of Programme Sites Supported Internationally	N/A	2 (Macedonia & Zambia)	1 in development in the US	N/A	N/A
Universal/targeted	Targeted	Targeted to vulnerable families referred by social services plus universal dimension through referred first-time parents	Universal within area of disadvantage	Originally universal within area of disadvantage – now progressive universal with significant referrals from Tusla.	Targeted-Universal
Age range of child	**1.4 - 4**	**0-3** but can be extended to 0-5	**Pre-birth - 5**	**Pre-birth to 3**[29]	**Pre-birth to 4**
Duration and frequency of home visit	30 minutes Twice a week	1 hr at least once a month, delivered more often where there is additional need	Minimum of 1 hr / Monthly[30]	1 hr+ Originally monthly Now varies weekly – monthly	Flexible depending on the need or availability of family
Duration of engagement	2 years	2-3-years	Pregnancy to school entry (5+ years)	2-years originally Now varies - 2- 5 years[31]	Flexible depending on the need of the family - Pregnancy to 4 years

[28] Currently there are 6 Home Visiting Programmes derived from the Community Mothers Programme site. One additional home visiting Programme, Parents First (originally a Home Start home visiting service) has been participating within a Community Mothers Programme Development Project and this has been included within the total count of 7.

[29] Some sites current continue to see children up until 5 years of age. Under Community Families the age proposed is pre-birth to 3 years with flexibility to extend to 5 years pending family need and funder agreement.

[30] Frequency varies depending on family wishes and situation.

[31] Under Community Families it is proposed to offer the programme for a maximum of 3.5 years with flexibility to extend this to 5.5 years pending family need and funder agreement. High need families can continue to receive the Programme on subsequent children.

Additional supports	Parent-toddler groups and other programmes run by the different community organisations that deliver ParentChild+	Can increase frequency of home visits	Supported access to wrap-around services[32]	Access to wrap-around community-based activities and services[33] provided	Access to other LGT community-based activities.
Structured or response led	Structured while being child-led	Structured with manual and flexible at point of delivery	Response led with manual	Originally structured with response-led elements.[34]	Response led within the framework.
Specific / Multidimensional	Specific	Multidimensional	Multidimensional	Multidimensional	Multidimensional
Pre-recruitment qualifications required	No pre-recruitment qualifications required	Aligned graduate qualification	Aligned graduate qualification	No pre-recruitment qualification[35].	Aligned graduate qualification[36]
Employed home visitors/volunteer home visitors	Employed	Employed	Employed	6/7 sites have employed home visitors	Employed
Pre-recruitment training required	2 hours information session	Not required	Not required	Not required	Not required
Programme training	**16 hours** of Programme Training plus **5 hours** pre-training tasks	**12 hours** of Programme training – 3 x 4 hr sessions + shadowing visiting with experienced staff	**5 days** of Programme training (35 hours) Followed by observation visits (2 days) Delivered by the National	Originally **6 hours** of 1 to 1 training delivered over 4 weeks before practice Delivered locally by the FDN in the HV's home to model	In-house and external

[32] Antenatal care, breastfeeding support, baby massage, evidence-based parenting programmes (Triple P / CoS)

[33] Mellow Bumps – area dependent, breastfeeding support, parent-baby groups, parent-toddler groups, infant massage, weaning workshops, first aid and other parent information sessions, evidence-based parenting programmes (CoS/Incredible Years / Triple P/ Parents Plus – depending on area).

[34] A home visitor guidebook has been developed for Community Families – this will enable a response led approach with a core guiding framework.

[35] Under Community Families it is proposed that a QQI level 5 qualification in an aligned sector is required.

[36] Note the Let's Grow Together IMH Home Visiting Model employs health/social care and early years professionals – (Speech and Language Therapists, Public Health Nurses, Early Years Educators, Social and community Development workers as home visitors)

			Programme Support Structure	the parent – HV relationship[37].	
Professional development mechanisms in place	• 2 hrs weekly local group support & supervision • QQI Level 6 and 7 online courses run by NCI for HVs & coordinators • 3 annual community of practice days and monthly online support sessions for coordinators Additional training offered at site and national level.	• Individual home visitor supervision at local site every 6 weeks • Annual 1-day Programme professional development day • Support to attend range of professional development training opportunities	• Peer Support and Capacity Building • Action Learning Coaching / Case review sessions 3 times a year • Individual supervision provided at local level or PFL can provide • Additional training is recommended[38]	• Originally, monthly supervision with FDN[39] • Community Mothers Community of Practice for Coordinators peer support– 6 weekly • Currently, mixed model of training across sites moving to a standardised minimum level of ongoing professional development.[40]	• Monthly supervision with IMH and Wellbeing Co-ordinator. • Monthly Group Reflective Practice Supervision • Monthly Infant Mental Health Network Group (Reflective Practice) • All staff trained in a comprehensive induction and CPD programme[41]
Main evaluation approach RCT/Quasi-Experimental and Peer Reviewed	• RCT USA 1984 peer-reviewed • RCT USA 2016 unpublished • RCT USA 2018 unpublished Total -	• RCT Ireland[42] 2015 published • Subsequent Evaluation by mixed methods published 2021	• RCT 2011 - Ireland with repeated data collection at 6 months 12 months 18 months 24 months	• RCT Ireland 1993 – 1 year of intervention • RCT Ireland 1997 – replication to Traveller Community • RCT Ireland 2000 – 7 year follow up original	• 1 RCT – US peer-reviewed • 5 Quasi-experimental design – US peer-reviewed

[37] Under Community Families model a new proposed training programme has been devised and is due to be piloted in 2023. It is planned to deliver training across Local Programme Sites involving a mix of group and individual depending on needs with an estimated 30 hours of direct training delivered over 4 weeks in parallel with 6 weeks of practice-based training. There is flexibility regarding the time frame of the practice-based experience depending on the background of the home visitor.

[38] A range of training programmes include - infant massage, Triple P (8 Week Group), Circle of Security.

[39] Under Community Families model weekly reflective practice, team peer learning and individual supervision is provided at a local level, initially weekly and then reducing in line with experience. A Community Families Community of Practice Peer Learning Network meets every 6 weeks.

[40] Under Community Families model a comprehensive list of external training in evidence-based Programmes or evidence informed practice is also recommended- trauma informed care, infant mental health, Circle of Security, Infant Massage, My Place to Play etc.

[41] All LGT home visiting staff are trained in Baby Massage, Circle of Security, New-born Observational Systems Training (NBO), PEEP (Getting to Know Your Baby Antenatal Programme), PEEP (Learning Together Programme), Hanen (Learning Language and Loving It).

[42] (Miller, Dunne, Millen, Neeson, & McGeady, 2015)

	• 5 RCTs Bermuda & USA • 6 quasi-experimental evaluations USA 3 studies in Canada & Ireland		36 months 48 months School age – 5 years • 2019 – follow up at 9 • Further data collection at 13 years due to take place in 2023 • Peer Reviewed in multiple journals	cohort[43] All published in peer-reviewed journals	
Child outcomes demonstrated through research – statistically significant	• improved cognitive ability & • improved language • improved social-emotional competence	N/A	• enhanced language development & increased chance of having above-average language • better approaches to learning & increased ability to attend • lower risk of behavioural issues & less risk of 'not being on track.' • lower risk of obesity • more advanced fine and gross motor skills • increased cognitive development &overall improved cognitive functioning improved outcomes on school performance in reading and maths	• increased uptake of immunisations • increased nutritional diet	• reduced impact of Mothers' ACE score on language development
Child outcomes– promising trends	• Impact on siblings • Frequency of library visits improving	Positive trends with small effect sizes • higher cognitive development	Positive trend toward • sustained socio-emotional outcomes	Increased early learning opportunities supported by parent	• reduced child abuse potential depending on the level of input with parents (dosage)

[43] This refers to the 'original model'. There have been no subsequent RCTs carried out within any of the other CMP sites.

		• increased prosocial behaviour • decreased difficult behaviour • fewer speech and language referrals			
Parenting outcomes demonstrated through research – statistically significant	• Improved parent-child relationship	• reduced parenting-related stress • increased knowledge of their child's development, improved confidence in their parenting role		• increased nutritional diet • improved scoring on measures of wellbeing – headache/self-esteem • improved scoring on interactions with children – singing/playing/reading	
Parenting outcomes – promising trends	• Improved parental involvement in child's education	N/A	N/A	N/A	• increased parent sensitivity (dose-response) • reduced harsh parenting (dosage response)
Was original evidence-based research funded in Ireland? How was this funded?	• Evidence base gained in USA and Bermuda. • Evaluative research carried out in Ireland in 2011 funded by Pobal Dormant Account Funds-Flagship Projects.	• Evidence base gained across the island of Ireland • Funded by Atlantic Philanthropies	• Evidence-based gained in Darndale, Dublin • Funded by Atlantic Philanthropies	• Evidence-based gained in Dublin, Ireland The Health Board carried it out, and it is unclear if this was supported by Bernard Van Leer Trust funding.	No The evidence base was developed in the US
Programme Governance and Research Office in Ireland	No - International governance from the US office	Yes	Yes –Northside Partnership, Darndale, Dublin	Presently no National Programme Support Office[44]	No, it is in the US Let's Grow Together has replicated and adapted

[44] Under the Community Mothers Programme Development Project, national governance for the successor Programme, Community Families will lie with the HSE under the National Healthy Childhood Programme and Tusla, the Child and Family Agency

	• ELI hold an international licence to implement and scale the Programme in Ireland • NCI Governing Body provides governance along with ELI Advisory Committee and Steering Group • The new ELI National Centre oversees programme governance and national research.				the implementation of the Michigan Model to fit the Irish ABC context with direct support from Michigan initially
Irish National Programme Support Structure Staffing	• 1 full time Coordinator • part-time support from wider ELI Team: Programme Director/ Research Finance, HR, ICT, Management & Governance from NCI	• 1 full time CEO • 1 full time manager • P/T Administrator • P/T training staff	• 1 full time Implementation Manager Additional support (part time): • Darndale HV Coordinator (Training) • Research Coordinator & Research Officer • Admin and Finance Officer. • Communications & PR Officer	N/A	N/A
National statutory and/or sustainable funding for National Programme Support Structure	• No • 11% state grant aid – once off grant. Cross-subsidised by wider organisational funding and substantial corporate and philanthropic	• No • Funded solely by an annual license fee & charges for the Growing Child materials paid by Local Implementation Sites	• No • National Programme Support Structure had no dedicated sustainable funding until 2022 It currently has 5 year funding under an	N/A	N/A

	grants		international initiative		
ICT: National Office database/CRM system	Currently using Microsoft Dynamics CRM in ELI Dublin site. Review underway.	Yes	Formal evaluation framework in place. Currently developing CRM for scaling to all sites	N/A[45]	N/A
ICT: Local Programme site database/CRM system	Excel data collection through established Sharepoint system	3 sites have a system in development	None reported	2 out of 7 Programme sites have a database/CRM	Yes - Let's Grow Together Database
Number of implementation sites supported	11 nationally	11 across the island of Ireland	9 sites in Ireland (inc. Darndale) 1 site in Chicago, Illinois	No National Programme Support Structure presently	No National Programme Support Structure presently
Total number of local implementation site coordinators	12 full time Managers 7FTE Coordinators 3 full time Coordinators 13 part time Coordinators	8 full time 3 part time Including NI	9 Ireland only	6 FTE Coordinators 4FT 3 PT	1 IMH & Wellbeing Coordinator
Total number of home visitors in FTEs and full time / part time	26 FTE 59 part time	? FTE 14 full time 32 part time	16.4 FTE 5 full time 19 part Time	17 FTE 33 part time	6.8 FTE 6 full time 1 part time
Total number of homes/families visited in 1 year	439	1738	420	1146	165
Total number of children receiving/benefitting from the Programme[46]	449	1863	420[47]	1263[48]	345

[45] A revised Community Mothers Programme, Community Families has a national programme CRM systems in development funded through philanthropy.
[46] Programmes provided data for 1 year period however this could have been any one year between 2020 – 2022 – data collection methods varied and so this was difficult.
[47] May be higher if more children in the family – this data is not collected
[48] Many children continue in the Programme to avail of Programme led groups bringing this figure to 2747

Total number of referrals received in 1 year[49]	445	920	450	1066[50]	130
Total number of home visits carried out in 1 year	11,960[51]	21,275[52]	5, 040[53]	12,447[54]	495
Funding received for Local Programme Site Implementation	€359,082	€1,204366[55]	€ 721,120.00	€1,000,000[56]	N/A
National Programme Support Structure costs	€149, 283	Not available	€28,000[57]	N/A	N/A

[49] Programmes provided data for 1 year period however this could have been any one year between 2020 – 2022 – data collection methods varied and so this was difficult.
[50] 2020 data
[51] Given the impact of COVID, visits can be arranged in a more flexible way to meet the family's needs for example: in the home, in a park or via a video phone call link. However, most home visits are in person in the child's home.
[52] Given the impact of COVID, visits can be arranged in a more flexible way to meet the family's needs for example: in the home, in a park or via a video phone call link. However, the majority of home visits are in person in the child's home.
[53] Based on minimum monthly visits but this may have been higher depending on family needs
[54] Not all sites count this data so this has been estimated based on diary entries for some sites in 2020. As above COVID limited visits in the home.
[55] This represents the funding received in Ireland and excludes funding received for services delivered in Northern Ireland
[56] This is a collated figure from all sites that reported costs in 2020 and may not be accurate today.
[57] This excludes recent funding to support implementation in Chicago.