Developing a framework for a family-focused preventive intervention using the Delphi method

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Abstract

This paper reports on the use of the Delphi method to develop a framework for a family-focused preventive intervention. 65 knowledgeable individuals from diverse backgrounds discussed the topics and techniques of family-focused intervention, the definition of its target population, appropriate recruitment and implementation strategies and the profile of the group leaders during the four rounds of the study. The findings illustrate the acceptability of family-focused preventive interventions in Belgian social work provided that they are culturally appropriate. The study also made a number of suggestions to support the implementation of family-focused interventions in practice. The Delphi method serves as a useful guide for the design and implementation of innovative and socio-culturally relevant interventions.

Key Words: family-focused preventive intervention, parenting adolescents, Delphi studies, cultural adaptation

Introduction

This paper reports on the use of the Delphi method to develop a framework for the design and implementation of a family-focused preventive intervention in Belgian communities. Family-focused preventive interventions address adolescent problem behaviour through preventative interactions with both the adolescents and their parents (Hogue & Liddle, 1999). The interventions are influenced by family systems theory, cognitive behaviour theory, attachment theory, developmental theory and social-ecological theory. Recent reviews have confirmed the capacity of family-focused interventions to reduce risk factors and enhance protective factors for the onset and persistence of youth problem behaviours (Farrington & Welsh, 1999; Kumpfer & Alvarado, 2003). Developmental research provides three fundamental explanations for the effectiveness of family-focused interventions with adolescents. Firstly, the bi-directionality of family members' development and family-functioning supports the use of family-focused interventions that influence both (Parke, 2004). Secondly, adolescents increase their influence on family functioning particularly during the first years of adolescence (Steinberg & Morris, 2001). Both parents and adolescents face the challenge of finding the right balance between autonomy and connectedness (Steinberg & Silk, 2002). Therefore, interventions with adolescents need to go beyond parenting practices to include family communication and the quality of the parent-adolescent relationship. This is achieved through family-focused inter-

ventions (Smith et al., 2004). Thirdly, developmental research asserts the interdependence of the individual with the family, peers, school, the community and society at large (Bronfenbrenner, 1986; Lerner & Simi, 2000). Therefore, interventions targeting adolescents and parents within their social environments, e.g. their family and their community, may yield more and longer-lasting gains (Peterson, 1995; Smith et al., 2004). In sum, family-focused preventive interventions with adolescents are theoretically sound and practically effective (Kumpfer & Alvarado, 2003; Moran, Ghate, & van der Merwe, 2004).

However, although there is a clear need for family-focused preventive interventions with adolescents, few such interventions are in use (Hogue & Liddle, 1999). Interventions that target families with adolescents are mostly indicated or treatment interventions (Munoz, Mrazek, & Haggerty, 1996) that deliver services to individual families who are at high risk of or experiencing clinical problems (Austin, Macgowan, & Wagner, 2005). Only a few family-focused interventions are selective interventions that target multiple families in community-based groups. Well-researched examples include the first Adolescent Transitions Programme (ATP; Dishion & Andrews, 1995) and the Strengthening Families Programme (SFP; Kumpfer, Molgaard, & Spoth, 1996). These interventions differ on a number of attributes, such as the scope of the programme, the type of parent and adolescent involvement and the intensity of services. They have in common, among other things, the fact that the programme is highly standardised and that a risk status assessment is conducted to determine eligibility for participation in the programme (Hogue & Liddle, 1999). Both interventions, however, have been developed, implemented and evaluated in the USA. Therefore, their transferability to other countries cannot be taken for granted (Jack, 2005). This observation recently prompted a UK-based study into the limits and possibilities of involving young people in parenting programmes (IYPP; Hoskin & Lindfield, 2005). In Belgium too, the need for such research has been recognised (De Mey, Moens, van Leeuwen, & Verhofstadt-Denève, 2000). Several authors have also pronounced the need for studies that test empirically the feasibility and the cultural appropriateness of interventions involving parents as well as adolescents (Coleman & Roker, 2001; Deković, Janssens, & Van As, 2003). Therefore, an ongoing programme of research was initiated with a view to developing, implementing and evaluating an innovative family-focused preventive intervention, the Families in Transition (FIT) programme (Engels, 2006).

The FIT programme is group based and involves a parent module, an adolescent module and a family module. Throughout the modules opportunities are provided to normalize parenting stress and to build social support, exercises are implemented to improve parenting practices, and (role-)plays are implemented to support parent-adolescent communication and relationships. A key element of the program is the Contact Game that was developed with a view of providing an opportunity for parents and adolescents to improve family communication and the quality of their relationship (Vanlommel, Engels, & Heughebaert, 2004). Central in the Contact Game is that it appeals to parents as well as adolescents and puts them in a position where they have to cooperate in a safe but competitive environment. In the game, the interests of parents – to discuss parenting related topics – and adolescents – to win the game – are inextricably intertwined. One cannot discuss parenting related topics without highlighting the competitive aspect of the game, and vice-versa. An elaborate discussion of the elements of the programme, including introductory and information centred activities, exercises and role-plays, is provided in the Contact Book (Engels & Andries, 2004). The long-term follow-up of the FIT programme is currently being undertaken, but both the feasibility and the immediate follow-up results proved promising (Engels & Andries, 2007; Engels, Lambrecht, & Andries, 2006). The design and implementation of the FIT programme were informed by a framework developed through a Delphi study.

Why Delphi?

Delphi is a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem (Linstone &

Turoff, 1975). In this study, the content of an intervention, the risk status of the target population, the recruitment strategies, the implementation strategies and the profile of the group leaders were to be decided upon. We therefore conducted a Delphi study that comprised a broad exploration of possibilities followed by an informed decision on a coherent framework for family-focused intervention. A Delphi study was well suited to this project, as it is designed to show convergence of opinions and to identify dissent among a group of experts who fill out the successive iterations of a questionnaire (van Zolingen & Klaassen, 2003). The method allows for the consultation of multiple individuals with knowledge relevant to the problem under investigation. In particular, we wanted to involve experts in prevention, experts in care, academics, government officials, parents and adolescents. These divergent backgrounds had to be represented in the study for the framework to be acceptable and realistic for clients and professionals within different settings.

We might reasonably expect a Delphi study to be effective for these purposes, as we met three appropriateness criteria (Dawson & Brucker, 2001; Linstone & Turoff, 1975). Firstly, there are no clear guidelines for the design and implementation of family-focused intervention (Hogue & Liddle, 1999). Moreover, local experts as well as adolescents and parents needed to contribute towards the discussion in order to make the framework socio-culturally relevant and credible (Bogenschneider, 1996; Lerner & Simi, 2000). A Delphi study was appropriate in this regard, as the method allows a group of individuals to contribute towards the structured discussion of a complex topic (Linstone & Turoff, 1975). Secondly, the individuals who needed to contribute towards the discussion came from diverse backgrounds as regards experience and expertise. At both the local and the international level, there have for a long time been gaps between developmental research and intervention practice and between preventive and care approaches in the field of child and family welfare, and there is a real need for these gaps to be filled (Cicchetti & Hinshaw, 2002; Farmer & Farmer, 2001; Tilbury, 2005). Thirdly, considerable disagreement between the panellists could be expected, as individuals working in different services appear to constitute different 'cultures' (Farmer & Farmer, 2001). Therefore, a structured discussion method that gives all the participants anonymity until the end of the study – as does the Delphi method – was appropriate as it allows them to express themselves freely.

Research questions

We formulated five research questions that were to be answered by the Delphi study.

(1) What topics and techniques need to be included in the intervention?
(2) How can the target population of the intervention be defined?
(3) What recruitment strategies are appropriate?
(4) How can the intervention be implemented?
(5) What is the ideal profile of the group leaders?

Method

Pilot study

We conducted a pilot study with a view to preparing and facilitating the Delphi study. We reviewed the literature on family-focused intervention (Engels, 2006) and held 38 face-to-face meetings with experts. With each of these experts we discussed the issues that needed to be addressed in the Delphi study. They were particularly concerned with bridging the gap between theory and practice, i.e. how (developmental) theory can be translated into a feasible

and effective intervention. They recommended that the Delphi study should focus not only on the nature and scope of the intervention, but also on the organisational aspects. Following these meetings, we asked the experts to nominate experts – including themselves – for the Delphi study. Based on recommendations for programme planning through Delphi studies (Delbecq, Van de Ven, & Gustafson, 1975; Okoli & Pawlowski, 2004), a number of these nominees were subsequently invited to participate in the Delphi.

Participants

Prior to the start of the Delphi, 71 nominees formally agreed to participate in the study; 65 (91.5%) did indeed participate, while 6 (8.5%) declined because of a job change or a substantive change in their job description. These 65 participants in the Delphi study (also referred to as the panellists) included experts in youth care (15), experts in prevention (17), academics and government officials (15) and parents and adolescents (18). The experts in youth care included practitioners and specialists working in non-residential youth care programmes, residential youth care programmes, mental health services, psychiatric services or drug abuse treatment centres. The experts in prevention included practitioners and specialists responsible for preventive services in schools, communities, youth centres or parent education and support centres. The academics and government officials involved in the study conducted research in or were responsible for policy-making in one or more of these settings. The experts in care, experts in prevention, academics and government officials together formed the group of professional panellists. Men (22) and women (25) were equally represented. Half (23) of the professional panellists had a university degree, several (17) were employed in a managerial post within their organisation and half (25) had children between the ages of 10 and 15. The parents (6) and adolescents (12) in the panel came from Caucasian families and diverse socio-economic backgrounds. Of the parents (4 mothers and 2 fathers), two were housewives, two were skilled labourers and two were teachers. The adolescents (5 girls and 7 boys) were between 14 and 17 years of age and were enrolled in mainstream (7) or vocational (5) education. None of the parents or adolescents had experienced severe parenting problems in their family. Through the involvement of these non-professional panellists, a user perspective was incorporated in the study (Boote, Barber, & Cooper, 2006; Hasson, Keeney, & McKenna, 2000).

Study design and analysis

The Delphi study comprised four rounds. The study stood midway between a policy Delphi and a decision Delphi. In a policy Delphi, the divergence of opinions is pivotal, as different possibilities are explored in order to support later decision-making (Turoff, 1975). A decision Delphi results in decisions that set out guidelines for an aspect of social development (Rauch, 1979). In our study, we explored divergent opinions and possibilities in the first and second questionnaire round and then decided on a framework for a family-focused intervention during the third round questionnaire and the group meetings. Similar approaches have been used in clinical guideline development (Murphy et al., 1998) and curriculum development (Clayton, 1997). An extensive rationale for this methodology can be found elsewhere (Engels & Kennedy, in press).

The round 1 questionnaire (Q1) involved asking the panellists open-ended questions on the topics and techniques of family-focused intervention (six questions), the target population (seven questions), the recruitment strategies (three questions), the implementation strategies (six questions) and the profile of the group leaders (four questions). At the end of each group of questions, the participants were invited to raise any further issues (Table 1).

Table 1
First round open-ended questions per research question

Research questions Round 1 questions
(1) What topics and techniques need to be included in a family-focused intervention?
(a) What topics need to be included in a family-focused intervention for the prevention of youth problem behaviour?
(b) Can you rank these topics from most to least important?
(c) What needs to be stressed with adolescents and what with parents?
(d) What can influence the content of the sessions?
(e) What techniques need to be included in the intervention?
(f) What materials need to be developed for the intervention?
(2) How can the target population of the intervention be defined?
(a) What parents and adolescents should the intervention target?
(b) Why?
(c) What are the advantages/disadvantages of targeting specific groups of parents and adolescents?
(d) How can we name these groups?
(e) What characteristics of the target group(s) need to be taken into account?
(f) What target groups are hard to reach for family-focused intervention?
(g) What criteria can be specified for participation in the intervention?
(3) What recruitment strategies are appropriate?
(a) How can we approach families for participation in the intervention?
(b) What do families need to know about the intervention upon recruitment?
(c) How can we strengthen participant motivation at the start of the intervention?
(4) How can the intervention be implemented?
(a) How many sessions can the intervention consist of?
(b) What is the minimum, maximum and ideal period that elapses between the start and the end of the intervention?
(c) What time of the year is best suited to start and end the intervention?
(d) How many adolescents and how many parents can participate per group?
(e) What needs to be taken into account to determine group size?
(f) Can the intervention consist of sessions for parents and adolescents together? Or are sessions for parents only and sessions for adolescents only more appropriate?
(5) What is the ideal profile of the group leaders?
(a) Who can facilitate the program sessions?
(b) What expertise, experience and knowledge should the group leaders possess?
(c) How can the group leaders be prepared for the intervention?
(d) What support needs to be provided for the group leaders during the intervention?

The round 2 questionnaire (Q2) presented all the proposals mentioned in the 58 Q1s that were returned within two months. Some of the proposals were grouped and reformulated, but none were omitted (Hasson et al., 2000). All the proposals regarding the topics and techniques of the intervention (161 proposals), the target population (71 proposals), the recruitment strategies (55 proposals), the implementation strategies (108 proposals) and the profile of group leaders (63 proposals) were presented in four-point Likert-scale questions (strongly disagree, disagree, agree and strongly agree), with the possibility for the panellists to add comments or argue their positions. Proposals were retained if they fitted into the categories of large agreement (LA) or large disagreement (LD), indicating that at least 75% of the panellists endorsed or rejected a given proposal. Thus, LA applied if 75 to 100% of the respondents (strongly) agreed with a proposal, whereas LD applied if 75 to 100% of the respondents

(strongly) disagreed with a proposal. Other proposals were not retained because panellists held divergent views, agreed insufficiently or both.

The round 3 questionnaire (Q3) presented the panellists with a set of 17 paragraphs that summarised the proposals classified as LA or LD on the basis of the 53 Q2s received. The paragraphs presented the topics and techniques of the intervention (4 paragraphs), the target population (4 paragraphs), the recruitment strategies (2 paragraphs), the implementation strategies (4 paragraphs) and the profile of group leaders (3 paragraphs). The panellists were asked for each of these paragraphs whether they agreed or disagreed and whether they had any comments. By grouping the proposals retained into paragraphs, we moved towards a decision on a coherent framework for a family-focused intervention.

The final decision on the framework was taken during the two group meetings ($n_1 = 18$, $n_2 = 23$) that concluded the Delphi study. The proposed framework consisted of the (sometimes slightly reworded) 17 Q3 paragraphs, as each of these had achieved at least 75% agreement of the 42 panellists returning Q3. Although some issues remained unresolved, both group meetings concluded with 100% agreement on the total of the 17 paragraphs, i.e. the framework for family-focused intervention.

Results

The Delphi study generated a wealth of qualitative and quantitative information relevant to the five research questions. We present a summary of this information and the discussions that were held during the successive rounds, emphasising the framework for the family-focused intervention that was approved during the group meetings.

The first research question regarding the topics and techniques to be incorporated in the family-focused intervention generated 161 proposals. Most of the proposals (124) concerned the topical scope of a family-focused intervention. These proposals were largely supported and grouped into six broad topics, i.e. family communication, parenting adolescents, school, sexuality, substance use and leisure. Rather than presenting these topics in a standardised format, the panellists proposed that the actual topics addressed should reflect the participants' needs and concerns. Thus, the topics are intended to direct the scope of the family-focused intervention towards a fixed range of topics that are considered to have a clear link with parenting. Within this range, parents and adolescents should have sufficient opportunities to set priorities and to exchange experiences in order to increase the relevance of the intervention. This can be achieved through a range of group facilitation techniques, such as (small) group discussions, exercises, skills training techniques and information giving. Depending on the group members' expectations and the group leaders' expertise, role-play and therapeutic play can be added to facilitate group and family interaction.

The second research question concerned the definition of the target population of the family-focused intervention. Two aspects were discussed in depth during the study. A first discussion arose over the question as to whether parents only, adolescents only or both parents and adolescents should be targeted. Some experts argued that the involvement of adolescents in the intervention would harm rather than help families, whereas others argued that the idea was noble but unrealistic. Nevertheless, a large majority agreed that both parents and adolescents should be involved through a module for parents, a module for adolescents and a module for families. Many panellists also considered working with parents only a possibility, e.g. if adolescents could not be motivated to participate. A second discussion focused on whether all the families with adolescents or only a specific subgroup among them should be targeted. A large majority agreed that family-focused intervention should be open to all but that an extra effort should be made to attract particular at-risk groups. Among the different at-risk groups, the panel identified families with parenting problems and families with adolescents with behavioural problems as the highest priority, since their prospects can be seriously compro-

mised if problems persist. Families expressing a need for support also need to be given priority, because the prospects in these families can diminish rapidly when continuing demands for support are not met.

The panellists proposed many recruitment strategies. The potential partners in the recruitment process were many and varied, ranging from local community leaders to the mass media. However, a large majority of the panellists agreed that community services and national organisations with strong local ties are best placed to recruit families. Local cooperation with such organisations makes for effective person-to-person recruitment. The mass media, in contrast, foster impersonal recruitment. The production of a leaflet was considered to be a helpful additional strategy. Also, it was agreed that information about the family-focused intervention should be concise, clear and personalised. Potential participants need to be visited at home by a group leader to discuss thoroughly the approach of the programme and the motivation of (the) parent(s) and (the) adolescent(s) to enrol.

The fourth research question encompassed several practical aspects connected with the implementation of the intervention. The initial questions concerned the duration and intensity of the intervention, the planning of the intervention in the calendar year, the number of participants per programme and the kind of sessions to be implemented. The experts suggested that the duration and intensity of the intervention could vary considerably, i.e. in principle between two and twenty sessions could be organised over two to twelve months. Most experts, however, agreed that the intervention should be limited to ten sessions over two to four months. The intervention should be planned between September and May to avoid having sessions during the exam periods and the summer holidays. The panel members identified fourteen as the ideal number of participants per programme, with ten as a minimum and sixteen as a maximum. In each group, the number of parents and adolescents should be approximately equal. Therefore, each family would be required to enrol with at least one parent and one adolescent. The number of participants per session depends on the nature of the session: sessions within the parent module involve parents only, sessions within the adolescent module involve adolescents only and sessions within the family module involve both. At the end of the intervention, each parent and each adolescent should have participated in at least five sessions.

The last research question concerned the ideal profile of the group leaders. The panellists felt that group leaders should be professionals with considerable experience, i.e. persons who have been working in a psychosocial setting for several years and have at least a bachelor's degree in a psychosocial discipline. Furthermore, group leaders should have experience of working with groups and should have proven expertise in parenting adolescents. The panellists also endorsed the idea that two group leaders should facilitate each intervention session, because this creates numerous opportunities during group work, e.g. groups can be split or one trainer can focus on training content while the other focuses on group interaction. The group leaders should also be prepared for and supported during the implementation of the intervention.

Discussion

The Delphi study proved appropriate for the development of a framework to guide the design and implementation of a family-focused preventive intervention involving adolescents. The structured group discussion yielded input on many aspects of intervention design and implementation by experts in prevention, experts in care, academics, government officials, parents and adolescents. The panellists had extensive discussions on the topics and techniques of the intervention, the definition of the target population, the recruitment strategies, the implementation strategies and the profile of the group leaders.

Table 2
Response rates of the Delphi panel and its subpanels

	Round 1			Round 2		Round 3		Round 4	
Delphi panel ($N = 65$)	n	N	%	n	%	n	%	n	%
All subpanels		58	89.2	53	81.5	42	64.6	41	63.1
Experts in prevention	17	14	82.4	13	76.5	8	47.0	10	58.8
Experts in care	15	15	100.0	15	100.0	13	86.7	13	86.7
Academics and government officials	15	14	93.3	14	93.3	11	73.3	12	80.0
Parents and adolescents	18	15	83.3	11	61.1	10	55.6	6	33.3

Two limitations of the Delphi study should be noted. First, the degree of participation differed between the subpanels from round 3 on (Table 2). The four subpanels were proportionately represented in rounds 1 and 2, $\chi^2(3, N = 58) = 1.10$, $p = .78$, and $\chi^2(3, N = 53) = 3.73$, $p = .29$, but not in rounds 3 and 4, $\chi^2(3, N = 42) = 9.65$, $p < .05$, and $\chi^2(3, N = 41) = 11.75$, $p < .01$. In rounds 3 and 4 the experts in prevention and the parents and adolescents were poorly represented. During telephone follow-up calls several experts in prevention told us that the workload in their sectors is too heavy in the period during which we asked them to complete Q3 and to participate in the final workshops, i.e. June and the first days of July. This probably accounts for a significant number of non-participants, as there was no substantial dropout until round 3, whereas the highest dropout usually occurs in the first round (van Zolingen & Klaassen, 2003). However, timing cannot explain the steadily declining participation of parents and adolescents. In response to telephone reminders, some parents and adolescents reported that the successive Delphi questionnaires were hard to fill out primarily because they had difficulty understanding the exact meaning of some questions and suggestions. Also, the parents and adolescents held slightly more divergent opinions than other subpanels, as was revealed by chi-squared tests comparing the Q2 and the Q3 answers between subpanels. Although divergence was limited to 25 proposals in round 2 and one paragraph in round 3, a second limitation of this study is that it may have been subject to self-selection. In particular, parents and adolescents – and perhaps also professionals – who were less motivated for or interested in the research topic may have dropped out of the study. Therefore, the observed convergence of opinions in the study potentially represents a bias towards the ideas of those who are more interested in or motivated for family-focused intervention. This illustrates the difficulty of keeping panellists motivated throughout the rounds of a Delphi study. Perhaps reducing the length of the questionnaires, constructing different questionnaires for each subpanel or both might have reduced the threat of self-selection (van Zolingen & Klaassen, 2003). Also, the results of the Delphi study might have benefited from combining it with the strengths of interview methods (Kennedy, 2004).

Irrespective of these methodological issues, the study generated the blueprint of an intervention that can be compared with existing family-focused preventive interventions in several aspects. As regards the topics and techniques of the intervention, the panel reasoned for an intervention targeting multiple topics via a diversity of intervention techniques. This approach allows the group leaders to target multiple family-related risk and protective factors for an array of youth problem behaviours. Such an approach is consistent with the need for programmes targeting multiple outcomes via a variety of strategies (Nation et al., 2003). It differs, however, from highly standardised approaches such as ATP and SFP in that it allows for the adaptation of the intervention in response to participants' needs and concerns (Hogue & Liddle, 1999).

The panellists used a somewhat double standard in their definition of the target population of the family-focused intervention. On the one hand, they decided for an intervention open to all

families, marking the intervention as universal, while on the other hand they specified that an extra effort should be made to cater for at-risk families, marking the intervention as selective (Munoz et al., 1996). Given the panels' plea for targeted person-to-person recruitment through community services and national organisations, this definition can best be understood as a matter of principle, that is, any family can enrol, but recruitment efforts need to be directed towards specific families (Harachi, Catalano, & Hawkins, 1997). A formal risk status assessment of these families is undertaken only after engagement in the programme has been agreed upon during an informal interview with the family. This approach resembles that of the IYPP project, but differs from the often proclaimed exhaustive risk and protective factor assessment applied to assess suitability of participation in a programme (Hogue & Liddle, 1999).

The intensity of services tends to vary substantially across family-focused interventions, ranging from only 4 to over 30 sessions. Most interventions, however, consist of between 8 and 12 sessions, involving parents, adolescents or both (Lochman & van den Steenhoven, 2002). Similarly, the panellists reasoned for an intervention that allows each parent and adolescent to engage in at least five out of a total of ten sessions. However, whereas most interventions involve either a family module or a parent module and an adolescent module, the panellists proposed a parent module, an adolescent module as well as a family module. Each of these modules needs to be facilitated by educated, experienced and well-prepared group leaders, a factor that is essential for effective programming (Moran et al., 2004; Nation et al., 2003).

Over and above these recommendations relevant to the design of the family-focused preventive intervention, the study revealed some pertinent indications to support the feasibility of such an intervention in Belgian social work practice. Firstly, the fact that the panellists agreed upon a framework for a family-focused preventive intervention illustrates the potential acceptability of such an approach. Likewise, other risk- and protection-focused approaches such as Communities that Care have reported limited resistance to the implementation of approaches originally developed in the USA (Jonkman, Junger-Tas, & van Dijk, 2005). Secondly, the engagement in and the enthusiasm for the study by families and professionals with diverse backgrounds illustrates the perceived relevance of the topic across 'cultures'. One implication is that the implementation of family-focused preventive intervention can benefit from but can also be an incentive for greatly needed multi-agency collaborations in communities (Farmer & Farmer, 2001). Thirdly, the study drew attention to some specificities of Belgian social work practice. In particular, services are usually open to all children and their families, regardless of age, sex, ethnicity and the level of problems experienced. Also, group leaders are used to adapting intervention content to the needs and concerns of families. Therefore, some modifications to the USA models of family-focused interventions are proposed in that a more flexible approach to programming is advocated and that a formal risk status assessment is implemented only after engagement in an intervention has been agreed upon. Similar differences have been reported in the IYPP project (Hoskin & Lindfield, 2005), indicating a need for careful adaptation of family-focused interventions to European contexts. Together, these three observations provide support for the feasibility of family-focused preventive intervention in social work practice if sufficient room for cultural adaptation is provided.

We conclude that we have illustrated how a framework for the design and implementation of a family-focused preventive intervention can be developed through a Delphi study. The use of the Delphi method in the area of programme planning and design is one of the methods' earliest applications (Delbecq et al., 1975), and it still appears to be an appropriate one. The resulting framework indicates that family-focused approaches are acceptable to families and professionals from a diverse range of backgrounds. However, adequate cultural adaptation is necessary to support the practical feasibility of a family-focused intervention.

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