Promoting the Well-Being of Families and Children:
A Study of Family Support Services in the Health Sector in Ireland
Report to the Department of Health and Children

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Introduction

The Department of Health and Children initiated a national review of family support services in 2003 with the support of a Steering Group, the Health Boards, the Eastern Regional Health Authority and the Health Boards Executive. This study is one element in that review which also involves a Liaison Group drawn from each Health Board and a Consultative Forum comprising representatives from a broad range of stakeholders involved in family support services in Ireland. The overall purpose of the review is to develop a strategic statement which will guide the future development and operation of family support services in the health sector.

Evolution of services for families and children

In Ireland as elsewhere, the development of services for families and children is being shaped by a broadly similar set of policy concerns. These concerns include the need to achieve a healthier balance between prevention, early intervention and late intervention; increased statutory obligations arising from legislative developments; pressures in responding to newly emerging needs; the importance of ensuring effectiveness and value for money; and a growing awareness of the need to place family well-being at the heart of all policies and services for children and their parents. The growth of family support services is one outcome of these concerns. Another is the growing requirement for better understanding of the factors which influence the well-being of families and children in all their diverse circumstances since this is a prerequisite for developing needs-based services. Equally, there is a growing appreciation of the need for evidence-based interventions to help families and children and to evaluate the outcomes of whatever services are offered. There is also a concern that the multi-dimensional needs of families and children require a multi-agency approach and the development of partnership models which involve inter-agency and inter-professional cooperation.

The experience in Ireland is similar to that in other countries where developments tend to be driven by a service-oriented, rather than a needs-oriented, paradigm. Not
only are service outcomes rarely evaluated but needs are often understood from the limited perspective of what services can offer. In Ireland there is very little systematic data on the needs of families and children partly because services do not collect data in a manner which can be aggregated and analysed but also because, to date, there have been very few studies on the well-being of families and children.

Like Ireland, many countries have systems which divide services into categories called child protection, children in care and family support. International experience suggests that systems which have high levels of activity in the areas of child protection and children in care (such as the US) tend to have low levels of family support activity, while others (such as the UK) which have lower levels of activity in the areas of child protection and children in care tend to have higher levels of family support activity. Ireland, which holds a similar position to England as measured by the rates of children in care - at approximately 50 per 10,000 children in 2001 - also seems to fit this pattern, a finding which invites further reflection and investigation as part of the context for developing and rebalancing services for families and children in Ireland.

Most of the resources spent on child care services in Ireland are allocated to child protection and children in care although there is almost no evaluation of these services. Ironically, it is family support services that are more likely to undergo evaluation and the results of these studies, both in Ireland and internationally, shows the positive outcomes that are possible with different types of family support interventions.

**Services Provided by Health Boards for Families and Children**

This report analyses how services for families and children are organised and delivered through Health Boards. The picture which emerges is one of considerable organisational complexity and diversity from one Health Board to another coupled with significant professional disenchantment at the capacity of the system to meet the needs of families and children. Our analysis suggested that the current organisation of services throughout most of the country promotes division rather than integration. In many regions, structures are confusing and create frustration both within and outside the Health Boards. There is a lack of organisational alignment and little evidence of any over-arching vision or principles driving cohesive development or fostering collective responsibility.

Resources for child care services have increased significantly in recent years. In general, however, this increased investment has not enabled Health Boards to simultaneously meet statutory obligations to families and children who are in crisis while also expanding services in the areas of prevention and early intervention.
Rational arguments and strong empirical evidence support the case for investment in prevention and early intervention.

The present system seems to be informed by a belief that the best way to discharge statutory obligations is to extend and reinforce investment in child protection and children in care. The possibility that a more developed system of family support services might help to protect children and reduce the population of children in care has not been fully explored. The organisational and resource implications of achieving a better balance between prevention, early intervention and late intervention have still to faced.

**Family Support Services**

Family support services fall into two main categories: (i) general family support services which are offered to a wide range of families for the purpose of either preventing problems or addressing them after they have emerged; (ii) childcare family support services which are offered to families in order to promote child development and facilitate parents who wish to work. A census was carried out of these services based on those which received funding from Health Boards in 2002.

The census revealed that the largest share of resources spent on family support services are allocated to late intervention rather than prevention and early intervention. This challenges the widespread perception that family support is mainly used as a form of prevention and early intervention.

An important result of the census is that Health Boards with the lowest levels of family support provision have the highest rates of children in care while those with the highest level of family support provision tend to have the lowest rates of children in care. The reasons for this could include any or all of the following: (i) family support services may help prevent children going into care; (ii) the cost of keeping children in care may inhibit the development of family support services; (iii) there may be other factors influencing both the provision of family support services and the admission of children to care such as levels of need, professional practices and/or management approaches to each type of service. Whatever the explanation, this result highlights the need for a clearer strategy to inform the development of services for families and children.

**Principles to Inform the Future Development of Services for Families and Children**

The evidence and analysis presented in this report indicates that change is required in the design and delivery of services for families and children. The present system
tends to be crisis-driven and services which involve late intervention tend to absorb most of the available resources relative to prevention and early intervention. The system tends to be service-led and output-focused rather than needs-led and outcome-focused. Effective intra-agency and inter-agency working tends to be the exception rather than the rule. The case for change therefore is compelling.

We suggest that two key principles should provide the framework for developing services into the future. The first principle is to design services that meet the needs of families and children. The second principle is to provide a balanced continuum of services involving prevention, early intervention and late intervention. Each of these principles imply a number of more detailed considerations which need to be taken into account.

The principle of designing services to meet the needs of families and children has a number of practical implications as follows:

- Cultivate a system that is needs-led rather than service-led
- Adopt a child-and-family-centred approach
- Understand need from a holistic, multi-dimensional perspective
- Analyse need in terms of risk and protective factors
- Promote a common approach to needs assessment
- Assess the needs of families and children who do not use services
- Keep services outcome-focused
- Build services which are helpful and supportive
- Ensure services are ethical

Similarly, the principle of providing a balanced continuum of services to meet the needs of families and children entails a number of practical implications:

- Recognise the current imbalance between prevention, early intervention and late intervention
- Invest appropriately in prevention, early intervention and late intervention
- Find the right balance between universal and targeted services
- Find the right balance between practical and therapeutic interventions
- Develop family support in the context of other services for families and children
- Develop multidisciplinary and inter-agency working
- Ensure an equitable distribution of services
Options for the Future Development of Services for Families and Children

In order to facilitate the development of a strategy we suggest that two options should be given serious consideration. These are:

- Option One: Develop and rebalance family support services
- Option Two: Develop and rebalance all services for families and children.

It is clear that these options are not mutually exclusive since the second is essentially a more comprehensive version of the first. However they are presented as separate options since they allow for the possibility of bringing about the changes required in a manner which can be phased in over time and takes full account of the circumstances likely to affect the change process. It is worth emphasising that implementation of either option will need to be done in a way which expands the overall package of services for families and children rather than developing one set of services at the expense of another. In other words, rebalancing will need to be done within a framework which facilitates expansion rather than contraction of services given that the overall supply of services is inadequate to meet the needs of those families and children who presently seek a service.

Option One: Develop and rebalance family support services

This option builds upon an existing commitment to develop family support services which has resulted in the creation of new and promising services for families and children such as Springboard, Teen Parenting Programme, Youth Advocacy Programme, etc. New resources are being targeted at the development of innovative services and there is clear evidence in the case of Springboard that this is an effective service. The use of new resources to trigger a process of service innovation is clearly a positive development and has done much to show the expanding possibilities of family support services. The rationale for Option One therefore is to build on these developments but to do so in ways which are more in line with the principles outlined in the report.

Option Two: Develop and rebalance all services for families and children

This option requires the development of all services for families and children and the creation of a sharper focus on needs and outcomes while also re-orienting services towards a more appropriate balance of prevention, early intervention and late...
intervention. As such, it poses a major challenge for the reform of all services for families and children. Other countries are going through a similar reform process and we can learn from their experience. At the same time there is no ready-made blueprint for this option and its success will depend on all stakeholders working together to create a framework which integrates needs, services and organisational frameworks. In order to advance this option, the report proposes a number of steps as a broad framework for implementation.

Conclusion: A Way Forward

It needs to be recognised that an overall strategy to develop services for families and children involves a number of different Government Departments and their agencies, including the voluntary and community sector as well as families themselves. Each Government Department needs to begin that process internally while also taking account of the cross-departmental and inter-agency issues involved. For this reason it is appropriate that the primary focus of the strategy being developed by the Department of Health & Children should be on services for families and children within the health sector.

Given that context, we suggest that the following points should be considered as requirements for implementing the strategy:

1. Generate a commitment at all levels of the health service - Department of Health & Children, Health Services Executive, Regions - to the strategy and the principles which underlie it.

2. Appoint a person in each region to lead and champion the implementation process on a full-time basis.

3. Draw up a plan for implementing the strategy with a clear timeframe and performance indicators against which to check if targets are being met at key milestones.

4. As part of the study of needs, arrangements will have to be put in place so that the views of service users are taken into account on an on-going basis.

5. Ensure that adequate resources are allocated to implement the plan particularly where this involves studies to assess needs, identify services which are known to work, facilitate staff training and development, undertake evaluation of services, etc.

6. Put support structures in place to allow for the exchange of experience among different regions so that each can learn from the other.

7. Draw upon relevant international experience where services for children and families are being developed and rebalanced.
8. The implementation process needs to be tested at every stage to ensure its compliance with the core principles informing the overall strategy. This will be done within each region but will also be an intrinsic part of the reports prepared by each region on their implementation process.

This is far from being an exhaustive list of the issues that need to be considered in moving towards implementation of a strategy to develop a balanced continuum of services for families and children. However they are indicative of the complexity of what is involved and the need for skilfulness in tackling the technical and human issues which arise in moving to a new era of service delivery for families and children. Like all challenges, this process is also likely to be rewarding not only for families and children who will benefit from improved services but also for staff who are directly involved in the design and delivery of those services.
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Ms. Mary Hargaden, Department of Health & Children
Ms. Sue Kane, Department of Health & Children and Western Health Board
Mr. Gerry Maguire / Mr. Paul Nulty, Department of Health & Children
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Ms. Mary Golden, National Children’s Office

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The study involved extensive consultation with professionals and managers responsible for child and family services generally and family support services in particular. These consultations have had a major influence on the report. Interviews were held with Assistant Chief Executive Officers in each Health Board where they have responsibility for child and family services. Focus groups were held in each Health Board area with 10-20 professionals directly involved in the management and delivery of family support projects and services. In addition, focus groups were held with groups of professionals from each Health Board including: Directors of Public Health Nursing, Principal Social Workers, Superintendent Community Welfare Officers, and Managers in residential and foster care.

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Need

Need arises when the level of well-being experienced by individuals, families or communities, falls below a threshold that is regarded as either normal or minimal. The concept of need recognises that well-being is multi-dimensional and implies a shared understanding of the minimum threshold of well-being so that those who fall below it are said to be in need. Although the concept of need is amenable to scientific measurement using standardised instruments to measure key indicators of well-being and their thresholds, there has been no systematic study of the prevalence of need among families and children in Ireland.

Risk and Protective Factors

A risk factor has a negative impact on well-being while and a protective factor has a positive influence on well-being. Need therefore is the outcome of risk and protective factors at work in shaping the well-being of individuals, families and communities. For example, the well-being of a child may be adversely affected by conflicts between parents (a risk factor) but positively affected by a good relationship with each parent (a protective factor).

Prevention, Early Intervention, Late Intervention

Health and social services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (late intervention, sometimes referred to as treatment). These concepts can be illustrated using the example of interventions to promote the well-being of children where prevention could take the form of ensuring that pregnant mothers are healthy
and have healthy lifestyles; early intervention could involve regular screening of children in terms of developmental milestones or supporting mothers who may show early signs of post-natal depression; late intervention would involve addressing emotional, behavioural or intellectual difficulties which are displayed when the child goes to school or serious difficulties in the parent-child relationship.

Child Care Services

Child care services are interventions funded by the health sector in response to the statutory duty under the Child Care Act 1991 “to promote the welfare of children ... who are not receiving adequate care and protection”. The term covers three types of service: (i) child protection sometimes referred to as ‘child welfare and protection services’ (ii) children in care comprising fostering, adoption, residential homes including ‘high support’ and ‘special care’ (iii) family support programmes which offer practical and therapeutic assistance to families, both inside and outside the home. ‘Child care services’ are not to be confused with ‘childcare services’ whose function is to promote child development and facilitate parents who wish to work.

Family Support Services

Family support services which are funded by health sector fall into two categories. The first category is general family support services which are offered to a wide range of families for the purpose of either preventing problems or addressing problems after they have emerged. For example, some services such as Community Mothers, Lifestart, Homestart, etc., are offered to prevent family problems occurring while others such as family support projects, Springboard, Teen Parenting, Youth Advocacy, Family Welfare Conferences, etc., are offered when problems are beginning to emerge or have already developed. The second category is childcare family support services which are offered to families in order to promote child development but may also facilitate parents who wish to work. Examples include pre-school services & nurseries as well as parent & toddler services.

Inputs

Inputs refer to the human, physical and financial resources required to produce a service. They are usually measured by ‘input indicators’ such as number of staff, size of premises, annual expenditure, etc.
**Outputs**

Outputs refer to the amount of services produced by an organisation. They are usually measured by ‘output indicators’ such as number of persons attending a programme, number of sessions / consultations offered, number of participants achieving certification at the end of a programme, etc.

**Outcomes**

Outcomes refer to the impact of a programme. They are usually measured by ‘outcome indicators’ and examples from family services would include improvements in the psychological well-being of parents and children, improvements in the parent-child relationship, improvement in the relationship between parents, etc.

**Monitoring**

Monitoring refers to the process of recording input and output indicators and tracking their change over time.

**Evaluation**

Evaluation refers to the process of assessing the outcome or impact of a programme. At a minimum, this involves comparing the well-being of programme participants (sometimes referred to as the ‘experimental group’) before and after their participation on the programme. Ideally, a thorough evaluation should also involve comparing the ‘experimental group’ with a matched group who have not participated in the programme (sometimes referred to as the ‘control group’) in order to identify the amount of outcome that can be directly attributed to the programme; this ideal form of evaluation is usually referred to as a ‘randomised control trial’.

**Mainstreaming**

Programmes whose funding is guaranteed from one year to the next are said to be mainstreamed. Mainstreaming does not imply that a programme is universally or even widely available.
In 2003, the Department of Health and Children initiated a national review of family support services with the support of a Steering Group, the Health Boards, the Eastern Regional Health Authority and the Health Boards Executive. This study is one element in that review which also involves a Liaison Group drawn from each Health Board and a Consultative Forum comprising representatives from a broad range of stakeholders involved in family support services in Ireland. The overall purpose of the review is to develop a strategic statement which will guide the future development and operation of family support services within Ireland’s health sector.

The specific objectives of the study, as stated in the terms of reference, are to:

- Compile a comprehensive overview of family support services provided by Health Boards or funded by them.
- Identify and report on the current use of resources and the management of resources.
- Identify gaps in service provision.
- Identify and report on the views and experiences of families, practitioners, managers and funding stakeholders involved in service provision and service use.

These objectives are met in the six chapters of the report. We begin by discussing the needs of families and children since these are the needs which family support services are endeavouring to address (Chapter One). This is followed by a review of the changing policy context which is shaping the evolution of services for families and children, both in Ireland and internationally (Chapter Two). Services for families and children are delivered by professionals and volunteers who work in organisations and these, in turn, are part of larger administrative and political systems. In Chapter Three we examine how the system of services for families and children works in practice and how its dynamics affect the outcome of services. Chapter Four describes the range of services in different Health Boards and includes an overall appraisal of service delivery, drawing on our consultations with key stakeholders throughout the country. Chapter Five reports on the results of a census of family support services.
support services which were funded by Health Boards in 2002\(^1\). Finally, in Chapter Six we draw together the different strands of the report and outline some principles and options that could inform the future development of services for families and children.

\(^1\) A separate report on the census, including detailed results for each Health Board, is available; see McKeown, K., and Haase, T., 2004, A Census of Family Support Services in Ireland: Results of a Census of Family Support Services which were funded by Health Boards in 2002, Dublin: Department of Health & Children.
Chapter 1
Understanding the Needs of Families and Children

1.1 Introduction

Our report begins with a review of the needs of families and children since that is why services are provided. Services are only worthwhile if they meet those needs. It is essential therefore in reviewing family support services to understand the needs which services are endeavouring to meet.

As the term is generally understood, need arises when the level of well-being experienced by individuals, families or communities falls below a threshold that is regarded as either normal or minimal. The concept of need recognises that well-being is multi-dimensional and implies a shared understanding of the minimum threshold of well-being so that those who fall below it are said to be in need. Factors which have a negative impact on well-being are usually referred to as ‘risk factors’ while those which have a positive influence are described as ‘protective factors’. Need therefore is the outcome of risk and protective factors at work in the shaping the well-being of individuals, families and communities. In the case of children, need has been defined as follows: “A child is in need if his or her health or development is actually impaired or likely to become so in the absence of remedial services. Statements of needs for healthy development are a snapshot of risk and protective factors operating in the child’s life”2.

We begin our analysis with a broad international overview of what is known about the needs of families and children (Section 1.2). In doing so, we draw upon three different approaches to understanding these needs namely the scientific perspective (Section 1.2.1), the policy perspective (Section 1.2.2) and the consumer perspective (Section 1.2.3). This is followed by a review of the relatively limited material which exists in Ireland on the needs of families and children (Section 1.3). We conclude by summarising the key findings and highlighting their implications for our review of family support services (section 1.4).

2 See www.dartington-i.org /commonlang
1.2 Overview of Needs

Much is known about the physical health of children and its determinants but knowledge about their social and psychological needs, and the way in which parents and other carer’s needs impair child development, remains relatively primitive. Indeed, there is considerable disagreement about how to understand the cause of social need and even its definition but on two points there is a meeting of minds.

The physical health of children has improved markedly over the last century, and continues to improve. At the same time, the psychological health of children is generally declining. By way of illustration, infant mortality in Ireland has improved ten-fold since 19013 whereas in the same period most indicators suggests, consistent with other western developed nations, there has been an increase in alcohol and drug misuse, adolescent depression and anti-social behaviour4. While there is no evidence to suggest, and no theoretical reason to pre-suppose, that the nature and level of children’s social and psychological needs differ from one western developed nation to another, research indicates considerably different service responses, even between European states5. This suggests much more could be learned about the causes of social need and there could be much greater sharing of ideas about effective interventions.

At least three contrasting approaches have been taken to understanding the social needs of families and children each of which has implications for understanding the role of family support activity.

1.2.1 Scientific Perspective

The scientific perspective seeks to identify the chains of effect that lead to abnormal patterns of child development, where abnormal is understood to mean significantly different from the mean. In other words, what causes children to behave badly, to have difficulties at school, to be withdrawn or depressed, et cetera? This type of evidence depends on longitudinal studies of children selected to be representative of all children and from evaluation studies of interventions designed to improve child development6. What has been learned from this perspective?

First, nearly all social and psychological problems represent a combination of genetic and environmental risks including family, school and community influences. There is increasing understanding of the relative contribution of genetic and environmental risks7 and the way the latter can multiply the effects of the former8. The implications

3 Bradshaw, 2002
4 Rutter and Smith, 1995
5 Colton & Hellinckx, 1993
6 Maughan, 2001
7 Ashbury and colleagues, 2003
8 Stevenson, 2001
for child and family services are that interventions which deal with one aspect of risk only are unlikely to be successful.

Second, environmental risks are best understood as a chain of negative effects that can be offset by protective factors\(^9\). For example, one route to anti-social behaviour is overcrowding that leads to maternal depression which reduces quality of parenting and the amount of supervision given to the child\(^{10}\). Parents in these contexts who have themselves been well parented, a potential protective factor, are less likely to have anti-social children\(^{11}\). By definition, risks accumulate over time and the more enduring the risk the greater the likelihood of social and psychological problems. The implications of this research are that interventions targeted on specific risks in a chain of negative effects are more likely to be effective than general supports while long-term interventions will be needed for problems that have been long in gestation.

Third, most children exposed to environmental stressors do not develop social and psychological problems\(^{12}\) implying that good assessment is a pre-requisite for the effective use of scarce children’s services resources.

### 1.2.2 Policy Perspective

Historically, the scientific perspective has not driven social policy on families in Ireland or elsewhere. In general, public policy has been shaped by a range of concerns about the well-being of families and children with the result that the family is now increasingly a subject of public debate in Western societies. On the one hand, trends and developments within the economy and society at large are seen to be having a major impact on the internal life of the family, and there is concern that the family should get greater protection and support. On the other hand, changes in the constitution and functioning of the family are seen to be having significant effects on society and the economy. What are primarily personal and private choices about partners and children entail significant public consequences, and there is a concern that a legitimate societal interest in some of the family’s functions should be protected.

Figure 1.1 attempts to summarise the nine different contexts within which governments are currently talking about the family. The two arrows connecting the family to each area of concern indicate two different approaches by the State to family policy and the provision of family services. The first approach is a mainly passive form of intervention, represented by the dotted arrow, and is based on the recognition that the family today takes more diverse forms and that public services

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9 Morton and Frith, 1995  
10 Rutter, Giller and Hagell, 1998  
11 Quinton & Rutter, 1988  
12 Haggerty, 1994
need to adjust accordingly. This approach essentially involves accommodating to new family forms and situations. The second approach is a mainly active form of intervention, represented by the solid arrow, and is based on the recognition that the family has, potentially or actually, such serious consequences for society that public authorities have a legitimate interest in seeking to influence what is happening to the family. This approach essentially involves promoting vital family functions.

Figure 1.1 Public Policy Concerns about the Family

Source: McKeown and Sweeney, 2001:9

1.2.3 Consumer Perspective

Partly prompted by increased attention to human rights, in recent years there has been greater attention to the perspectives of the consumers of services for families and children. Evidence on consumer views tends to depend more on qualitative research than on orthodox scientific method. It points towards potential mismatches between needs and services. On the whole, parents who seek help for their children are looking for practical, child-centred and time-limited interventions focused on specific difficulties they are experiencing at a particular moment in their child's development\(^\text{13}\). Parents recognise that problems come and go across the life span; a child may be anti-social at five years but well-behaved at seven; an adolescent may be depressed at 14 years but fine by 15 years. Parents do not see a distinction

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\(^\text{13}\) Axford, Little and Morpeth, 2003
between the development needs of children at risk and other children; all children are children in need at some point in their development. An implication for children’s services is the considerable mismatch between what is offered and what consumers want or need. In practice, this draws attention to the importance of an approach to service development which is both needs-led and outcome-focused, a theme which we develop further in Chapter Six below.

1.3 Needs of Children in Ireland

In Ireland, the National Children’s Strategy has developed a ‘whole child perspective’\textsuperscript{14} for understanding the needs of children and identified nine dimensions of well-being as central to normal child development. These dimensions are:

- physical and mental well-being
- emotional and behavioural well-being
- intellectual capacity
- spiritual and moral well-being
- identity
- self-care
- family relationships
- social and peer relationships
- social presentation

As indicated above, this definition implies that children whose well-being falls below agreed thresholds on one or more of these dimensions is said to be in need. Although the concept of need is amenable to scientific measurement through the use of standardised instruments to measure key indicators of well-being and their thresholds, there has been no systematic study of the prevalence of need among families and children in Ireland. As a result, there is no standardised evidence-base on which to identify families and children whose well-being falls below acceptable levels. This is a major obstacle to the development of services as the current Health Strategy makes clear: “An underlying issue contributing to problems in service provision is the lack of good-quality information about the needs of children and the existing capacity of the system to deliver good outcomes”\textsuperscript{15}. The National Children’s Strategy also observed that, “despite ... the considerable resources being committed by the Government to children, there continues to be limited empirical data and research-based understanding of their lives”\textsuperscript{16}. Prior to this, the

\textsuperscript{14} National Children’s Strategy, 2000:27
\textsuperscript{15} Department of Health and Children, 2001:140
\textsuperscript{16} National Children’s Strategy, 2000:38
Commission on the Family reached a similar conclusion: “The Commission’s examination of the effects of policy programmes and services on families has highlighted the dearth of research into families, family members and how children from different backgrounds fare in the longer term”\(^{17}\).

There is an increasing acceptance of the importance of developing a common framework for assessing needs as a prerequisite to developing a more coordinated and integrated approach to services for vulnerable families and children. Examples of these which have been developed in the UK include the Framework for the Assessment of Children in Need and their Families\(^{18}\) as well as the Common Language Tools for Children in Need\(^{19}\). In Ireland a range of instruments have been applied to measure the well-being of parents and children and these have been used with both service users\(^{20}\) and the general population\(^{21}\). The latter study, although relatively small and pilot in nature, goes some way towards bridging the gap in our understanding of need. This study, based on a random sample of 250 parents and children, examined the relative importance of four broad sets of factors which, according to the international research, are known to have some direct or indirect influence on the well-being of families and children. These factors are:

1. Family processes, notably the way in which conflicts are addressed, the inter-generational history of family relationships, attitudes to parenting and family roles, etc.

2. Individual characteristics notably personality traits such as positive and negative emotionality as well as psychological independence and interdependence; and

3. Family circumstances such as life events, education, social class, hours worked, etc.

4. Family type as indicated by whether one lives in a one- or two-parent household and whether the parents are married, cohabiting, single or separated.

The study examined the relative importance of these different variables on the well-being of parents and children in different family types – married, cohabiting, single and separated. The results, as summarised in Figure 1.2, throws valuable light on the pathways that influence family well-being. Each variable can be seen as simultaneously a risk and a protective factor in the sense that a factor which increases risk correspondingly reduces protection and vice versa.

It emerges from Figure 1.2 that the three direct influences on the well-being of parents and children in all families are: family processes, psychological traits and the socio-economic context. Family type per se has no direct effect on family well-being.

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\(^{17}\) Commission on the Family, 1998:504  
\(^{18}\) UK Department of Health, 2000  
\(^{19}\) See Little and Mount, 2003; see also www.dartington-i.org.uk/commonlanguage  
\(^{20}\) McKeown, Haase and Pratchke, 2001; 2004a; 2004b; 2004c; McKeown, Lehane, Rock, Haase and Pratchke, 2002  
\(^{21}\) See McKeown, Pratschke and Haase, 2003
when all other factors have been taken into account. The results also show the family well-being is *indirectly* influenced by variables such as the parents’ support networks, the grandparents’ couple relationship and a range of socio-economic factors such as social class, education, job satisfaction and age. Some of these variables are referred to as ‘direct influences’ because they impact directly on well-being while others are referred to as ‘indirect influences’ because they do not impact on well-being but do impact on the variables which directly influence well-being.

Figure 1.2 Model of Direct and Indirect Influences on Family Well-Being

These results, though far from definitive since they are based on a relatively small ‘community’ sample of 250 families and do not include ‘clinical’ samples, are nevertheless helpful in offering guidance on how family support services might intervene to improve family well-being. In particular, they provide a context for examining which variables a family support service might endeavour to influence, whether that influence is direct or indirect and its relative importance in the overall determination of family well-being. As such, it offers an important corrective to the tendency found in some of the literature on family support services to isolate support
networks as the only key variable through which family well-being is enhanced. The research findings, as summarised in Figure 1.2, indicate that supports networks are not the only variable affecting family well-being and moreover their influence on family well-being seems to be indirect, rather than direct. This model provides the beginnings of a framework for helping to ensure that services are more explicitly needs-driven and remain focused on the outcomes which they were designed to achieve.

1.4 Summary and Conclusion

We began our review of family support services in this chapter with a discussion of need in order to highlight the fact that this is the foundation on which services are based. Too often, service development seems to be driven by a service-oriented, rather than a needs-oriented, paradigm. Not only are service outcomes rarely evaluated, an issue which we discuss at greater length in the next chapter, but needs are often understood from the limited perspective of what services can offer. In Ireland there is very little systematic data on the needs of families and children partly because services do not collect data in a manner which can be aggregated and analysed but also because there have been no serious epidemiological or longitudinal studies of families and children.

We have seen in this chapter that the State supports families for a wide variety of reasons related to health, education, income, employment, family relationships, child protection, etc. The impact of these policies and services on family well-being is often difficult to measure. Other research which we reviewed in this chapter indicates that while income affects the well-being of parents and children, and may be particularly important for those on lowest incomes, factors such as the quality of family relationships and the personality traits of family members may be even more important. In relation to income, it is worth noting the level of consistent poverty in Ireland was halved between 1994 and 2001 although inequality as measured by relative income poverty, increased over the same period.

Some services have attempted to combine the scientific, policy and consumer perspectives on need. These and other developments call attention to the importance of ensuring that service development is solidly evidence-based so that theories and ideologies about what is good for families and children are continually tested against the evidence in the search for interventions which work to make demonstrable improvements in well-being.

22 See, for example, Hill, 2002
23 In May 2004, the National Children’s Office invited tenders to undertake a national longitudinal study of children in Ireland.
24 In 1994, 8.3% of the population were consistently poor compared to 4.7% in 2001 (National Anti-Poverty Strategy, 2002; National Action Plan Against Poverty and Social Exclusion, 2003, Annex 1). Consistent poverty refers to those having 60% of median income and experiencing basic deprivation. See also Whelan, Layte, Maitre, Gannon, Nolan, Watson and Williams, 2003.
25 In 1994, 15.6% of the population were relatively poor compared to 21.9% in 2001 (National Anti-Poverty Strategy, 2002; National Action Plan Against Poverty and Social Exclusion, 2003, Annex 1). Relative poverty refers to those having 60% of median income.
2.1 Introduction

Family support services are a relatively recent development in the overall evolution of services for families and children. For decades, the standard response by State agencies to the needs of children experiencing neglect or abuse was to remove them from their families and to place them in residential care. Dissatisfaction with these arrangements led to the growth of foster care in recognition of the importance to children of living in a family context. In more recent decades, greater emphasis has been given to supporting children and their families at home and to make effective use of all agencies that have a role to play in improving child development, particularly those children whose well-being may be at risk. Viewed from this perspective, the existing arrangement of services for families and children carries the marks of an historical evolution over many decades and this should be borne in mind when reflecting on the current arrangement of services for families and children.

In this chapter we set out the changing policy context which is shaping the provision of services for families and children. We begin with a review of some of the major international developments where public policy in a number of countries is responding to a changed understanding of the needs of families and children (Section 2.2). This is followed by a more detailed consideration of the reasons which are influencing the current development of family support services in Ireland (Section 2.3). We conclude with a brief summary of the key points and their significance for this review (Section 2.4).

2.2 International Developments

Like Ireland, all developed western nations are struggling with the challenge of how best to support families and children. Given that children’s needs do not differ significantly from one country to another, it is rather surprising that more effort has not been invested in sharing ideas across borders. Ireland has much to learn from other countries, and other countries can learn much from Ireland. This raises the
questions: what are the common themes? and what is the pattern of emerging solutions?

The legacy of using residential care as one of the responses to children in extremely vulnerable families continues to hinder the development of children’s services, and family support programmes in particular. There have been large-scale de-institutionalisation programmes in England and Spain but the residential option remains strong in the United States, Russia and the Benelux countries. There is no evidence that residential services have appreciable benefits for children’s development although neither are they always as harmful as supposed. Some studies in the UK indicate that when children are separated from their families in the long term, the outcome for half these children is highly unsatisfactory with poor school attendance, high levels of social exclusion and heightened levels of anti-social behaviour. However any assessment of the impact of alternative care needs to take account of the outcomes experienced by a matched group of children who have not been in care. In England, some progress is being made by establishing common performance targets for children’s services, such as the reduction of impairment, social exclusion and the improvement of quality of life.

Most European and Australasian countries have radically improved inter-agency co-operation. The needs of families and children are not confined to single domains that can be adequately dealt with by a single discipline or agency. Much of the improvement has stemmed from a requirement for effective sharing of information so that, for example, one part of children’s services is aware of child protection concerns known to another. There remains relatively little inter-agency co-operation at the point of service delivery in most countries. Once a course of intervention is agreed, a single professional generally holds responsibility for implementing the plan. The introduction of common assessment procedures, training modules and performance targets is increasingly being tried as a solution to these emerging problems.

In many countries, individual cases of child abuse or neglect have tended to heighten fears about ‘risk’ and ‘danger’ and this has added momentum to the predominant focus on child protection at the expense of family support services which are sometimes seen as soft tools for a hard job. Rather ironically, the child mortality rate attributable to maltreatment when the child is known to children’s services is

26 UK Department of Health, 1998
27 Casas in Colton and Hellinckx, 1993
28 Dansokoho, 2003
29 Knorth in Colton and Hellinckx, 1993
30 Rutter, 1981
31 Jackson, 1987
32 Sinclair and Gibbs, 2002
33 Sinclair and Gibbs, ibid
34 Axford, 2003
35 Hallett and Birchall, 1992
extremely small (less than one per 100,000 children) and dwarfed by accident rates and avoidable deaths from medical procedures. Increasingly, the leaders of services for children (politicians, policy makers and managers) are becoming aware of their responsibility to acknowledge the risk being taken by professionals in seeking to balance prevention with the protection of children from abuse or neglect.

Most jurisdictions now acknowledge the requirement for radically improved management information systems regarding the needs, services and outcomes for families and children they seek to serve. Most countries devote less than half of one per cent of expenditure on children’s services to research and evaluation, compared to at least one per cent on medical care and five per cent in most industrial contexts. On the whole, children’s services seem to have collected too much information and done too little with it. Emerging solutions stress the benefits of doing more with less by connecting clinical and management data, focusing on variables known to be useful and improving the use of information technology.

The costs of children’s services have generally grown year-on-year above the level of inflation and this is true in Ireland as elsewhere. As a result, most developed countries are now taking an interest in the cost-benefit ratio of the various programmes they offer. This interest has led to a heightened awareness of the benefits of rigorous evaluation techniques, especially those that randomly allocate potential programme recipients to experimental and control groups. Unfortunately, most well designed cost-benefit evaluations have concentrated on new interventions, including some family support programmes, but have not extended to traditional solutions such as residential and foster care. This means the new has to prove its value but the existing does not.

European children’s services are increasingly adopting a series of consistent principles, most of which tend to favour family support solutions. These reflect a requirement to look at all aspects of a child’s development, and not just in the area of pressing concern. There is a growing recognition that interventions should endeavour to work on evidence about strengths as well as weaknesses in the child’s development and seek to build on inherent resilience. The historical tension between services for children and services for family members is being replaced by an understanding that meeting children’s needs frequently requires addressing the needs of all family members. At the same time, family support services are still struggling to find appropriate ways of supporting families with children in care.

37 Sloper and Quilgars, 2002
38 UK Children’s Directorate, 2003; Community Care Division, 2002
40 Sheldon 1986; Farrington, 2003
41 Parker et. al. 1991
42 Garmezy 1994; Gilligan, 2001; Rutter, 1987; Rutter 1979
43 Millham, Bullock, Hosie and Haak, 1986
families where children are at high risk, as well as families which have complex problems.

Finally, a clearer pattern of service development, implementation and evaluation is emerging leading to the gradual improvement of children’s services and a more solid place for family support activities at its heart. Cross-agency commitment to change is seen as a pre-requisite to success. Finding a common language to facilitate communication and using evidence about the needs of children locally is another essential ingredient. A logical conclusion of these developments, now being reached in some European countries, is to see children’s services as part of integrated family services aimed at promoting the well-being of all family members, including children.

2.3 Developments in Ireland

One of the key themes defining the evolution of public policy on children in Ireland over the past 25 years has been the re-discovery that families are central to the well-being of children. The 1980 report by the Task Force on Child Care Services stated boldly that “the welfare of children in general is inseparable from the well-being of families and therefore social policy should begin with families”. The report openly criticised the existing child care system for its lack of support to enable children to live with their families: “Children are often removed from their homes when what is required in their interests and those of their families is the provision of support services of various kinds”. In both its tone and content, the report makes the case for family support with a clarity which has not since been surpassed: “Since we consider that the primary emphasis of children’s services should be on the child within the context of his family, we attach particular importance to the services which can help families to care for their children in their own homes”.

The legislative basis for the existing child care system is The Child Care Act, 1991 which states that “it shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection” (Section 3, Subsection 1). In exercising this function, health boards shall “having regard to the rights and duties of parents … regard the welfare of the child as the first and paramount importance” (Section 3, Subsection 2b). The Act also states explicitly that the health boards shall “have regard to the principle that it is generally in the best interests of a child be brought up in his own family” (Section 3, Subsection 2c). This legislative framework is clearly enabling of family support, particularly to families and children who are most vulnerable, as specified in Section 8 of the Act.

In the mid-1990s, the establishment of a Commission on the Family (1995-1998) underlined the importance being attached to the family within public policy, a view
reinforced by the Commission’s conclusion that “the experience of family living is the single greatest influence on an individual’s life and the family unit is a fundamental building block for society”47. The Commission also reaffirmed the importance of family support services as “a primary preventative strategy for all families facing the ordinary challenges of day-to-day living and has a particular relevance in communities that are coping in a stressful environment”48.

The National Guidelines for the Protection and Welfare of Children were published in 1999 and clearly affirm “the statutory responsibility of health boards to provide support services to the families of children who may be at risk of abuse or neglect”49. Equally important, the guidelines stress the key role which family support services can play in prevention and early intervention given that “early intervention can help to prevent any worsening of current difficulties being experienced by a family and will assist the development and growth of protective factors”50.

In tandem with these developments, one also finds evidence of a growing concern about the appropriateness and effectiveness of services for families and children, particularly through the Health Board’s child protection system. In a study carried out in the South Eastern Health Board, for example, the authors concluded by observing that “the child welfare apparatus, in general, continues to be primarily child protection focused; … assessments and interventions appear to be made more in the context of ‘dangerousness’ rather than ‘need’”51. The authors recommended that “Allegations of child abuse and neglect must continue to receive an immediate response, but such problems should be framed within the broader ambit of ‘families in need’, where other crucial categories of family and individual difficulties, which are likely to feature also in child abuse and neglect cases, are considered in the serious manner they deserve, and offered a similarly comprehensive response from a community social work service”52. Consistent with this, a study in the Mid-Western Health Board, concluded with the observation that “distinguishing ‘welfare’ and ‘protection’ systems implies a false separation which endangers the provision of the full range of services needed in each case. The best way forward is to develop integrated services where workers and systems have the skills and knowledge to respond to the mixed protection and welfare needs evident in child care practice”53. Our analysis in Chapter Six suggests a way forward which addresses these difficulties.

One consequence of the growth in services targeted at child protection concerns during the 1980s and 1990s is that it overshadowed a wide range of existing services for families which were provided by Social Workers in Health Boards and by organisations such as social service councils in the voluntary sector. These services

47 Commission on the Family, 1996:13
48 Commission on the Family, 1998:16
49 Department of Health and Children, 1999: 59
50 Department of Health and Children, 1999: 59
51 Buckley, Skehill and O’Sullivan, 1997:206-207
52 Buckley, Skehill and O’Sullivan, 1997:207
53 Ferguson and O’Reilly, 2001:267
were typically community-based, informed by a community development perspective, and had a focus on prevention and early intervention. The significance of these services in promoting the well-being of families is now being rediscovered under the rubric of family support.

The rediscovery of family support is particularly evident in the significant expansion of services towards the end of the 1990s. In 1998, for example, the Government launched Springboard, an initiative of 15 family support projects which grew to 21 projects by 2003\textsuperscript{54}. In 1999, the Government also committed itself to establishing 100 Family and Community Centres throughout the country in line with a recommendation in the report of the Commission on the Family\textsuperscript{55}. In addition, the National Development Plan 2000-2006 contains a substantial allocation of funds to childcare, community and family support and youth services, all of which are supportive, directly or indirectly, of family life\textsuperscript{56}.

The refocusing of services towards families is also evidenced by the initiative of Health Board CEOs in 1999 to establish Best Health for Children, a programme which has produced three strategy documents\textsuperscript{57} all of which give central importance to the child in the context of its family and which views “parents as key to the child’s health and well being”\textsuperscript{58}. Similarly, the White Paper on Early Childhood Education affirmed the role of parents as “the prime educators and experts on children’s needs”\textsuperscript{59}.

These developments are consolidated in the current health strategy of 2001 - Quality and Fairness: A Health System for You – which summarises the evolution of child care services throughout the 1990s in the following terms: “The dominant focus in child care services since the early 1990s has been on the protection and care of children who are at risk. More recently, the policy focus has shifted to a more preventative approach to child welfare, involving support to families and individual children, aimed at avoiding the need for further more serious interventions later on”\textsuperscript{60}. The current health strategy makes the explicit commitment that “family support services will be expanded”\textsuperscript{61} and this includes the following proposed developments:

- Child welfare budgets will be refocused over the next seven years to provide a more even balance between safeguarding activities and supportive programmes
- Springboard Projects and other family support initiatives will be further developed
- Positive parenting supports and programmes will be expanded

\textsuperscript{54} For an evaluation of Springboard, see McKeown, Haase and Pratschke, 2001; 2004a; 2004b; see also McKeown, 2000; 2001; McKeown and Sweeney, 2001
\textsuperscript{56} Ireland, 1999:192-195; see also the Programme for Prosperity and Fairness, 2000.
\textsuperscript{57} Best Health for Children, 1999; 2001; 2002
\textsuperscript{58} Best Health for Children, 2002:9
\textsuperscript{59} Department of Education, 1999:111
\textsuperscript{60} Department of Health and Children, 2001:71, see also 139-140
\textsuperscript{61} Department of Health and Children, 2001:165
• Effective out-of-hours services will be developed in all health board areas as a priority
• Family welfare conferences and other services required to support the Children Act, 2001 will be introduced
• Priority will be given to early interventions for children with behavioural difficulties.62

It is clear therefore that, over the course of two decades, the family has come centre-stage in public policy thinking about the needs of children while services are increasingly informed by the twin principles enunciated in the National Children’s Strategy of being “child-centred” and “family-oriented”.63 In practice, family support has attracted additional resources and recruited additional staff and this also raises challenges as to how these developments can be integrated within the existing framework of services for families and children, both within Health Boards and in partnership with other agencies whose remit is also the support of families. That is one of the challenges which has prompted this review and will be addressed later in the report.

2.4 Summary and Conclusion

In this chapter we have seen that the evolution of services for families and children is being shaped by a broadly similar set of policy concerns in Ireland as elsewhere. These concerns include the need to achieve a healthier balance between prevention, early intervention and late intervention; the rising costs of child care services and related questions about their effectiveness and value for money; a growing awareness of the need to place family well-being at the heart of all policies and services for parents and children and a multi-agency approach to deliver those services. The growth of family support services is one outcome of these concerns. Another is the growing requirement for better understanding of the factors which influence the well-being of families and children in all their diverse circumstances since this is a prerequisite for developing needs-based services. Equally, there is a growing appreciation of the need for evidence-based interventions to help families and children and to evaluate the outcomes of whatever services are offered.

All of these developments can be traced in Ireland through the evolution of policies for families and children as exemplified in the Child Care Act (1991), the Commission on the Family (1995-1996), the National Guidelines for the Protection and Welfare of Children (1999), the National Children’s Strategy (2000), the development of Springboard and other family support initiatives (1998 and onwards) as well as the

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62 Department of Health and Children, 2001:71; see also 165
63 National Children’s Strategy, 2000:10
current Health Strategy (2001) which makes an explicit commitment to the development of family support services.

These developments point the way towards a more balanced approach to services for families and children which is more solidly based on evidence about need and involves a continuum of services comprising prevention, early intervention and late intervention. In subsequent chapters we analyse these developments in more detail, particularly as they relate to Ireland, and this will form the basis for the principles and options which we propose in Chapter Six.
3.1 Introduction

Services to families and children are delivered by professionals who work in organisations and these, in turn, are part of larger administrative and political systems. As a result, the design and delivery of services typically carries the imprint of these wider systems and can come to reflect the interests of service providers as much as, if not more than, the interests of service users. In any review of services therefore it is always appropriate to ask ‘whose interests is the system serving?’ and ‘how well is the system meeting the needs of the families and children it purports to serve?’ In order to address these questions, we begin by reviewing some of the international experience on the system dynamics which typically operate in services designed to meet the needs of families and children (Section 3.2). As we shall see, much of this experience is similar, and therefore directly relevant, services for families and children in Ireland. The core question of whether services are meeting needs can only be determined through careful monitoring and evaluation, and we examine the implications of this in the next section (Section 3.3). One indication of a commitment to evaluation and evidence-based practice is that services continue to receive funding and support only if they have been shown to make significant improvements in the well-being of families and children. In view of this we review a range of family support services from different countries where these have been subjected to evaluation and where some indicators of their effectiveness have been established (Section 3.4). We conclude by drawing attention to the overall significance of the analysis for the development of family support services in Ireland (Section 3.5).

3.2 The System Dynamics of Services

As with physical health, the social needs of children greatly exceed services, family support included, to meet those needs. This fact results in rationing through
system dynamics that strongly predict who will get help, as well as the nature and length of that help. For example, residential and foster care services tend to be supply-led which implies that take-up is equivalent to places available rather than need for those services. As a result, length of stay becomes an important mechanism for controlling the dynamics of this part of the system, influencing the availability of places to smaller or larger numbers of children in need. Research on system dynamics reveals little about the impact on child development but can be important in understanding how some aspects of service provision can be altered such as the balance between family support and other children’s services.

Although data sources remain limited, particularly in Ireland, the number of referrals to children’s services is much greater than is generally recognised. In England, where some authoritative data exists, one in four children are referred to health, education, social care, youth justice or police services each year because of a social need. It seems reasonable to project that as many as two-thirds of children come to the notice of services over a five year period.

Most referrals for help, according to some UK research, are initiated by the parents of children in need. Where professional concerns arise, they are most likely to originate with general practitioners, health visitors and teachers. England is the only European country to have reliable evidence on referral routes; there the majority of parents (about 57%) turn to their doctor, health visitor or their child’s teacher when looking for help with a social need. These data imply that parents and other carers tend to be reasonable assessors of their own children’s social well-being, that they are looking for practical, targeted support for the problems they identify, and that demands far exceed available supply.

For a minority of children, the intervention of child protection services may involve periods of separation in residential and / or foster care settings, and these separations are subject to their own set of system dynamics. For example, there are extraordinary variations in the separation rates both within and between countries that are not explained by patterns or levels of need. In Ireland, although this data needs to be interpreted with care, there are significant variations between Health Boards in the rate of admission to care and in the outcome of child protection investigations. In the UK, most separated children are returned home to relatives within six weeks of separation and most re-unions endure meaning that families
experience residential and foster care as a family support. However about eight per cent of separated children do not return to their families in the long-term and for about half of the non-returners (i.e. four per cent of those separated) the output is highly unsatisfactory with poor school attendance\(^75\), high levels of social exclusion\(^76\) and heightened levels of anti-social behaviour\(^77\). However, as indicated above, any assessment of the impact of alternative care needs to take account of the outcomes experienced by a matched group of children who have not been in care.

It is clear from these observations that system dynamics have a significant influence on the way in which children’s services function and this, in turn, impacts on family support services. As a result, the amount of family support activity in the system seems to be inversely related to the amount of child protection activity, including the rate of children in care. Figure 3.1 attempts to illustrate this pattern by showing that, over time, the growth in family support activity tends to be associated with a decline in child protection activity. As a result, systems which have high levels of child protection activity (such as the US\(^78\)), tend to low levels of family support activity while others (such as the UK) which have lower levels of child protection activity tend to have higher levels of family support activity. Ireland, which holds a similar position to England as measured by the rates of children in care\(^79\), also fits this pattern as our analysis in Chapter Five below illustrates. This analysis is based on a census of family support services which were funded by Health Boards in 2002 and shows that those Health Boards with the highest levels of family support provision tend to have the

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\(^75\) Jackson, 1987  
\(^76\) Sinclair and Gibbs, 2002  
\(^77\) Sinclair and Gibbs, ibid  
\(^78\) Melamid and Brodbar, 2003  
\(^79\) The rate of children in care in Ireland in 2001, calculated per 10,000 children, was 51 (Department of Health and Children, 2002:15). This is almost identical to the rate of children in care in England in 2001, also calculated per 10,000 children, which was 52 (See Social Information Systems, 2001:37).
lowest rates of children in care while those Health Boards with the lowest levels of family support provision tend to have the highest rates of children in care. Although it is not possible to offer a definitive explanation for this association, it provides food for further reflection and investigation as part of the context for developing and rebalancing services for families and children in Ireland.

System dynamics are a useful instrument in the development of children’s services since they are open to manipulation. For example, Dartington has experience in using tools to reduce the number of separations, shorten length of stay and increase the number of returns of separated children. This can increase the amount and quality of family support. Whether these changes have any impact on child development outcomes, and so reduce social need, is as yet unknown.

3.3 Monitoring and Evaluation

One of the ways in which the dynamics of services can be made more accountable and transparent is through monitoring and evaluation which is increasingly recognised in all areas of public policy as a mechanism to achieve quality and accountability. The Health Strategy states that “monitoring and evaluation must become intrinsic to the approach taken by people at all levels of the health services”. In the area of services for children, the National Children’s Strategy makes a commitment “to improve evaluation and monitoring of children’s services”.

Despite these commitments, there is considerable scope for improvement in monitoring and evaluating services for families and children. In order to achieve that improvement, it needs to be acknowledged that monitoring and evaluation usually has significant resource implications in terms of the time and expertise available to professionals which limits the capacity to undertake the type of evaluations that would meet normal scientific standards.

The core concepts at the heart of all monitoring and evaluation are summarised in Figure 3.2. These concepts – notably objectives, inputs, outputs and outcomes - are widely understood and draw attention to the type of indicators which are required to monitor the performance of programmes and services.

Based on these concepts, three types of performance indicators are normally used for monitoring purposes:

1. Input indicators, which measure the financial and human resources used to produce a particular service.

80 Little, Madge, Bullock and Arruabarrena, 2002
81 Department of Health and Children, 2001:179
82 National Children’s Strategy, 2000:398
83 For an introduction, see McKeown, 1999
2. Output indicators, which measure the quantum of service produced usually by reference to the throughput of persons using a service over a period of time such as the number of childcare places, number of persons attending a parenting course, number of participants achieving certification at the end of a programme, etc.

3. Outcome indicators, which measure the impacts of a programme on the well-being of clients such as improvements in the psychological well-being of children and parents as well as improvements in the factors which directly or indirectly improve well-being such as improvements in parenting and relationship skills, enhancement of support networks, feeling more financially secure, etc.

It will be clear from this that performance indicators dealing with inputs and outputs are more measurable than outcome indicators even though the latter is a more important test of a programme’s true worth. For this reason, there is a tendency for performance indicators to focus predominantly, if not exclusively, on input and outputs and to neglect outcomes. This can be seen in the performance indicators currently used to monitor child care programmes in Health Boards which, in abbreviated form, include the following:

- Number of children in care with written care plans and an allocated Social Worker
- Number of children awaiting foster care placements and number of approved foster carers
- Number of operational pre-school centres, including those inspected
- Number of first assessments for Inter-Country Adoption
- Number of child protection case conferences held where the parent / guardian was invited and attended.

In addition to monitoring, the framework in Figure 3.2 draws attention to the type of evaluation questions which need to be addressed in assessing all family services on a more periodic basis. These questions include:

- Is the service effective in achieving its goals? This involves comparing the objectives and outcomes of that service.
- Is the service efficient in achieving its goals? This involves comparing inputs, outputs and outcomes in similar services.
- Do the outcomes represent significant improvements in the well-being of families? This involves comparing the well-being of families before and after the intervention.
- Would the outcomes have occurred without the intervention? This involves comparing the well-being of families who have received the intervention with those who have not.
• Are the outcomes sustainable? This involves comparing the well-being of families at the end of an intervention and some time later (perhaps 1-5 years) to determine if the improvement was sustained after the intervention ceased.

One of the key requirements in developing models of evaluation for family services is the use of standardised instruments for measuring the well-being of children and adults. This is a significant challenge, particularly in the case of children, where measurement instruments must be sensitive and appropriate to the child’s age and stage of development. The range of internationally available measurements instruments which have been tried and tested for validity and reliability is quite considerable and their selection requires an awareness of the underlying concepts which they measure as well as their appropriateness to the culture and circumstances of Irish society.

A number of these measurement instruments have been used in studies and evaluations of family well-being in Ireland\[^{84}\] and are summarised in Table 3.3.

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\[^{84}\] McKeown, Haase and Pratchke, 2001; 2004a; 2004b; 2004c; McKeown, Pratchke and Haase, 2003; McKeown, Lehane, Rock, Haase and Pratchke, 2002
### Table 3.3 Selected Instruments for Measuring the Well-Being of Parents and Children

<table>
<thead>
<tr>
<th>Parent Well-Being</th>
<th>Scale for Measuring Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical and Psychological Well-Being</td>
<td>1. Revised Symptom Checklist&lt;sup&gt;85&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>2. Scales of Psychological Well-Being&lt;sup&gt;86&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>3. General Health Questionnaire&lt;sup&gt;87&lt;/sup&gt;</td>
</tr>
<tr>
<td>Quality of Couple Relationship</td>
<td>1. Marital Satisfaction Scale&lt;sup&gt;88&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>2. Social Intimacy Scale&lt;sup&gt;89&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>3. Dyadic Adjustment Scale&lt;sup&gt;90&lt;/sup&gt;</td>
</tr>
<tr>
<td>Quality of Parent-Child Relationship</td>
<td>1. Parent-Child Relationship Inventory (PCRI)&lt;sup&gt;91&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2. Parent-Child Conflict Tactics Scale (CTS-PC)&lt;sup&gt;92&lt;/sup&gt;</td>
</tr>
<tr>
<td>Child Well-Being</td>
<td>Scale for Measuring Well-Being</td>
</tr>
<tr>
<td>Physical and Psychological Well-Being</td>
<td>1. Health and Daily Living Scales&lt;sup&gt;93&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2. Beck Youth Inventories of Emotional and Social Impairment: Self-Concept, Anxiety, Depression, Anger and Disruptive Behaviour&lt;sup&gt;94&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>3. Multidimensional Students’ Life Satisfaction Scale&lt;sup&gt;95&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>4. Strengths and Difficulties Questionnaire (SDQ)&lt;sup&gt;96&lt;/sup&gt;</td>
</tr>
<tr>
<td>Child-Parent Relationship</td>
<td>1. Index of Parenting Style&lt;sup&gt;97&lt;/sup&gt;</td>
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</tbody>
</table>

In addition to the measurement of well-being (the dependent variable), the evaluation of programmes must also give equal consideration to the factors which directly or indirectly influence well-being (the independent variables) such as relationship skills, personality variables, socio-economic characteristics, support networks, inter-generational and extended family influences, etc. Appropriate statistical methodologies are also required to assess the independent effect of a programme or service while holding all other factors constant in order to avoid the danger of concluding that a service is not effective when it is, or vice versa.

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87 Goldberg, 1972; Goldberg and Williams, 1988.
89 Miller and Lefcourt, 1982.
90 Spanier, 1976.
93 Moos, Cronkite, Billings, and Finney, 1986.
97 Lamborn, Mounts, Steinberg and Dornbusch, 1991.
In looking at the challenges facing the evaluation of services for children and families therefore it is necessary to take stock of all the technical and human demands which this entails. These demands are considerable but so too are the benefits in terms of developing quality services which are more effective and more accountable to both funders and service users.

### 3.4 Examples of Effective Family Support Services

In recent years, there has been a trend in many European and North American States for intensive and enduring family supports which have an identifiable logic to explain why the intervention might be expected to improve outcomes for families and children. These types of programs are more likely to be subjected to rigorous evaluation and so give a better indication of effectiveness. In this section, we describe nine family support programmes which meet either the minimum or ideal standards of evaluation\(^98\), as defined above. These programmes offer contrasts in the type of approach taken and are used to illustrate general patterns of effectiveness across a range of family support services.

#### 3.4.1 The Community Mothers Programme in Ireland

The Community Mothers Programme aims at using experienced volunteer mothers in disadvantaged areas to give support to first-time parents in rearing their children up to one year old. The programme was evaluated by randomised control trial in 1990\(^99\) with a subsequent follow-up seven years later\(^100\), a robust model of evaluation which is relatively unique in Ireland. The evaluation was based on the programme as implemented in the then Eastern Health Board region where local mothers were trained and employed to carry out structured visits to first-time (and some second-time) mothers with a focus on parenting skills, parent self-development as well as health care, nutrition and other aspects of child development. Compared to the control group, children receiving the intervention were more likely to receive all their immunisations, to be read to daily, to be breast-fed for longer and to receive a better diet. There was evidence of improved psychological health for the mothers. In the seven-year follow-up, the authors found that “The Community Mothers programme sustained beneficial effects on parenting skills and maternal self-esteem 7 years later with benefit extending to subsequent children”\(^101\). Walter Barker has

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98 The Glossary of Key Terms at the beginning of this report defines evaluation as a process of assessing the outcome or impact of a programme. At a minimum, this involves comparing the well-being of programme participants (sometimes referred to as the ‘experimental group’) before and after their participation on the programme. Ideally, a thorough evaluation should also involve comparing the ‘experimental group’ with a matched group who have not participated in the programme (sometimes referred to as the ‘control group’) in order to identify the amount of outcome that can be directly attributed to the programme; this ideal form of evaluation is usually referred to as a ‘randomised control trial’.

99 Johnson, Howell and Molloy, 1993

100 Johnson, Molloy, Scallan, Fitzpatrick, Rooney, Keegan and Byrne, 2000

101 Ibid:337
developed and tested similar models internationally, including Ireland, for the Bernard van Leer Foundation and found similar good outcomes\textsuperscript{102}. There is also a connection with the work of NEWPIN for older children described below.

### 3.4.2 Instapje and Opstapje: Netherlands

Projects Instapje (for children less than 18 months) and Opstapje (for four to six year olds) in Netherlands are designed to provide a better quality of support between parent and child, and to increase parental and child participation in school. *Instap* means finding an entrance and *Opstap* getting a better vantage point; the additional *je* refers to the young age of the children being supported. The aim is improved child development especially as manifest in the child’s behaviour. Results of the evaluation by Baaker and colleagues\textsuperscript{103} suggest better support for the children and slight improvements in development but negligible benefit in terms of parent-child relationships. The programme is not dissimilar to a variety of parenting models designed and evaluated with extremely promising results by the Oregon Social Learning Center\textsuperscript{104} now being tested in Europe\textsuperscript{105}.

### 3.4.3 Family Preservation: United States

In a series of rigorous experiments, John Schuerman\textsuperscript{106} and colleagues have evaluated the effectiveness of family preservation programmes, which are akin to family support in Europe,\textsuperscript{107} and aim to reduce the numbers of children in care. The nature of the intervention is designed to change system dynamics (with child development as an unmeasured by-product) with the result that relatively little is known about outcomes. However the studies do indicate that these programmes can reduce the number of children in care, although not in cases of cocaine-exposed infants, and may reduce risk of abuse and neglect for families where the primary need is parenting skills. There is some evidence that family preservation services help families with housing difficulties, and may reduce risks to development associated with these difficulties.

### 3.4.4 Family Support: England

Possibly the only evaluation in England of family support services in their broadest sense was undertaken by Jane Gibbons and colleagues\textsuperscript{108}. They contrasted two

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\textsuperscript{102} Barker, 1987 onwards. For refs: http://web.ukonline.co.uk/oaw/publications.htm (V/N see motivation!)
\textsuperscript{104} Patterson, Reid and Dishion, 1992
\textsuperscript{105} Scott (continuing)
\textsuperscript{106} Schuerman, Rzepni and Littell, op cit.
\textsuperscript{107} Little, M., 2000
areas with similar child populations but contrasting approaches to family support. In ‘Newpath’, family centres were developed by several agencies and the voluntary sector. Social workers operated from the family centres and worked alongside other specialists offering community and family support. ‘Oldweigh’ offered more orthodox provision. The study found modest effects on children’s well-being and concluded that support of family, friends and neighbours, very often produced by family support services, is as important as professional help.

3.4.5 Middle Childhood Programmes: United States

Mark Greenberg at the Prevention Research Center in Penn State University is arguably the leading designer and evaluator of family support programmes aimed at reducing impairment to child development. His work extends to middle childhood. Two programmes, PATHS and FastTrack, have been tried in several US states and recently in Europe. PATHS\(^{109}\), which is an acronym for Promoting Alternative Thinking Strategies, focuses on emotional recognition and self-regulation and produces significant improvements in behaviour and problem-solving skills as well as a reduction in the need for special education placements. FastTrack\(^{110}\) is focused more on education outcomes. Generacion Diez\(^{111}\) extends these ideas to migrant populations and includes a focus on English as a second language, improving parent-teacher involvement and the child’s social skills. Unlike many other targeted family support programmes, Greenberg’s work appears to replicate well across different geographical locations.

3.4.6 NewPin, PIPPIN and HomeStart: England

A series of programmes developed in England have focused on improving the self-esteem and confidence of parents, thus improving their parenting skills and their ability to negotiate services that will lead to improved child development. Van der Eyken\(^{112}\) describes the aims of Homestart as restoring mother’s control over their own lives and so creating a healthy environment for children. NewPin relies on parents in the community to reduce emotional stress and depression in mothers, boost their self-esteem and improve the quality of parent-child relationships\(^{113}\). PIPPIN, also based on a parent self-esteem model, aims to increase engagement between parent and child in the first months of life\(^{114}\). Each of these programmes has demonstrated some success in meeting goals, although only NEWPIN has been rigorously evaluated. One of the challenges facing these programmes is their

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109 See: http://www.prevention.psu.edu/PATHS/
110 Conduct Behaviour Research Group, 1992 and Dodge, 1993
111 See: http://www.prevention.psu.edu/
112 Van der Eyken,1990
113 Cox, 1996
114 See http://www.pippin.org.uk/
replication across children’s services and a lack of matching interventions for those that can most benefit\textsuperscript{115}.

3.4.7 Youth Development Programmes in the United States and England

There has been a long history in the United States of experimenting with ways of preventing what are called ‘generic risk-taking behaviours’ in adolescents. These behaviours include early sexual relationships, unhealthy use of drug, alcohol and other substances as well as other behaviours that may be unhealthy in the longer term. Several reviews\textsuperscript{116} point towards targeted programmes that provide opportunities and support to help youth gain the competencies and knowledge they will need to meet challenges associated with key life transitions. Programmes that engage throughout adolescence appear to be the most effective in carefully constructed evaluations\textsuperscript{117}. Increasingly these programmes are being built into mainstream education within the United States. England will become the first European country to experiment with their use when 25-35 youth development programmes scheduled to begin in 2003. In Ireland, a range of programmes directed at adolescence has recently been introduced such as the Youth Advocacy Programme and Big Brother Big Sister (BBBS). BBBS have been evaluated through randomised control trials with very positive results\textsuperscript{118}.

3.4.8 Home Visitation: United States

Most European countries have some form of home visitation programme for new mothers. Since these programmes are universal and have both high professional and consumer approval, there has been little systematic evaluation. In the United States, home visitation, as it is called, is rare. David Olds\textsuperscript{119} has designed and evaluated several programmes in at least seven US states beginning in Elmira New York in the 1970s. The goal has been to enhance support to mothers during pregnancy in order to improve child outcomes and maternal development. Measured outcomes have been maltreatment of children, hospitalisation, and employment opportunities for mothers, the latter being taken to indicate improved economic well-being for the child. Significant effects have been found for mothers who receive additional services co-ordinated by a nurse visiting the home; provision of home visitation services alone brings no identifiable effect. Effect sizes vary from 15 percentage points for

\begin{itemize}
\item \textsuperscript{115} Cox, 1996 op cit.
\item \textsuperscript{116} Roth et. al. 1998; Hatcher and Scarpa, 2002
\item \textsuperscript{117} Tierney, Grossman and Resch, 1995; Hahn, Leavitt and Aaron, 1994
\item \textsuperscript{118} Tierney, Baldwin Grossman, Resch, 2000
\item \textsuperscript{119} Olds and Kitzman, 1990
\end{itemize}
maltreatment to 33 percentage points for hospitalisation; a by-product of the intervention is reduced family size.

3.4.9 Springboard: Ireland

Springboard is a family support programme designed to improve the well-being of families and children in Ireland and to improve the organisation and delivery of services generally. In this respect, it is similar to SureStart in the UK. It was first introduced in 1998 with 18 projects and by 2003 it had grown to 21 projects. All Springboard projects have a general strategy of being open and available to all families, parents and children in their communities as well as a more specific strategy of working intensively with those who are most vulnerable, including those about whom the Health Boards have child protection concerns. As with other family support programmes, it offers a range of interventions including individual work, group work, peer support, family work, advocacy and practical help. The evaluation of Springboard was based on nearly 200 parents and 300 children who received intensive support over an 18 month period and used a range of standardised instruments to measure their well-being at the beginning and end of the intervention\(^\text{120}\). The key findings showed that a quarter of the children experienced a clinically significant improvement in their well-being (as measured by the Strengths and Difficulties Questionnaire) and a similar proportion of parents recorded an improvement in the parent-child relationship (as measured by the Parent-Child Relationship Inventory). About double this proportion of parents and children believed their lives had improved as a result of Springboard. As with other evaluations, strict comparisons of Springboard with other interventions are difficult to make due to differences in target groups as well as different measurement instruments.

3.4.10 Overview

Each of the examples selected here represents intensive and enduring approaches to family support. In most cases they are based on a logic model that identifies chains of risk as they affect well-being and set out why the intervention might interrupt those chains so leading to better outcomes for families and children\(^\text{121}\). Cox\(^\text{122}\) has set out some of the weaknesses of these programmes such as poor sensitivity and specificity of risk assessments with the result that many families who could benefit miss out. Most of these interventions have been mainstreamed in the sense that their funding is guaranteed from one year to the next although this does not imply that

\(^{120}\) McKeown, Haase and Pratchke, 2001
\(^{121}\) Little, Axford and Morpeth, forthcoming
\(^{122}\) Cox, 1996 op cit
these programmes are universally or even widely available. Nevertheless the programmes represent a range of practical and therapeutic supports for families and children and are known to be effective as well as having high levels of consumer satisfaction. One of the fundamental challenges therefore is to both extend the reach and the targeting of family support programmes such as these.

3.5 Summary and Conclusion

In this chapter we have seen that the process of designing and delivering services has its own system dynamics which, however unintended, can affect the impact of those services in meeting the needs of families and children. Like Ireland, many countries have systems which divide services between child protection, children in care and family support. Our analysis suggests that systems which have high levels of child protection activity (such as the US), tend to low levels of family support activity while others (such as the UK) which have lower levels of child protection activity tend to have higher levels of family support activity. Ireland seems to fit this pattern as well, a finding which provides food for further reflection and investigation as part of the context for developing and rebalancing services for families and children in Ireland. Our analysis also drew attention to the general lack of data and analysis on the impact of services for families and children, particularly those involving child protection and children in care. Ironically, it is family support services that are more likely to undergo evaluation and the results of these studies, drawing from a wide international experience, shows the positive outcomes that are possible with a range of family support interventions.
4.1. Introduction

This chapter describes how services for families and children are organised, managed and perceived within Health Boards with particular reference to family support services. It is based on written information supplied by Health Boards and a wide-ranging consultation process with professionals and managers responsible for child and family services. The chapter draws upon interviews held with Assistant Chief Executive Officers in each Health Board with responsibility for child and family services as well as focus groups with other professionals including Principal Social Workers, Directors of Public Health Nursing, Superintendent Community Welfare Officers, and Managers in residential and foster care. We also draw upon the results of focus groups held in each Health Board area with 10-20 professionals directly involved in the management and delivery of family support projects and services, both statutory and voluntary. In addition, the chapter briefly describes some of the services that support families from the perspective of other Government Departments.

Family support services which are provided or funded by Health Boards have developed in a variety of service contexts including child care, disability, mental health, and acute hospitals. Health Boards also provide support to families with adult-related needs including the elderly, carers at home and through the income support of Community Welfare Services. Most of the data in this chapter was supplied by personnel working in the child care area, particularly through the Liaison Group which was established to facilitate this study and, for that reason, the chapter has a predominant focus on child care services. Information on family support services in the areas of disability, mental health and acute services was sought but relatively little was received. This is partly due to the fact that many of these services are not explicitly labelled as ‘family support’ although it is clear that they provide significant support to families where children have a variety of special needs.

The chapter is divided into seven sections. We begin by giving an overview of all Health Board services for children including their management and staffing structures as well as their integration and coordination (Section 4.2). We then focus
specifically on child care services, their organisation at regional and community care level, and some indication of resource allocation within child care (Section 4.3). This is followed by an overview of how family support services have developed in Health Boards over recent years (Section 4.4) as well as a brief description of family support services provided through other Government Departments (Section 4.5). Against this background, we summarise the views of key stakeholders in the health care system on the organisation and delivery of services for families and children. These stakeholders - which include Assistant Chief Executive Officers, Principal Social Workers, Directors of Public Health Nursing, Superintendent Community Welfare Officers, Managers in residential and foster care as well as professionals directly involved in the management and delivery of family support projects and services – offer a unique insider view on how the current system is working in practice (Section 4.6). Finally, we conclude by identifying a number of key issues and challenges which face the present system of services for families and children (Section 4.7). Our response to these issues comes in Chapter Six where we outline a set of principles and options for the future development of these services.

4.2 Organisation of Health Board Services for Children

4.2.1 Services provided and funded by Health Boards

Health Board services for children (aged 0-18 years) comprise several categories as follows:

1. *Child Care*, which focuses mainly on the social needs of children and families, represents services aimed at fulfilling the Health Boards’ statutory responsibilities to protect children from abuse and neglect while promoting their welfare through the provision of family support and other services.

2. *Child Health* is concerned primarily with the health of children and is provided in community-based settings. It includes developmental assessments of young children, immunisation and contributes to disease surveillance.

3. *Child and Adolescent Psychiatry* consists of community-based and acute services traditionally provided to children and young people up to 16 years. Current mental health legislation obliges Health Boards to provide these services for children up to 18 years.

4. *Disability* includes services for children with intellectual and physical disabilities and those with sensory impairments.

5. *Hospital services*.

6. *Health Promotion* including a range of local and national initiatives.
7. **Community Welfare** offering income support on an emergency basis to families in need.

Health Board services to children and adults are grouped according to whether they are provided in ‘community’ or ‘hospital’ settings. Most Health Board services for children and families are provided in the community with the exception of medical services provided in hospitals and services offered during acute phases of mental illness. A limited number of services straddle both the hospital and community sectors. These include paediatrics as evidenced by some Health Boards introducing positions called ‘Community Paediatric’, and psychiatry where access to hospital services is an integral part of providing a comprehensive range of psychiatric services.

### 4.2.2 Management and staffing structures

The management and staffing structures of Health Boards are complex and diverse, at both regional and community care level.

**Regional / Health Board Level**

At one time, responsibilities at senior management level were allocated on a functional basis. This involved Programme Managers who had responsibility for ‘community care’, ‘acute hospitals or ‘special hospitals’. During the 1990s the introduction of a ‘care group approach’ to planning and delivering services was reflected in management structures, initially in the east of the country, and then spreading to some other parts. There are now a number of care groups including ‘children and families’, ‘elderly’, ‘disability’ and ‘mental health’. This regrouping coincided with the introduction of the title of Assistant Chief Executive Officer (ACEO) to replace that of Programme Manager. In addition, some Health Boards began allocating senior management responsibilities on a geographical basis. At present, there are very few senior managers in Health Boards, below Chief Executive Officer level, with comparable portfolios of responsibility.

Following the introduction of the care group model a number of positions, notably ‘Director’ and / or ‘Regional Coordinator’, were created in areas such as ‘children and families’, ‘disability’, etc. The remit of these positions is with planning, quality assurance, training, policy and service development but they do not normally have executive responsibilities.
Community Care Area Level

Each Health Board region is divided into Community Care Areas (CCAs) and all but two Health Boards (NWHB and MHB123) have three or more CCAs. These geographical units are managed by General Managers. Almost all staff at Community Care Area level are managed by the General Manager including the various ‘heads of discipline’, such as Principal Social Worker, Directors of Public Health Nursing, Principal Speech & Language Therapists. In most Health Boards budget-holding responsibilities are confined to CEOs, ACEOs, Hospital Managers and General Managers.

It is evident that, at both regional and community care level, a mixture of functional and geographical approaches have been taken to the development of management and staffing structures. As we shall now see, these affect the integration and coordination of services.

4.2.3 Integration and co-ordination of services

Health Board services provided to children tend to operate in a separate rather than an integrated manner. These separations largely reflect divisions between types of services, professional approaches and the CCA management structure. Initiatives are being introduced within and between Health Boards that reflect a desire to achieve a more coordinated management and professional approach to providing services for children. The NWHB, for example, is undertaking a substantial change management programme which started in September 2002. This programme of change attempts to integrate the Health Board’s child-related health and social services at regional level. The NWHB is also developing a common approach to assessing need amongst relevant professionals. Some other Health Boards (notably SHB, MHB, WHB and MWHB) have established committees comprising personnel from different child-related services in an effort to support a more coordinated approach to provision. Other Health Boards (for example, SWAHB and the NEHB) have included statements in their strategic plans reflecting a recognition of the importance of integrating services for children.

The Health Boards Executive (HeBE) fosters conjoint working between Health Boards and has initiated a ‘Programme of Action for Children’ that has an overall aim of providing an integrated health services framework for children. This programme, which is still at a consultative stage, has taken responsibility for some national initiatives for children particularly in the areas of child health (through implementing

123 Throughout the report, the following acronyms are used: ERHA = Eastern Regional Health Authority; NAHB = Northern Area Health Board; ECAHB = East Coast Area Health Board; SWAHB = South West Area Health Board; NEHB = North Eastern Health Board; NWHB = North Western Health Board; MHB = Midland Health Board; WHB = Western Health Board; MWHB = Mid-Western Health Board; SHB = Southern Health Board; SEHB = South Eastern Health Board.
the Best Health for Children strategy\textsuperscript{124} and child care (through implementing Children First: National Guidelines for the Protection and Welfare of Children\textsuperscript{125}).

A programme of reform for the health services has been initiated as a result of the Audit of Structures and Functions in the Health System (2003), commissioned by the Department of Health & Children\textsuperscript{126} and the Report of the Commission on Financial Management and Control Systems in the Health Service (2003), established by the Department of Finance\textsuperscript{127}. In an effort to progress reform, the Department of Health & Children together with officials from HeBE and the ERHA are working on a number of projects. One of these projects is ‘Primary, Continuing and Community Care’ which provides the main context for services currently provided to children by, and on behalf of, Health Boards. The unfolding of this project will indicate the possibilities and pace with which coordination and integration of services provided to children might be introduced. These changes will provide an important context for the development of family support services provided from a health perspective.

4.3 Child Care Services

4.3.1 Services included in ‘Child Care’

Child care services have been developed by Health Boards in response to their statutory duty “to promote the welfare of children …… who are not receiving adequate care and protection” (Child Care Act 1991). More recently the term ‘child care’ is being replaced by the term ‘services for children and families’. Whatever the term, the following services are normally included in this category:

- Child protection, sometimes referred to as ‘child welfare and protection services’
- Children in care comprising fostering, adoption, residential homes including ‘high support’ and ‘special care’
- Family support programmes and projects which, in general, offer practical assistance to families inside and outside the home and may also intervene therapeutically to strengthen family functioning
- Day nursery services
- Neighbourhood Youth Projects
- Parent support schemes such as the Community Mothers Programme
- Domestic violence
- Pregnancy counselling
- Teen parenting programmes.

\textsuperscript{124} Best Health for Children, 1999, 2001, 2002
\textsuperscript{125} Department of Health and Children, 1999
\textsuperscript{126} Prospectus, 2003
\textsuperscript{127} Commission on Financial Management and Control Systems in the Health Service, 2003
Some health boards also include the following services in this category:

- Psychology
- Child and adolescent psychiatry
- Services for children and young people misusing drugs.

Child care services are further sub-divided into three groups namely (i) child protection (ii) children in care, sometimes referred to as ‘cared for children’ or ‘alternative care’ and (iii) family support. The quality and quantity of information on these three types of services varies considerably.

Health Boards gather information on child protection cases in different ways and therefore it is not possible to aggregate or compare most of the data collected. A Child Care Management Information Project is underway to tackle this problem.\(^{128}\)

Information on children in care is collected through the Child Care Interim Minimum Dataset and the most recent data is for the year 2001\(^{129}\). This data indicates that the vast majority (77%) of children in care are in foster care. Only a minority of children (16%) are in care for reasons of physical, sexual or emotional abuse. The single most important reason why children are in care is “parents unable to cope / parental illness” (30%) followed by “neglect” (28%). A disproportionate number of children in care are from lone parent families (40% compared to 15% of lone parents in the general population) which may indicate poorer access to support networks relative to two parent families. When the reasons for admission into care are summarised into “child-centred” and “family-centred” reasons, the results indicate that 48% of children are in care for family-centred reasons, a finding which raises questions about the unexploited potential of family support services as both an alternative to placing children in care as well as a method for prevention and early intervention. The fact that the vast majority of children (77%) are in care for over a year suggests that this form of intervention may not be as supportive as it could be of the re-integration of families. At the same time, initiatives such as the Family Rights Group which supports the parents of children in care in the Mid-Western Health Board are endeavouring to address this issue as is the National Association of Young People in Care.

As regards family support services, the general lack of information about this sector was addressed through the census of family support services which was commissioned as part of this study\(^{130}\). A survey of service users’ satisfaction with these services was also undertaken as part of the census. The results of this study, as summarised in Chapter Five, provide valuable insights into those family support services which were funded by Health Boards in 2002.

\(^{128}\) See Social Information Systems, 2002
\(^{129}\) Department of Health and Children, 2002
\(^{130}\) A separate report on the census, including detailed results for each Health Board, is available; see McKeown, K., and Haase, T., 2004, A Census of Family Support Services in Ireland: Results of a Census of Family Support Services which were funded by Health Boards in 2002, Dublin: Department of Health & Children.
4.3.2 Organisation of child care services

Regional / Health Board Level

Child care usually represents one of a number of senior management responsibilities at ACEO level. Two Health Boards (NAHB, ECAHB) have appointed ACEOs with sole responsibility for child care. Also at regional level, there are Directors / Regional Coordinators for child care services in almost all Health Boards. Some Health Boards (ECAHB, SWAHB) have appointed Child Care Operations Managers at regional level in addition to Directors. A number of Health Boards have also appointed Coordinators of Family Support Services and Managers of Residential Services with region-wide responsibilities. The NWHB has a different structure in place to support a more integrated approach to service delivery to children and families led by a Regional Manger of Children’s Services.

Community Care Area level

At CCA level, Principal Social Workers usually have responsibility for child protection, children in care and family support services and report to the General Manager. Child Care Managers are appointed in each CCA. The nature and range of duties undertaken by Child Care Managers varies within and between Health Boards. For example, some Child Care Managers are reported to oversee all child care services including child protection, services for children in care and family support (MWHB). In other Health Boards, Child Care Managers do not have an overseeing role but may be involved in service development, or specifically involved in assessing and processing child protection referrals.

It is clear from this that the management arrangements for child care services reflect the complexity and diversity of structures in place throughout the Health Board system.

4.3.3 Resource allocation within child care

Comprehensive data is not available on the total allocation of funds to child care services in Health Boards. However data is available on the amount of new funds made available by the Department of Health & Children for service developments between 1997 and 2003. These are summarised in Table 4.1 and reveal that new resources amounting to €182 million were spent on child care services in this period. The growth in new resources reached a peak in 2002 with the addition of €48 million to child care services. The practical implication of these developments can be seen in the ERHA, which covers about one third of the population, where the child care budget was around £28m in 1997\(^{131}\) and rose to over €120m 2002\(^{132}\), an increase of nearly 240%, an annual average increase of 40%.

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\(^{131}\) Eastern Health Board/Impact Review Group on Child Care and Family Support Services, 1997

\(^{132}\) Eastern Regional Health Authority, 2003, personal communication.
The allocation of resources within the child care budget of each Health Board is summarised in Table 4.2. This reveals that the largest share of child care resources are allocated to children in care and child protection with family resources absorbing the remainder. Given that children in care and child protection are essentially forms of late intervention and crisis-management, it is fair to conclude that prevention and early intervention receive least resources in child care services. When it is realised, as our analysis in Chapter Five reveals, that most resources within family support are also allocated to services which involve late interventions, the extent to which prevention and early intervention are under-resourced becomes even more dramatically clear.

**Table 4.1 Additional Resources Allocated to Health Boards for Child Care Services, 1997-2003**

<table>
<thead>
<tr>
<th>Year</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR£ /£</td>
<td>IR£12m</td>
<td>IR£8m</td>
<td>IR£15m</td>
<td>IR£31.75m</td>
<td>IR£33.1m</td>
<td>£47.81m</td>
<td>£7.979m</td>
<td>–</td>
</tr>
<tr>
<td>€</td>
<td>€15.24</td>
<td>€10.16</td>
<td>€19.05</td>
<td>€40.31</td>
<td>€42.03</td>
<td>£47.81m</td>
<td>£7.979m</td>
<td>€182.579</td>
</tr>
</tbody>
</table>

Source: Child Care Policy Unit, Department of Health & Children.

**Table 4.2 Percentage Allocation of Financial Resources in Health Boards Between Children in Care, Child Protection and Family Support, 2003**

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Children in Care %</th>
<th>Child Protection %</th>
<th>Family Support %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAHB</td>
<td>48</td>
<td>25</td>
<td>27</td>
<td>100</td>
</tr>
<tr>
<td>SWAHB</td>
<td>45</td>
<td>25</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>ECAHB</td>
<td>52 (i)</td>
<td>31 (i)</td>
<td>14 (i)</td>
<td>100</td>
</tr>
<tr>
<td>NEHB</td>
<td>47 (ii)</td>
<td>36 (ii)</td>
<td>17 (ii)</td>
<td>100</td>
</tr>
<tr>
<td>NWHB</td>
<td>45</td>
<td>31</td>
<td>24</td>
<td>100</td>
</tr>
<tr>
<td>WHB</td>
<td>43</td>
<td>11</td>
<td>46</td>
<td>100</td>
</tr>
<tr>
<td>MHB*</td>
<td>26</td>
<td>61</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>MWHB</td>
<td>63</td>
<td>15</td>
<td>22</td>
<td>100</td>
</tr>
<tr>
<td>SHB</td>
<td>60 (iii)</td>
<td>29</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>SEHB</td>
<td>67</td>
<td>13</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Data supplied by each Health Board.

*The data are indicative rather than definitive estimates.

(i) Based on data from Community Care Area Two only. (ii) Based on data from the Louth Community Care Area Two only. (iii) In the SHB, Children in Care is further broken into foster care (34%) and residential care (26%).
4.4 Family Support Services from the Child Care Perspective

4.4.1 Providers of family support

The majority of family support services, as our analysis in Chapter Five reveals, are provided by voluntary agencies and community groups with funding from Health Boards and other sources. Coordinators of family support services at regional level, where they exist, have a role in promoting the development of family support services in both the Health Board and in the voluntary / community sector. In some Health Boards (SHB), relationships with voluntary agencies are managed by the Community Work Department under the Principal Community Worker. In others (MWHB), Principal Community Workers in each county are involved in developing family support programmes.

Family support is provided directly by Social Workers and Public Health Nurses amongst their other Health Board activities as well as by Community Welfare Officers. Family Support Workers have been appointed to child protection teams and provide a range of practical supports to families usually on an outreach basis. These Family Support Workers also become involved in what is considered to be child protection work such as supervising access visits between parents and children. Family Support Co-ordinators appointed at CCA level normally report to Principal Social Workers and usually have responsibility for supervising the Health Board’s Family Support Workers.

4.4.2 Establishing and locating family support services

Decisions to establish family support services are not made on the basis of a systematic approach to gathering and analysing information on need. Family support services are usually located in areas of disadvantage and are unevenly distributed throughout the country. The Department of Health & Children has provided dedicated funding to Health Boards for the purpose of establishing family support projects such as Springboard, Youth Advocacy Programme, Teen Parenting Programme, etc.

4.4.3 Policy and family support

There is no national policy guiding the development of family support services and no clear objectives to determine what such services might achieve. Children First: National Guidelines for the Protection and Welfare of Children\textsuperscript{133} includes guidance

\textsuperscript{133} Department of Health and Children, 1999
concerning family support services and states that “Each Community Care Area should have a family support service plan, which should take account of the views of all relevant service providers and representatives of community organisations.” However, these Guidelines have not yet been introduced throughout the country. Some Health Boards (notably NEHB, WHB, SEHB) have developed policy, principles and guidelines in relation to family support services. In addition, the WHB has established a Child and Family Research and Policy Unit in association with NUI Galway.

### 4.5 The Provision of Support to Families by Other Government Departments

#### 4.5.1 Department of Social & Family Affairs

In addition to its traditional role of income support, this Department has become increasingly involved in the provision of family support. In 1995 the then Minister for Social, Community and Family Affairs established the Commission on the Family (1995-1998) with the brief “to examine the effects of legislation and policies on families and make recommendations to the Government on proposals which would strengthen the capacity of families to carry out their functions in a changing economic and social environment”. Following the publication of the Commission’s reports, the Family Affairs Unit was established within the Department. More recently this Department developed the Family Support Agency which, under the Family Support Agency Act 2001, has responsibility for funding and supporting a range of services including the family mediation service, marriage and relationship counselling services, family support services, family and community services resource centres and well as the provision of information on a range of matters affecting the family.

#### 4.5.2 Department of Education & Science

This Department provides a range of programmes which target families and children in disadvantaged areas. These programmes include the Early Start Pre-School Programme, the Home-School-Community Liaison Scheme, Breaking the Cycle, the 8 to 15-Year-Old Initiative, the Stay in School Initiative, and an initiative entitled ‘Giving Children an Even Break by Tackling Disadvantage’. These initiatives have the board aim of supporting children to maximise their potential within the educational system and, as such, contribute to the support of families in disadvantaged areas.

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134 Department of Health and Children, 1999:59
4.5.3 Department of Justice, Equality & Law Reform

The Equal Opportunities Child Care Programme is part of the National Development Plan (2000-2006)\textsuperscript{136} and is administered through Area Development Management. The programme has been allocated over €350m for the purpose of developing childcare facilities and services. This initiative is informed by a labour market perspective rather than a family support perspective and its core objective is to enable parents to participate in employment, training or education while their children are in childcare\textsuperscript{137}.

This Department is also involved in supporting young people at risk of becoming involved in anti-social and criminal behaviour. It does this through supporting the Garda Youth Diversion Projects, an anti-crime measure aimed at providing preventive activities and interventions for marginalised young people. These projects are primarily targeted at young people rather than families per se but can provide valuable support to parents coping with troubled teenagers\textsuperscript{138}.

4.6 Stakeholder Observations on Services for Families and children

As already indicated, this study involved extensive consultation with many of the key stakeholders in each Health Board who are professionally involved in managing and delivering child and family services. These include Assistant Chief Executive Officers, Principal Social Workers, Directors of Public Health Nursing, Superintendent Community Welfare Officers, Managers in residential and foster care, as well as professionals directly involved in the management and delivery of family support projects and services. We now present a synthesis of their views since this provides an insider view on how the system just described is working in practice.

4.6.1 Understand the historical context of service development

Child care services have developed rapidly in recent decades. Building on the Child Care Act 1991, there is now an elaborate regulatory framework for both children in care (mainly in the form of regulations\textsuperscript{139}, standards\textsuperscript{140} and guidance notes\textsuperscript{141}) as

\begin{itemize}
  \item Child Care (Placement of Children in Residential Care) Regulations, Statutory Instrument, SI No 259 of 1995;
  \item Child Care (Placement of Children in Foster Care) Regulations, Statutory Instrument, SI No 260 of 1995;
  \item Child Care (Placement of Children with Relatives) Regulations, Statutory Instrument, SI No 261 of 1995;
  \item Child Care (Standards in Children's Residential Centres) Regulations, Statutory Instrument, SI No 397 of 1996
\end{itemize}

\begin{itemize}
  \item National Standards for Children's Residential Centres;
  \item National Standards for Foster Care;
  \item National Standards for Special Care Units;
  \item National Guidelines on the use of Single Separation in Special Care Units; all available at www.issi.ie
\end{itemize}

\begin{itemize}
  \item Safeguarding and Child Protection; Children's Complaints Work; Children's Access to Information; Children's Consultation; Leaving Care and Aftercare Support; all available at www.issi.ie
\end{itemize}
well as child protection (notably Children First\textsuperscript{142}) but none for family support. In line with the adage that ‘money follows regulation’, there have been substantial increases in funding and, as indicated earlier in this chapter, child protection and children in care absorb the largest share of resources within child care. These developments have come about against a backdrop of widespread public, political and media concerns which were legitimately raised following the disclosure of system failures in child care services, some of them stretching over many decades. Health Boards have also had to fill significant gaps in residential care services following the decline in services provided by Religious Orders. In addition, the rapid expansion of child care services within the Health Boards has been challenged by the difficulty of recruiting and retaining experienced professionals as well as the need for more appropriate and effective management systems. In this historical context therefore, family support services have not received the attention they deserved and their neglect signifies a wider range of issues within Health Boards, some which have already been identified in this report.

4.6.2 Services are scarce relative to need

There is consensus that the level of services for families and children is low relative to the need. Given this overall scarcity, families who present the most serious child protection concerns to Health Boards tend to receive priority. As a result, services for families and children, including family support services, tend to involve late interventions with a focus on crisis-management. Despite the expansion of family support services in recent years, it is noteworthy that many of these initiatives – Springboard, Youth Advocacy Programme, Teen Parenting Programme – are all forms of late intervention. Any rebalancing of services must address the imbalance between children in care, child protection and family support but must also address the imbalance within family support itself. The current imbalance in child and family services is perceived to be undermining their effectiveness as well as the overall morale of staff. Sometimes professionals, such as Public Health Nurses, who are directly involved in prevention and early intervention, cannot access family support services for families in need, particularly those families who require nothing more than some practical support over a relatively short period, due to the scarcity of services such as Community Mothers, Lifestart, Homestart, etc.

4.6.3 Rebalancing services will take time

The current system is seen as self-perpetuating in that the absence of prevention and early intervention will continue to generate more and more demands for crisis

\textsuperscript{142} Department of Health and Children, 1999
interventions with its focus on ‘child protection’ rather than ‘child welfare’. Any rebalancing therefore could take up to 15 years to bear fruit.

4.6.4 Services are unevenly distributed

Services are unevenly distributed geographically with the result that areas with apparently similar needs have quite different levels of service provision. Services for families are perceived to be particularly scarce in rural areas and, in some cases, are aggravated by lack of transport although the results of the census of family support services in Chapter Five do not support this perception. Need is not the primary criterion determining the distribution of services and there has been no systematic attempt in any Health Board to assess the overall level or pattern of need among families as a basis for allocating services.

4.6.5 Lack of coordination

There is a widespread perception that the three pillars in the Health Boards’ core services for families and children – (i) children in care (ii) child protection and (iii) family support - are not well coordinated with each other, while access to more specialised services for families and children (such as mental health, speech and language, etc) appear even less coordinated. The same applies to the coordination of services between agencies outside the ambit of Health Boards. When coordination works well within these structures it is usually attributable to the pioneering work of individuals on the ground although this is seen as inconsistent with the principles of fairness and quality. Poor coordination stems from the lack of co-ordination at national level and from the uni-disciplinary way in which services are organised and managed. Perhaps as a result of this, some professionals also seem to think about the needs of families and children in a uni-disciplinary way. There is no mandate for services to work together with the result that they sometimes work in isolation and decide what they will, and will not, offer. Families, in turn, have to adapt to the needs of these services rather than vice versa.

4.6.6 Family support is seen as the ‘poor relation’

The financial and legal systems in Health Boards are perceived to privilege services for children in care and child protection over family support in the sense that the former are ‘ring-fenced’ while the latter are not. This creates the perception that family support is the ‘poor relation’ in services for families and children. As a result, family support has been project-led rather than policy-led and these projects, in turn, are not distributed on the basis of a careful assessment of the geographical distribution of need or the most appropriate overall balance between prevention, early intervention and late intervention.
4.6.7 Managing and financing services are separate functions

The financial system in Health Boards seems to give little budgetary autonomy to service managers and this makes service planning and coordination more difficult. Our consultations indicated that decisions on resource allocation are usually taken at some distance from service managers and often bear little resemblance to what is identified as required in service plans. As a result, there appears to be gap within Health Boards between those who plan and finance services and those who manage and deliver services on the ground. Possibly because of this, there is a fear of taking risks and finding imaginative solutions as well as a general feeling of being unsupported.

4.6.8 Voluntary sector is a key player in family support services

Some of the most innovative family support projects have been in the voluntary sector which is perceived to have the twin advantages over Health Boards in their greater flexibility and acceptability within the community. However voluntary organisations typically work in an environment of less public accountability compared to Health Boards and some can be selective in the type of clients who receive a service or indeed the type of service offered; many, as we shall see in Chapter Five, seem to have no service contact with the Health Board. In the area of family support, some organisations – particularly social service organisations like Sligo Social Services, Limerick Social Services, ClareCare, etc. - have been in existence for many years and offer a wide range of family services which combine child welfare and child protection. Our consultations on the role of the voluntary sector raised a number of general issues such as to the most appropriate balance between statutory and voluntary provision, improving accountability through service agreements, parity of pay rates in the statutory and voluntary sectors, standardisation of training for Family Support Workers as well as the overall fragmentation of the service and funding environment.

4.6.9 Guidelines on quality

Some of the criteria proposed for good family support services include the following:

A. Building a trusting and respectful relationship with the family
B. Focusing on family functioning as the way to protect the child
C. Consulting the family on how to match services to needs
D. Offering practical and therapeutic services as required
E. Coordinating services from different disciplines, as required, around the family through care plans and key working
F. Advocating for the family
G. Locating services within the community and delivering them in a naturalistic setting
H. Being more imaginative in terms of efforts to include fathers, extended family, and other members of the community.

4.6.10 Recognise diversity of needs

Our consultations indicated that family support services require responsiveness to the diverse needs of families with children in all age groups up to the age of 18 years including: early years, transitions to school including after-school, in-school and out-of-school services, alcohol and drugs, parenting and relationship programmes, depression, financial problems, and non-national families.

4.6.11 Finding the right mix of services

A major challenge for the development of family support services is to find the most appropriate mix of services in each area. For example, the consultations raised questions such as: how does Springboard fit in with the family support services of Health Boards, particularly Family Support Workers and Child Care Workers?; what is the most appropriate mix of voluntary and statutory providers and how should this be managed? Some describe the existing range of family supports as a ‘continuum’ as if to imply an integrated spectrum of services. The reality, as many have observed, is more haphazard and discontinuous essentially because family support has been project-driven rather than policy driven with no overall management or direction.

4.6.12 Explore the potential of integrating child care

There are isolated examples of how services for children in care are being used to keep families together. In the generality of cases, there seems to be little evidence of support for rehabilitative programmes which could help families re-unite with a child who has been placed in care. The present system could do more to incentivise keeping families together. For example, day and respite fostering can be helpful, particularly if relationships are developed between resourceful foster parents and families in need. Community-based services can help both foster-parents and residential care workers while residential homes with trained and experienced staff can be a resource for foster parents and troubled families. The period when children are in care offers an opportunity to work with families to develop parenting capacity
in preparation for the child’s return home. At present these opportunities for rehabilitation and reunification are not fully exploited and there seem to be few incentives to do so because divisions between service categories do not encourage joint working towards keeping families together. It is also essential that good quality alternative care is available where families, despite best efforts, are unable to care for their children safely.

4.6.13 Lack of focus on outcomes

There is very little evaluation of how existing services are working to enhance the well-being of families and children. This is partly due to the fact that there are no agreed outcome indicators and the absence of evaluation. This undermines good, evidence-based, practice.

4.6.14 A multi-dimensional approach to services

A strategy for families and children, which gives priority to prevention and early intervention, must be multi-dimensional and focus on all the factors which affect well-being, both inside and outside the home. This includes housing, the quality of the environment and amenities, pre-school, school and after-school services, sport and leisure, and a range of community-building activities. This means that a wide range of Government Departments and agencies need to be involved and to work in a coordinated fashion at local and national level. This is already happening through RAPID and CIÁR but tangible results are slow to emerge.

4.6.15 A national policy on family support is needed

We have seen that national policy arrangements exist for children in care (mainly in the form of regulations\textsuperscript{143}, standards\textsuperscript{144} and guidance notes\textsuperscript{145}) as well as child protection (notably Children First\textsuperscript{146}) but none for family support. Some perceive the way forward as thinking less in terms of separate policies and services for children in care, child protection and family support and more in terms of prevention, early intervention and late intervention with a corresponding structure of services and

\textsuperscript{143} Child Care (Placement of Children in Residential Care) Regulations, Statutory Instrument, SI No 259 of 1995; Child Care (Placement of Children in Foster Care) Regulations, Statutory Instrument, SI No 260 of 1995; Child Care (Placement of Children with Relatives) Regulations, Statutory Instrument, SI No 261 of 1995; Child Care (Standards in Children’s Residential Centres) Regulations, Statutory Instrument, SI No 397 of 1996

\textsuperscript{144} National Standards for Children’s Residential Centres; National Standards for Foster Care; National Standards for Special Care Units; National Guidelines on the use of Single Separation in Special Care Units; all available at www.issi.ie

\textsuperscript{145} Safeguarding and Child Protection; Children’s Complaints Work; Children’s Access to Information; Children’s Consultation; Leaving Care and Aftercare Support; all available at www.issi.ie

\textsuperscript{146} Department of Health and Children, 1999
resources to deliver these in an integrated way. For example, a prevention and early intervention team could be formed around a family centre comprising the personnel from Primary, Community and Continuing Care Services; these could include Public Health Nurses, Social Workers, Community Mothers, Family Support Workers / Home Helps as well as representatives from other agencies and from the community. We would see this as one of the possible outcomes which could follow from the strategic options suggested below in Chapter Six.

4.7 Conclusion

This chapter has analysed how Health Board services for families and children are organised and delivered while also offering an insight into how those who operate the system perceive it from the inside. The picture which emerges is one of considerable organisational complexity and diversity from one Health Board to another coupled with considerable professional disenchantment at the capacity of the system to meet the needs of families and children. This is a stark finding and in this concluding section we highlight some of the key issues which have emerged.

First, the current organisation of services promotes division rather than integration. Structures are confusing and create frustration both within and outside the Health Boards. There is a lack of organisational alignment and little evidence of any overarching vision or principles driving cohesive development or fostering collective responsibility.

Second, the majority of resources going to families and children are absorbed by late interventions which often deal with crises rather than with prevention and early intervention. This is despite rational arguments and strong empirical evidence\textsuperscript{147} for investment in prevention and early intervention, and within a context of substantial increases in funds being allocated to child care services in recent years.

Third, there is a strong commitment to the belief that the best way to discharge statutory obligations is to extend and reinforce investment in child protection and children in care. This is despite three important facts:

(i) There are almost twice as many children in care because their parents were unable to cope or were ill, compared to those who have been abused. Almost half of the population of children in care have been admitted for “family-centred” reasons. There is also a disproportionate number of children in care from lone parent households. All of this points to the still unexplored possibility

\textsuperscript{147} See, for example, Karoly, et al., 1998 who used US data from the Elmira Prenatal & Early Infancy Project as well as the Perry Preschool Programme to show that every dollar spent on prevention and early intervention yields 3-4 dollars in return. According to James Heckman (1999), winner of the Nobel Prize in Economics in 2000, “Policies that seek to remedy deficits incurred in early years are much more costly than early investments wisely made, and do not restore lost capacities even when large costs are incurred. The later in life we attempt to repair early defects, the costlier the remediation becomes.” See also Greenwood et al, 1998; Duncan and Brooks-Gunn, 1997; Cameron and Heckman, 1999. For a review of this literature, see McKeown and Sweeney, 2001, Chapter Four.
that a more developed system of family support might considerably reduce the population of children in care. In addition, the fact that the vast majority of children are in care for over a year suggests a relatively long – and possibly permanent – stay away from their natural parents. Again it is reasonable to ask if family support services could reduce the length of stay, in addition to reducing the numbers admitted in the first place.

(ii) Continued and increasing investment in child protection and children in care seems to have done little to change the situation in which Health Boards continue to struggle in response to crises and recurring problems. As a strategy this manifestly is not working.

(iii) There is almost no evaluation of those services which are absorbing most of the resources and insufficient account seems to be taken of the positive outcomes of family support services which have been examined.

Fourth, the evidence that family support may be a more effective and appropriate means of protecting children (in the majority of cases) and promoting their welfare has not adequately been internalised by service planners. Plainly, the evidence of the impact and effectiveness of well designed and delivered family support is not, in the main, what is driving current service developments.

Fifth, the concern to improve the balance of service provision between prevention, early intervention and late intervention is well-founded. To do this properly will mean taking account of the fact that most resources are allocated to options which involve late interventions, including those within family support services. This is because most family support services are responding to families and children where problems are already developed. This conflicts with the commonly held view that, in general, family support services are located at the ‘softer’ preventive end of the service spectrum. Ironically this misconception has been one of the most powerful influences in maintaining family support as the poor relation of child protection and children in care. Increasing family support services will not in themselves improve the balance between prevention, early intervention and late intervention. A better understanding of how resources are used and the kind of difficulties being tackled by family support services must inform that task. However it is important to increase the range and number of family support services through a balance of prevention, early intervention and late intervention.

Sixth, and finally, developing an appropriately balanced continuum of services corresponding to the continuum of need that exists in the community implies gathering and analysing information on need. This would provide a basis for taking a truly needs-led approach and would inform decisions about issues such as voluntary/statutory provision, appropriate locations for services, and the skills and attitudes required of staff. Such an approach could also drive greater co-ordination and integration of services for families and children.
5.1 Introduction

This chapter is based on a census of family support services\textsuperscript{148}. The population covered by the census comprises family support services in receipt of Health Board funding in 2002, whether the service was delivered directly by a Health Board or by another agency. The chapter begins by defining the range of services included in the census and the justification for that definition (Section 5.2). Three limitations to the census have been identified and accordingly some care is needed in making inferences from the census about the overall provision of family support services in different parts of the country (Section 5.3). The response rate to the census is analysed by Health Board and by type of service in order to establish its comprehensiveness (Section 5.4). Our analysis begins by comparing the prevalence of family support services in each Health Board relative to its population (Section 5.5). This is followed by a detailed description of the characteristics of those family support services who completed the census including their type (Section 5.6), location (Section 5.7), organisation (Section 5.8), financial characteristics (Section 5.9), staffing (Section 5.10), premises (Section 5.11), service characteristics (Section 5.12), referral and inter-agency work (Section 5.13), monitoring and evaluation (Section 5.14), and service users (Section 5.15). The chapter also reports the results of a survey of service users, which was carried out in parallel with the census, in order to determine their satisfaction with family support services (Section 5.16). Finally, the chapter concludes with a brief summary of the key findings and their implications for the future development of family support services (Section 5.17).

5.2 Definition of Family Support Services Used in Census

The census covers two broad categories of service: (i) general family support services and (ii) childcare family support services.

\textsuperscript{148} A separate report on the census, including detailed results for each Health Board, is available; see McKeown, K., and Haase, T., 2004, A Census of Family Support Services in Ireland: Results of a Census of Family Support Services which were funded by Health Boards in 2002, Dublin: Department of Health & Children.
General Family Support Services

General family support services are offered to a wide range of families for the purpose of either preventing problems or addressing problems after they have emerged. For example, some services such as Community Mothers, Lifestart, Homestart, etc., are offered to prevent family problems occurring while other services such as family support projects, respite, Family Welfare Conferences, Teen Parenting, Youth Advocacy, etc., are offered when problems are beginning to emerge or have already developed. The following are the general family support services included in the census:

- Family Support Projects & Centres
- Family Support Services with a residential component
- Day Foster Care
- Respite Care
- Parent Support & Education Programmes such as Community Mothers Programme
- Family Support Workers in Health Board
- Family Welfare Conferences
- Family Support Services for Asylum Seekers
- Family Support Services for Travellers
- Traveller Health Initiatives
- Services for domestic violence including refuge services
- Home Management Advisory Services
- Parent & Toddler Services
- Springboard Projects
- Teen Parent Projects
- Pre-school services & nurseries including community child services
- After-school & out-of-school services
- Community Child Care Workers in Health Board
- Youth Services including Neighbourhood Youth Projects & Youth Advocate Programmes
- Mentoring Programmes
- Services for young people misusing drugs
- Youth Homeless Service
- Teenage Health Initiative
- Community Development Projects
Childcare Family Support Services

Childcare family support services are offered to families in order to promote child development but may also facilitate parents who wish to work. The following are the childcare family support services included in the census:

- Parent & Toddler Services
- Pre-school services & nurseries including community child services.

5.3 Limitations to the Census

The census has three limitations which means that it does not comprehensively enumerate all of the family support services available throughout the country. The first limitation is the exclusion of family support services provided by some Health Board professionals, notably Social Workers and Public Health Nurses, since this aspect of their work cannot be separately identified from the other core work of these professionals. The second limitation is the exclusion of a range of Health Board-funded family support services in the areas of mental health and disability. These were excluded because, relative to the services listed above, these involve separate administrative structures within Health Boards and would require separate liaison groups in order to compile lists of the different services. The third limitation is the exclusion of a wide range of family support services which, though not funded by Health Boards, are funded through other Government Departments and agencies such as the Department of Justice, Equality & Law Reform, the Department of Community, Rural & Gaeltacht Affairs and the Family Support Agency. A notable example is the provision of childcare services, many of which are not funded through Health Boards; the recent National Childcare Census identified 2,607 separate childcare facilities (60% of them privately run) \(^{149}\) compared to 836 childcare services listed by Health Boards for the purpose of this census, almost all of them community-based.

As a result of these limitations, some care is needed in making inferences from the census about the overall provision of family support services in different parts of the country. One of the key responsibilities on Health Boards is “to promote the welfare of children ... who are not receiving adequate care and protection” (Child Care Act 1991) and family support services which are funded by Health Boards are informed by this statutory remit. Thus the scope of this census is primarily defined by the Health Board’s responsibilities under the Child Care Act 1991.

The census is based on a list of family support services compiled by personnel in each Health Board. Every service on this list was sent a census form in October 2003. Due to a relatively modest response rate, particularly in the area of general family support services.

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149 Department of Justice, Equality and Law Reform, 200:27
services, it was decided to re-send the census form in April 2004 to those general family support services who did not respond. This resulted in a much higher response rate. We now proceed to examine the overall response rate since this is crucial in determining the confidence we can have that the results of the census provide a reliable picture of the family support services which were funded by Health Boards in 2002.

5.4 Response Rate to the Census

The response rate to the census was 56%. This was considerably higher for general family support services (68%) than for childcare family support services (44%). The response rate for general family support services is satisfactory because a substantial majority of these services are covered in the census. This is important because this category contains a great diversity of services, as can be seen from the list in the previous section, and therefore requires a high response rate in order to have confidence that this diversity has been captured. The response rate for childcare family support services, though considerably lower, is also satisfactory given that there are only two types of service in this category. Overall, therefore, the census provides a reliable basis from which to draw inferences about the characteristics of family support services which were funded by Health Boards in 2002, bearing in mind the limitations identified in the previous section.

5.5 Distribution of Family Support Services in Health Boards

The list of services, as supplied by Health Boards, indicates that they funded 1,596 family support services in 2002. These are divided almost equally between general family support services (48%) and childcare family support services (52%).

In order to compare the distribution of services across Health Boards, we calculated the number of family support services per 10,000 population. This is a simple comparison – indeed the only comparison which is possible with this data – and takes no account of considerations such as the level of family need in the different Health Board regions, the quality services offered, the number of people served by each service or the availability of other family support services in the regions. For these reasons, it is important to regard the data as no more than indicative of the different levels of service provision between Health Boards; in a subsequent section (Section 5.8) we will supplement this comparison by drawing upon the results of the census to estimate expenditure by Health Boards on family support services.
Table 5.1 shows the number of services in each Health Board per 10,000 population for (i) general family support services (ii) childcare family support services and (iii) all family support services\textsuperscript{150}. Additional data from the 2001 Interim Minimum Dataset is also included on the number of children in care per 10,000 children in each Health Board. The results reveal that the level of family support provision varies widely between Health Boards with a six-fold difference between the highest and the lowest. The Health Boards with the highest level of family support provision are in the western and southern parts of the country (notably NWHB, WHB, SHB and SEHB) while the lowest levels of provision are in the eastern parts of the country (notably NAHB, ECAHB, SWAHB) with the remainder holding an intermediate position (NEHB, MHB, MWHB).

The data in Table 5.1 also shows that Health Boards with the lowest levels of family support provision have the highest rates of children in care while those with the highest level of family support provision tend to have the lowest rates of children in care. It is not possible to explain this inverse association with the data available but the following possibilities, or a combination of possibilities, are worth considering: (i) family support services may help to prevent children going into care; (ii) the cost of keeping children in care may inhibit the development of family support services; (iii) there may be other factors influencing both the provision of family support services and the admission of children to care such as levels of need, professional practices and/or management approaches to each type of service. Whatever the explanation, the results provide food for further reflection and investigation.

Variations in the provision of family support services can be found not only between Health Boards but also between community care areas within Health Boards. It is frequently claimed that rural areas experience a much lower level of service provision than urban areas. Given the geographically dispersed nature of rural populations, it is not difficult to understand how people experience service provision in this way. However the distribution of family support services per 10,000 population suggests that, in a number of Health Boards, rural areas may have a higher level of provision than urban areas as measured by the number of family support services per 10,000 population. This can be seen in those Health Boards which have significant urban and rural populations (NEHB, WHB, MWHB, SHB). In the NEHB, for example, the more urban county of Louth has a lower level of provision (3.3) compared to the more rural area of Cavan / Monaghan (5.1). (Questionnaire completion rate of only 9.5% by childcare family support services in the NEHB may have impacted on these figures). Similarly, in the WHB, the more rural counties of Mayo (9.4) and Roscommon (11.2) have higher levels of family support services than the more urban county of Galway (6.0). In the MWHB, provision in the more rural counties of Clare (4.3) and North

\textsuperscript{150} Throughout the report, the following acronyms are used: ERHA = Eastern Regional Health Authority; NAHB = Northern Area Health Board; ECAHB = East Coast Area Health Board; SWAHB = South West Area Health Board; NEHB = North Eastern Health Board; NWHB = North Western Health Board; MHB = Midland Health Board; WHB = Western Health Board; MWHB = Mid-Western Health Board; SHB = Southern Health Board; SEHB = South Eastern Health Board.
Tipperary (4.9) is higher than the more urban county of Limerick (2.5). In the SHB, the pattern is less clear-cut with West Cork (11.4) having a much higher level of service provision than any other community care area including Kerry (4.9), North Cork (5.4), North Lee (5.2) and South Lee (4.5). In most cases, the higher level of provision in rural community care areas is attributable to a higher level of childcare family support services in those areas.

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Rates of General Family Support (i)</th>
<th>Rates of Childcare Family Support (i)</th>
<th>Rates of All Family Support (i)</th>
<th>Rates of Children in Care (ii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAHB</td>
<td>1.1</td>
<td>0.6</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>ECAHB</td>
<td>1.1</td>
<td>0.3</td>
<td>1.4</td>
<td>78 (ERHA)</td>
</tr>
<tr>
<td>SWAHB</td>
<td>1.3</td>
<td>0.5</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>NEHB</td>
<td>2.0</td>
<td>1.4</td>
<td>3.4</td>
<td>45</td>
</tr>
<tr>
<td>NWHB</td>
<td>3.0</td>
<td>6.2</td>
<td>9.2</td>
<td>34</td>
</tr>
<tr>
<td>MHB</td>
<td>2.7</td>
<td>1.0</td>
<td>3.7</td>
<td>37</td>
</tr>
<tr>
<td>WHB</td>
<td>1.9</td>
<td>5.8</td>
<td>7.8</td>
<td>25</td>
</tr>
<tr>
<td>MWHB</td>
<td>2.2</td>
<td>1.2</td>
<td>3.4</td>
<td>41</td>
</tr>
<tr>
<td>SHB</td>
<td>2.9</td>
<td>2.7</td>
<td>5.5</td>
<td>37</td>
</tr>
<tr>
<td>SEHB</td>
<td>1.9</td>
<td>3.3</td>
<td>5.2</td>
<td>45</td>
</tr>
<tr>
<td>Ireland</td>
<td>1.9</td>
<td>2.1</td>
<td>4.1</td>
<td>51(^{151})</td>
</tr>
</tbody>
</table>

(i) Derived from data supplied by each Health Board. (ii) Interim Minimum Dataset, 2001:15\(^{152}\)

It is worth emphasising that the analysis in this section is indicative only. Comparing rates of service provision per 10,000 population can be useful but it needs to be supplemented by additional data on the level of family need in the different Health

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151 It is significant to note that the rate of children in care per 10,000 children is almost identical in England (52) as in Ireland (51) for the years 2001/2002 (see Social Information Systems, 2001:37).
152 Department of Health and Children, 2002
Board regions, the quality services offered, the number of people served and the availability of other family support services in the regions. Accordingly, it is not possible to assess from this data alone if the overall distribution of services between or within Health Boards is equitable. Equally however it is worth stating that no one knows if the existing provision of family support services is equitable, either between or within Health Boards. This is a significant gap in information given the importance attached to the equitable distribution of services in the Government’s health strategy\textsuperscript{153}.

5.6 Type of Family Support Services

We have seen that the two categories of family support services – general and childcare – comprise a number of sub-categories within them (see Section 2). The census revealed that the main sub-categories within general family support services are family support projects and services (28%), youth services (10%), services for domestic violence (8%), parent support and education programmes (7%), community development projects (7%), as well as Health Board employees, both family support workers (6%) and community child care workers (5%).

Childcare family support services comprise mainly parent & toddler groups (77%) with pre-school services and nurseries making up the remainder (23%). In numerical terms, the largest concentrations of childcare family support services are to be found in those Health Boards which also have the highest overall provision of family support services (notably NWHB, WHB, SHB, SEHB).

5.7 Location Characteristics

The term ‘location’ refers to the type and extent of catchment area in which the family support service is located and whether it is within walking distance for service users. In addition to measuring these characteristics, the census also tried to determine if services were located in areas of disadvantage. The results indicate that nearly two thirds of services (65%) tend to be in areas which also have an ADM Partnership / Community Group while more than half (56%) have a project in the Community Development Programme. About a third of services are located in areas which also have the RAPID programme (36%), with a similar proportion having a Local Drugs Task Force (32%).

Given that more than half the population of Ireland (54%) live in a partnership area, these results suggest that family support services are slightly targeted, implicitly or explicitly, towards more disadvantaged areas. However in most Health Boards,
general family support services tend to be much more targeted at disadvantaged areas compared to childcare family support services. An exception to this is to be found in the eastern part of the country (notably NAHB, ECAHB, SWAHB, NEHB) where both general and childcare family support services tend to be heavily targeted at disadvantaged areas.

The census reveals that general family support services tend to have considerably larger catchment areas than childcare family support services. This is evident in the fact that nearly two thirds of general family support services (64%) have catchment areas covering a Health Board region (13%), a community care area (21%), a county (15%), a city or town (15%). By contrast, a similar proportion of childcare family support services tend to have catchment areas which are based on either the local neighbourhood (33%) or parish (30%).

The type of catchment area in which family support services are located is partly influenced by the rural-urban composition of the Health Board region. General family support services are more likely to be located in urban areas such as a city / town centre (40%) or in the housing estate of a city / town (18%). This is true for all Health Boards. By contrast, childcare family support services are somewhat more likely to be located in villages or rural areas (51%), particularly in those regions which have significant rural populations (notably NWHB, WHB, MWHB, SHB, SEHB).

An important location characteristic from the point of view of accessibility is whether the service is located within walking distance of service users, where ‘walking distance’ is defined by the distance that can be walked in no more than 10-15 minutes. The results of the census, based on those services which are not delivered within the home, indicate that childcare family support services tend to be more accessible than general family support services. Nearly three quarters (74%) of childcare family support services are within walking distance for over half their service users compared to less than six out of ten (57%) of general family support services. In general, all family support services tend to be more geographically accessible in the ERHA than in the other Health Board regions reflecting the rural/urban composition of their populations.

Overall, these results indicate a slight tendency for family support services to be located in areas of disadvantage, a tendency which is more pronounced for general family support services, and for those located in the eastern part of the country (notably NAHB, ECAHB, SWAHB, NEHB). General family support services also tend to serve larger catchment areas and to be located in urban areas while childcare family support services are slightly more likely to be located in rural areas, particularly in those regions which have significant rural populations (notably NWHB, WHB, MWHB, SHB, SEHB). Areas which have substantial rural populations (notably NEHB, NWHB, WHB, MWHB, SHB, SEHB) also tend to have services which are not within walking distance for service users and this may affect accessibility to these services depending on the extent of car ownership.
5.8 Organisational Characteristics

There has been considerable expansion in family support services in Ireland in recent years and this is reflected in the census returns. More than six out of ten services (62%) were set up in the past ten years. However the census also indicates that a significant proportion of family support services (19%) have been in existence for much longer, varying from eleven to twenty years, and a similar proportion (19%) were established over twenty years ago. There is very little difference in the mean ages of general (11.2 years) and childcare (11.5 years) family support services.

Most family support services, according to the census, are delivered directly by, or in partnership with, the voluntary and community sector (74%). In a pattern which is fairly consistent across Health Boards, childcare family support services are more likely to be delivered in this way (87%) compared to general family support services (65%). Health Boards are rarely involved in the direct delivery of childcare services but are involved in up to a quarter (26%) of family support services. In general, there is greater reliance on the voluntary and community sector in western and southern parts of the country (notably, NWHB, MWHB, SHB, SEHB), possibly reflecting a commitment to community development as part of the strategy of supporting families. A minority (3%) of family support services are delivered by private organisations.

An indicator of organisational development within the voluntary and community sector is that four in ten (39%) of these organisations are themselves part of larger parent organisations, particularly those involved in delivering general family support services. Another indicator of organisational development is that two thirds (68%) are registered companies limited by guarantee, although only about a fifth (22%) of these have charitable status. Again, organisations who deliver general family support services are significantly more likely to be registered companies than organisations delivering childcare family support services. The vast majority (92%) of voluntary and community organisations have a management committee and this is consistent across all Health Boards and for both categories of family support services.

Family support services, both general and childcare, which are delivered by voluntary and community organisations are more likely to have structures which give regular representation to service users (76%) compared to services provided by Health Boards (50%). In the voluntary and community sector, service user representation mainly occurs through the management committee (58%) but a significant minority (25%) indicated that they used ‘other structures’ for service user representation. In Health Boards, representation of service users occurs mainly through ‘other structures’ (35%) but also through local advisory committees (19%) and boards of management (11%).

Overall, these findings indicate that family support services, which have expanded considerably over the past decade, rely heavily on the voluntary and community
sector for their delivery. This sector is showing signs of considerable organisational development with nearly four out of ten being part of a larger parent organisation, particularly those involved in delivering general family support services. Three quarters of the services delivered by voluntary and community organisations have structures which give regular representation to service users compared to half the services delivered by Health Boards.

5.9 Financial Characteristics

The census asked each service to provide details on the financial cost of its service in 2002. The results indicate that the services who responded to the census cost €97 million in 2002. Given that this represents just over half (56%) of all family support services provided by Health Boards in that year, the estimated cost of all family support services in Ireland in 2002, based on the assumption that the pattern of costs is similar among respondents and non-respondents, is around €202 million. Most of this expenditure is attributable to general family support services which make up 78% of the total with childcare family support services accounting for the remaining 22%.

It is significant that, although Health Boards are a source of funding for all of the family support services in the census, their overall contribution to total funding is just over half at 53%. Their contribution to the cost of general family support services (57%) is higher than their contribution to childcare family support services (34%). However there is a good deal of variation between Health Boards in terms of their share of family support costs and this may be a reflection of the range of funding sources available in each region.

In addition to Health Board funding, family support services are supported financially by other statutory sources who contributed 35% to the overall cost of services. For general family support services, the most frequently cited sources of non-Health Board funding were: Department of Social and Family Affairs / Family Support Agency (33%), Vocational Education Committee (25%), Department of Justice, Equality and Law Reform (23%), Area Development Management Limited (18%), City / County Councils (17%), Department of Education and Science (13%), and Partnership Companies (12%). For childcare family support services, the most frequently cited sources of non-Health Board funding were: Department of Justice, Equality and Law Reform (27%), Area Development Management Limited (14%) and Partnership Companies (7%).

Non-statutory funders - such as grants from private and philanthropic organisations as well as fund-raising events – represent a considerably higher proportion of funding in childcare services (18%) than in general family support services (7%). Overall, however non-statutory funding accounts for less than a tenth (9%) of the total.
The average cost of family support services varies widely from one Health Board to another. This applies particularly to general family support services which are considerably higher in the ERHA, the NEHB and the MWHB than in other Health Boards. For example, the average cost of a general family support service in Ireland in 2002 was €208k but this varied from a high of €424k in the NAHB\(^\text{154}\) to a low of €129k in the SHB. Childcare family support services are also higher in the ERHA, the NEHB and the MWHB than in other Health Boards. It is difficult to explain this level of variation but the possibility of response error is unlikely to be the only factor.

A significant question in this context is whether there is any relationship between the average expenditure on each family support service and the number of services provided per head of population, given our earlier finding that the number of services per head of population is unevenly distributed between Health Board regions (see Section 4). This question is addressed in Table 5.2 and shows that the four Health Boards with the highest level family support services per head of population (NWHB, WHB, SHB and SEHB) also have the lowest cost per service, both for general and childcare family support services. Table 5.2 also shows that the total amount spent on family support services per head of population does not vary greatly between Health Board region, or at least varies much less than the variation in the number of services provided or the cost of those services. This finding prompts the suggestion that a key source of variation between Health Board regions is their differing capacities to generate services with broadly similar amounts of money. Since we have already established that those Health Board regions which have larger numbers of family support services per head of population have correspondingly lower numbers of children in care, this finding should merit further reflection and investigation in order to more fully understand how these associations are working in practice. Further analysis of the dynamic involved would require more information about the level of need in the different Health Board regions, the quality and impact of family support services, the differing capacities of organisations in the voluntary / community sector as well as the factors which influence both the development of family support services and the admission of children to care.

We have seen in the previous section that nearly three quarters of family support services (74%) are delivered through voluntary community organisations. Similarly, just over two thirds (68%) of all expenditure on family support services is spent through voluntary and community organisations. Services delivered through Health Boards account for a fifth (21%) of total expenditure although joint initiatives involving both Health Boards and the voluntary / community organisations absorb a further 6% of resources. In general, and with only two exceptions (SWAHB and MWHB), services delivered by Health Boards tend to cost more than services delivered by voluntary, community or private organisations although it is worth emphasising that the type of services delivered by Health Boards may also be different.

\(^{154}\) We have excluded the ECAHB from this comparison due to the small number of services (11) which provided details.
### Table 5.2 Expenditure (’000 Euro) on Family Support Services in each Health Board in 2002 with Additional Comparative Data

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Average Expenditure ('000 Euro) Per Family Support Service (i)</th>
<th>Expenditure Per Person ('000 Euro) on All Family Support Services (i)</th>
<th>All Family Support Services Per 10,000 Population (i)</th>
<th>Rates of Children in Care (ii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAHB</td>
<td>403</td>
<td>64.52</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>ECAHB</td>
<td>507</td>
<td>76.47</td>
<td>1.4</td>
<td>78 (ERHA)</td>
</tr>
<tr>
<td>SWAHB</td>
<td>217</td>
<td>41.99</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>NEHB</td>
<td>229</td>
<td>54.90</td>
<td>3.4</td>
<td>45</td>
</tr>
<tr>
<td>NWHB</td>
<td>80</td>
<td>64.91</td>
<td>9.2</td>
<td>34</td>
</tr>
<tr>
<td>MHB</td>
<td>146</td>
<td>60.60</td>
<td>3.7</td>
<td>37</td>
</tr>
<tr>
<td>WHB</td>
<td>128</td>
<td>66.77</td>
<td>7.8</td>
<td>25</td>
</tr>
<tr>
<td>MWHB</td>
<td>170</td>
<td>59.51</td>
<td>3.4</td>
<td>41</td>
</tr>
<tr>
<td>SHB</td>
<td>90</td>
<td>47.80</td>
<td>5.5</td>
<td>37</td>
</tr>
<tr>
<td>SEHB</td>
<td>82</td>
<td>40.47</td>
<td>5.2</td>
<td>45</td>
</tr>
<tr>
<td>Ireland</td>
<td>141</td>
<td>51.64</td>
<td>4.1</td>
<td>51</td>
</tr>
</tbody>
</table>

(i) Derived from data supplied by each Health Board (See Tables 4.1.1a to 4.1.3a).

(ii) Interim Minimum Dataset, 2001:15

In view of this pattern of expenditure, it is surprising that only 4% of organisations in the voluntary, community and private sectors have a formal contract with the Health Board, either through a service agreement or a letter of agreement. This situation may have changed since 2002.

Family support, like most services, is highly labour-intensive and this is reflected in the fact that 70% of expenditure is incurred on staff costs. This pattern is relatively uniform across the different Health Boards and between general and childcare family support services. Staff costs in an ‘average’ general family support service are €146k compared to €42k in an ‘average’ childcare family support project. Non-staff costs vary similarly from €61k in a general family support project to €14k in a childcare family support project.

There is a good deal of variation in the annual cost of both general and childcare family support services. In making these comparisons it is important to remember...

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that no judgements are warranted regarding the quality or cost effectiveness of these different services since that would require much more detailed information than is available from the census. In the childcare sector, the average cost of a preschool service and nursery is €61k while the average cost of a parent and toddler service is €22k. Turning to general family support services, the census reveals that two thirds (67%) of general family support services cost less than €200k. The largest single category within general family support services is ‘family support projects and services’ and the average cost of these in 2002 was €178k. Parent education and support programmes, which includes Community Mothers, are also available in every Health Board at an average cost of €242k. Springboard projects cost an average of €253k while services for domestic violence cost an average of €333k each. Family support services for Travellers cost an average of €403k.

An important implication of these results is that childcare services, which are primarily targeted at prevention and early intervention, are significantly less expensive than general family support services which tend to involve later intervention in the life of family problems. As a result, most of the resources within family support services are spent on late intervention rather than prevention and early intervention. There is no doubt that all of these services are valuable though no one knows which of them offers the best value for money or how best to strike the balance between prevention, early intervention and late intervention.

Overall, the results in this section suggest that total expenditure on all family support services in Ireland during 2002 was around €202 million, about 80% of it being spent on general family support services. Expenditure on family support services does not vary greatly between Health Board regions but those regions with the highest number of family support services per head of population had the lowest average cost per service suggesting differing capacities to generate services, both general and childcare, with the resources available. About 70% of the resources devoted to family support services are spent through voluntary and community organisations, few of whom had a formal contract with the Health Board in 2002 although that is likely to have changed somewhat since then. Family support services whose main focus is prevention and early intervention tend to be substantially cheaper than services with a focus on late intervention. It is worth emphasising that these findings do not imply any judgements about the quality or cost effectiveness of the different services since that would require much more detailed information than is available from the census.

5.10 Staff Characteristics

The census revealed that 11,800 personnel were working in family support services at the end of 2002. If, given the response rate, this represents 56% of the entire sector, then we estimate that over 21,000 personnel were engaged in family support
services in 2002. These are split 80/20 between general and childcare family support services respectively.

A striking feature of the workforce is that more than four in ten (44%) are volunteers; nearly half of those involved in general family support services are volunteers (48%) compared to over a quarter (27%) in childcare family support services. Just over a third of the personnel in all family support services (34%) are in paid employment, either full-time (19%) or part-time (15%), while employment schemes such as Community Employment, Jobs Initiative and the Social Economy constitute over a tenth (15%) of the workforce. These results reflect the major involvement of voluntary and community organisations in family support services although it may be unusual, even within that sector, to have such a high level of volunteerism. From this it would seem that family support services do not fit the usual ‘professional’ or ‘expert’ model of service delivery.

Significantly, the vacancy rate for full-time positions (5%) is higher than the overall vacancy rate (3%) among the organisations who completed the census. A majority of full-time staff (73%) have a third level degree or diploma which is relevant to their work while nearly half of all part-time staff (46%) have a relevant third level qualification; this varies little between general and childcare family support services.

5.11 Service Characteristics of Family Support Services

Family support services involve a range of interventions including individual work, group work, family work, peer support, information / advice, advocacy, practical help, mentoring, socialisation and play. The main forms of intervention offered by general family support services are individual work (77%),

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156 Individual work refers to any one-to-one sessions with the service user for the purpose of assessing needs or meeting developmental / therapeutic goals.
157 Group work refers to sessions with groups of parents or children and may involve sharing personal experiences, doing a course together, or sharing activities such as sport, recreation, arts and crafts, etc.
158 Family work refers to sessions with two or more members of the family for the purpose of assessing needs, drawing up a family plan, or meeting therapeutic goals.
159 Peer support refers to arrangements where people in similar circumstances, such as parents or adults dealing with a similar problem, offer support to each other.
160 Information / advice refers to the time spent giving information and / or advice to service users on their entitlements and how to access them as well as information and / or advice on more specialised services.
161 Advocacy refers to the time spent liaising and lobbying with other agencies to obtain services for the service user, accompanying them to appointments, writing letters on their behalf, helping to access financial assistance, etc.
162 Practical help refers to help offered to parents with everyday activities such as cleaning, cooking, shopping, getting children ready for school, child-minding, etc; it may also involve helping children with their homework, including the provision of space within the centre for this purpose.
163 Mentoring refers to formal arrangements where a more experienced person offers support to a less experienced person such as adults mentoring children or more experienced parents mentoring less experienced parents.
164 Socialisation and play refers to opportunities, mainly for children, to allow them to develop their socialisation skills through play and other forms of interaction, for example, pre-schools.
information / advice (68%), group work (65%) and advocacy (53%). By contrast, the main form of intervention in childcare family support services is socialisation / play (83%) as well as group work (58%).

Most family support services, both general and childcare, are centre-based (72%) in the sense that service users come to a centre, office or clinic to receive the service. However a substantial proportion of general family support services (43%) also provide a home-based service. Nearly half of all general family support services (47%) are engaged in activities which are directed at the community such as public lectures and courses, the distribution of leaflets and booklets containing information and advice, etc; less than a fifth of childcare family support services (18%) engage in these community-based activities. Over a tenth of services (13%), particularly those involved in general family support, undertake activities which are outside the community such as day-trips and weekends.

Family support services are mainly provided during weekdays between 9.00 am and 5.00 pm (87%). However a third of general family support services are available after 5pm (36%); a tenth (10%) of childcare services are available after 5pm. A tenth (10%) of both types of services are also available on weekdays before 9.00 am and on Sundays. A similar proportion of general family support services also offer a 24-hour service during weekdays (9%).

Some family support services offer food and beverages as part of their service. The census revealed that about half of both types of services provide either snacks (52% in the case of childcare services), or tea / coffee (54% in the case of general services). Around a tenth of all family support services offer breakfast (10%), lunch (15%), and / or dinner (11%).

5.12 Premises

Most family support services, as we have seen in the previous section, are centre-based. On average, these centres comprise 2-4 rooms. General family support services tend to be delivered in centres which have a larger number of rooms (4.4) than childcare family support services (2.4). This is a consistent pattern across Health Boards.

A majority of childcare family support services (56%) have an outdoor play facility but a much smaller proportion of general family support services (29%) have this facility. Childcare family support services are also more likely to be in centres which have access for wheel chairs (62%) compared to general family support services (52%). Most services in both categories (73%) have not had an access audit carried out on their premises within the past five years.
5.13 Referral and Inter-Agency Work

The majority of those who used general family support services in 2002 came through referrals (58%) with the remainder (42%) coming through self-referrals. However this varies considerably between Health Boards; for example, most clients in the NAHB (92%) came through referrals whereas most clients in the SHB came through self-referrals (81%). The main sources of referrals to general family support services are Health Board personnel, particularly Social Workers (67%) and Public Health Workers (45%). Community (39%) and voluntary (34%) organisations as well as schools, both primary (34%) and secondary (34%), are also important sources of referral. General family support services also make referrals to other services. More than half these services made referrals to counsellors (55%) and Social Workers (55%) while just under half (45%) made referrals to a voluntary or community organisation. It is clear from this that the vast majority of general family support services (87%) are in regular contact with other agencies.

By contrast, access to childcare family support services tends to be through self-referral (66%) but this too varies between Health Boards. For example, a majority of clients in the NAHB (78%) came through referrals whereas most clients in the SEHB came through self-referrals (90%). Where referrals occur, these tend to come from Public Health Nurses (32%), local residents (28%) and Social Workers (21%). In general, childcare family support services make few referrals to other services although a fifth (21%) made referrals to a Public Health Nurse and a smaller proportion (16%) made referrals to the primary school. In general, most childcare family support services (60%) are not in regular contact with other agencies.

5.14 Monitoring and Evaluation

There is a growing appreciation of the importance of monitoring and evaluating services, including those targeted at families and children. In view of this it is significant that more than half of all family support services (55%) claim to have undertaken an internal evaluation of their service within the past five years while more than a third (35%) have commissioned an external evaluation. General family support services are somewhat more likely to undertake evaluations than childcare family support services. These evaluations have tended to focus on a qualitative assessment of structures and procedures (69%) but some have also carried out case studies of service users (49%) and a significant minority (34%) have used standardised instruments\textsuperscript{165} to assess needs. These results suggest a relatively widespread awareness of the importance of monitoring and evaluation within family support services.

\textsuperscript{165} A standardised instrument takes the form of a questionnaire that has been independently tested and is a professionally recognised and approved assessment tool for measuring developmental and other needs.
5.15 Service Users of Family Support Services

The census reveals that 282,000 people used family support services in 2002. If, given the response rate of 56%, this is adjusted to include all family support services, then it is estimated that half a million people availed of family support services in Ireland during 2002. Parents (43%) and children (40%) are the main service users although ‘others’, such as adults who are not parents (17%), constitute a significant minority. As might be expected, children are the main users of childcare facilities (59%) even though parent and toddler groups make up three quarters of this service category.

General family support services have a much higher average number of users per service (594) compared to childcare family support services (82). There is also significant variation between Health Board regions in the average number of users per service. The range varies from 721 users per service in the NAHB and 661 in the SHB to 207 in the WHB and 158 in the SEHB. The variation in the number of users per service is not easy to explain and seems to bear no relationship to either the type or cost of each service, the number of staff involved or the size of premises. This level of variation would seem to imply that there is great diversity throughout the country in how family support services are delivered, particularly general family support services.

More than half of all services (56%) have a waiting list of service users. Most of those on a waiting list receive a service within three months (56%), but a significant minority have to wait longer than this (44%). On average, the number of persons on waiting lists for family support services in 2002 was equivalent to 5% of those who used the service in that year. General family support services tend to have more people on waiting lists than childcare family support services and children are more likely to be on waiting lists than parents in both categories of service.

Most service users stay with the service for at least a year. This is particularly true of childcare family support services where 90% of service users have been with the service for over a year compared to 60% of those using general family support services. In 2002, about 40% of all service users in both categories of service were new to the service which implies that about 60% were known to the service from the previous year.

5.16 Satisfaction With Services

As part of the census, each service was invited to distribute a one-page self-completion questionnaire to three service users which could then be posted back to the research team in a stamped-addressed envelope. Over 4,000 forms were distributed in this way and 22% were returned. This is a low response rate and it is difficult to determine if those who responded are truly representative of those who
did not. In addition, the forms were distributed by staff in each service and this may have created a bias towards more positive ratings of each service. Accordingly, the results should be taken as indicative rather than definitive. The majority of respondents are mothers (78%), the modal age is between 18 and 45 years (78%), and two thirds (67%) have been with the service for over six months. Nearly a fifth of the respondents (17%) are children.

The survey results, as summarised in Table 5.3, indicate an extremely high level of satisfaction with all aspects of the service. This uniformly high level of satisfaction with both general and childcare family support services may be due to the possibility that some services distributed the questionnaires to those who were known to be satisfied. Alternatively or in addition, it may be due to the possibility that those who continue to use a service are more likely to be satisfied with it and returned the questionnaire. Whatever the explanation, the results indicate a very high level of satisfaction and very little variability.

Table 5.3 Percent of Service Users Who ‘Always’ or ‘Often’ Agree with These Statements (N=988)

<table>
<thead>
<tr>
<th>Statement</th>
<th>% ‘Always’ or ‘Often’ Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am made to feel welcome by the service</td>
<td>99</td>
</tr>
<tr>
<td>I am listened to by the service</td>
<td>96</td>
</tr>
<tr>
<td>I am understood by the service</td>
<td>95</td>
</tr>
<tr>
<td>I enjoy coming to the service</td>
<td>96</td>
</tr>
<tr>
<td>The service gives me help just when I need it</td>
<td>94</td>
</tr>
<tr>
<td>The service is there to support me</td>
<td>97</td>
</tr>
<tr>
<td>The service is a big help to me</td>
<td>95</td>
</tr>
<tr>
<td>The service is a big help to my family</td>
<td>87</td>
</tr>
<tr>
<td>Staff in the service genuinely care about me</td>
<td>96</td>
</tr>
<tr>
<td>Staff in the service respect me</td>
<td>97</td>
</tr>
<tr>
<td>Staff in the service are helpful</td>
<td>98</td>
</tr>
<tr>
<td>Staff in the service are fair</td>
<td>97</td>
</tr>
<tr>
<td>Staff in the service are very good at what they do</td>
<td>98</td>
</tr>
</tbody>
</table>

Source: Tables 11.5a to 11.5m
Overall satisfaction with the service was measured by asking: ‘Overall, how satisfied are you with the service?’ All but 1% of respondents are satisfied or very satisfied with the service. We also asked respondents to rate the service relative to other services. The results indicate that more than eight out of ten (83%) rated both categories of service as better, or much better, than their experience of services such as schools, hospitals, GPs and local authorities.

The responses from service users were further analysed according to selected characteristics of the services. The only significant result to emerge is that service users are more satisfied with services provided by voluntary and community organisations than with those provided by Health Boards. Services delivered by private organisations received the highest satisfaction ratings of all, although there were relatively few in this category.

In interpreting these results it is important to note that satisfaction with a service does not imply that the service is effective. It is also worth noting that these high levels of satisfaction may not be truly representative of all service users given the possibility that only those who are satisfied may have responded while questionnaires may only have been distributed to those who were known to be satisfied with the service. In view of these caveats, it is all the more noteworthy that statistically significant variations in satisfaction levels were found between Health Boards and the community and voluntary sector.

5.17 Summary and Conclusion

This chapter gives a detailed profile of family support services in Ireland based on a census of services which were funded by Health Boards in 2002. We distinguish between two types of family support service: (i) general family support services which are offered to a wide range of families for the purpose of either preventing problems or addressing them after they have emerged; (ii) childcare family support services which are offered to families in order to promote child development and possibly facilitate parents who wish to work.

The overall response rate to the census was 56% but was considerably higher for general family support services (68%) than for childcare family support services (44%). This response rate is satisfactory in terms of reflecting the diversity of services and provides a reliable basis from which to draw inferences about the characteristics of family support services in general.

It is worth noting that the data produced by the census has three limitations from the point of view of establishing a comprehensive picture of family support services in Ireland: (i) family support services which are provided by some Health Board professionals, notably Social Workers and Public Health Nurses, are not included since this aspect of their work could not be separately identified; (ii) Health Board-
funded family support services in the areas of mental health and disability are not included due to the administrative difficulties of collecting this data; (iii) a wide range of family support services which, though not funded by Health Boards, are funded through other Government Departments and agencies, are not included, again due to the cost and administrative difficulties of collecting this data. Thus the scope of this census is defined primarily by the Health Board’s responsibilities under the Child Care Act 1991, the key one being “to promote the welfare of children …… who are not receiving adequate care and protection” (Child Care Act 1991). As a result of these limitations, some care is needed in making inferences from the census about the overall provision of family support services in different parts of the country.

With these considerations in mind, the key findings of the census are:

- Health Boards in the western and southern parts of the country (notably NWHB, WHB, SHB, SEHB), have much higher levels of family support provision than the more eastern parts of the country (notably NAHB, ECAHB, SWAHB) when their respective populations are taken into account.
- Health Boards with the lowest rates of family support provision have the highest rates of children in care.
- In some Health Boards (notably NEHB, WHB, MWHB, SHB), rural areas seem to have a higher level of service provision than urban areas mainly due to a higher level of childcare family support services.
- The main sub-categories within general family support services are: family support projects and services (28%), youth services (10%), services for domestic violence (8%), parent support and education programmes (7%), and community development projects. By contrast, childcare family support services comprise mainly parent & toddler groups (77%) with pre-school services and nurseries making up the remainder (23%).
- There is a slight tendency for family support services to be located in areas of disadvantage, a tendency which is more pronounced for general family support services, and for those located in the eastern part of the country (notably NAHB, ECAHB, SWAHB, NEHB).
- General family support services tend to serve larger catchment areas and to be located in urban areas while childcare family support services are more likely to be located in rural areas, particularly in those regions which have significant rural populations.
- Areas which have substantial rural populations tend to have services which are not within walking distance for service users and this may affect accessibility depending on the extent of car ownership in those areas.
- There has been considerable expansion in family support services in Ireland in recent years and this is reflected in the census with more than six out of ten services (62%) being set up in the past ten years. There is very little difference in
the mean ages of general (11.2 years) and childcare (11.5 years) family support services.

• Most family support services are delivered directly by, or in partnership with, the voluntary and community sector (74%). Nearly four in ten (39%) of these organisations are themselves part of larger parent organisations, particularly those involved in delivering general family support services.

• Family support services which are delivered by voluntary and community organisations are more likely to have structures which give regular representation to service users (76%) compared to services provided by Health Boards (50%).

• Total expenditure on all family support services in Ireland during 2002 was around €202 million, about 80% of it being spent on general family support services.

• Expenditure on family support services does not vary greatly between Health Board regions but those regions with the highest number of family support services per head of population had the lowest average cost per service suggesting differing capacities to generate services, both general and childcare, with the resources available.

• About 70% of the resources devoted to family support services are spent through voluntary and community organisations, few of whom had a formal contract with the Health Board in 2002 although this may have changed since then.

• Family support services whose main focus is prevention and early intervention tend to be substantially cheaper than services with a focus on late intervention.

• Over 21,000 personnel were engaged in family support services in Ireland in 2002.

• A striking feature of the workforce delivering family support services is that more than four in ten (44%) are volunteers. Just over a third are in paid employment, either full-time (19%) or part-time (15%), while employment schemes such as Community Employment, Jobs Initiative and the Social Economy constitute over a tenth (15%) of the workforce.

• A majority of full-time staff (73%) have a third level degree or diploma which is relevant to their work while nearly half of all part-time staff (46%) have a relevant third level qualification; this varies little between general and childcare family support services.

• General family support services offer assistance to families in a variety of ways through individual work (77%), information / advice (68%), group work (65%), and advocacy (53%). The main activity in childcare services is socialisation and play (83%).

• Most family support services (72%) are centre-based in the sense that service users come to a centre, office or clinic to receive the service. However a substantial proportion of general family support services (43%) also provide a home-based service. On average, these centres comprise 3-4 rooms.
• Family support services are mainly provided during weekdays between 9am and 5pm (87%). However a third of general family support services are available after 5pm (36%).

• About half of all family support services provide either snacks (52% in the case of childcare services), or tea / coffee (54% in the case of general services).

• A majority of those who used general family support services in 2002 came through referrals (58%) while access to childcare family support services was mainly through self-referral (66%). However there is great variation between Health Board regions in how these services are accessed.

• The vast majority of general family support services (87%) are in regular contact with other services.

• More than half of all family support services (55%) have undertaken an internal evaluation of their service within the past five years while more than a third (35%) have commissioned an external evaluation.

• We estimate from the census that over half a million people availed of family support services in Ireland during 2002. Parents (43%) and children (40%) are the main service users although ‘others’, such as adults who are not parents (17%), constitute a significant minority.

• General family support services have a much higher average number of users per service (594) compared to childcare family support services (82). However there is significant variation between Health Board regions in the average number of users per service which is not easy to explain since it seems to bear no relationship to the number of staff involved, the size of premises, the type of service or the average cost of services.

• Service users are extremely satisfied with family support services and regard them as better than other services such as schools, hospitals, GPs and local authorities. Greater satisfaction was expressed with services provided by voluntary and community organisations than with those provided by Health Boards.

These findings draw attention to a number of issues that merit further consideration in the overall context of developing family support services. Five issues in particular are worth reflecting on.

The first issue is that there tends to be an inverse relationship between the provision of family support services and the number of children in care. As a result, Health Boards with the lowest levels of family support provision have the highest rates of children in care while those with the highest level of family support provision have the lowest rates of children in care. It is not possible to offer a definitive explanation for this association but the following possibilities, or a combination of possibilities, are worth considering: (i) family support services may help to prevent children going into care; (ii) the cost of keeping children in care may inhibit the development of family support services; (iii) there may be other factors influencing both the provision
of family support services and the admission of children to care such as levels of need, professional practices and/or management approaches to each type of service. Whatever the explanation, the results provide food for further reflection and investigation.

The second issue is that family support services are distributed quite unevenly throughout the country when measured by the number of services per 10,000 population. Given that the total amount spent on family support services per head of population in each Health Board region does not vary greatly this prompts the suggestion that a key source of variation between Health Board regions may be their differing capacities to generate services with broadly similar amounts of money, including the differing capacities of organisations in the voluntary/community sector which deliver three quarters of all family support services. Since Health Board regions which have more family support services per head of population have correspondingly lower numbers of children in care, this finding should merit further reflection and investigation in order to understand how these associations are working in practice. Further analysis would require more information about the level of need in the different Health Board regions, the quality and impact of existing family support services, the differing capacities of organisations in the voluntary/community sector as well as the factors which influence both the development of family support services and the admission of children to care. It would seem from these results that the existing distribution of family support services may be inequitable in that families and children with similar needs may be offered quite different responses depending on the part of Ireland in which they happen to live. This is contrary to the principle of equity advanced in the Health Strategy: “Improving equity of access will improve health by ensuring that people know what services they are entitled to and how to get those services and that there are no barriers, financial or otherwise, to receiving the services they need” 166.

The third issue concerns the overall balance between prevention, early intervention and late intervention. It can be difficult to analyse services in terms of these categories since many offer a combination of all three. However some services, particularly childcare family support services, are almost exclusively directed at prevention and early intervention and these make up about half of all family support services. Some general family support services, particularly those involving parent education and support such as Community Mothers, Home Start, and Lifestart are also targeted at prevention and early intervention but most of the services in this category involve interventions which are often relatively late in the life of a family problem. The census makes clear that the average cost of services involved in prevention and early intervention are much cheaper than services involved in late intervention. Although we are not in a position to assess the cost effectiveness of different services, we do know from the census that most resources spent on family

166 Department of Health and Children, 2001:18
support services are allocated to late intervention rather than prevention and early intervention. This is despite the widespread perception that family support is a form of prevention. There is almost no information on whether specific services within family support – or indeed within child protection or children in care – are value for money so it is impossible to say whether prevention, early intervention or late intervention offer better value for money. However a number of studies have shown the pivotal importance of the early years for children\textsuperscript{167} and the cost effectiveness of prevention and early intervention\textsuperscript{168} and this type of information needs to be taken into account in making strategic decisions about the desired balance between these different forms of intervention. It is also worth remembering that, given the greater cost of late intervention relative to prevention and early intervention, a reduction in resources going to late intervention could purchase a correspondingly greater amount of prevention and early intervention services.

The fourth issue concerns the respective roles of Health Boards and the voluntary / community sector in delivering family support services. The cost of family support services in 2002 was around €200 million and most of these were delivered by the voluntary / community sector. This sector is highly diverse with a heavy reliance on volunteers, part-time workers and people on various employment schemes, while at the same time over a third are part of larger parent organisations. As such this sector does not conform to a standard or uniform model of service delivery and indeed this may be one of its strengths. Arrangements between Health Boards and this sector remain largely informal with few having service agreements, at least in 2002. At the same time, service users report a high level of satisfaction with services delivered by voluntary and community organisations and indeed a higher level than that recorded by services delivered by Health Boards\textsuperscript{169}. Voluntary and community organisations are also more likely than Health Boards to have structures which give regular representation to service users. There is clearly a case for more formal arrangements between Health Boards and the organisations they contract to deliver family support services. However these arrangements need to be developed in the broader context of a strategy for family support services which is better informed by studies of need among clinical and community populations as well as careful judgements about the overall balance between prevention, early intervention and late intervention. In that context, service agreements could justifiably specify the type of outputs and outcomes that might reasonably be expected from the allocation of Health Board

\textsuperscript{167} Duncan and Brooks-Gunn, 1997; Cameron and Heckman, 1999; Heckman, 1999. According to James Heckman (1999), winner of the Nobel Prize in Economics in 2000, “Policies directed toward families may be a more effective means for improving the performance of schools than direct expenditure on teacher salaries or computer equipment. Policies that seek to remedy deficits incurred in early years are much more costly than early investments wisely made, and do not restore lost capacities even when large costs are incurred. The later in life we attempt to repair early defects, the costlier the remediation becomes.”

\textsuperscript{168} See, for example, Karoly, et al., 1998 who used US data from the Elmira Prenatal & Early Infancy Project as well as the Perry Preschool Programme to show that every dollar spent on prevention and early intervention yields 3-4 dollars in return; see also Greenwood et al, 1998; for a review of this literature, see McKeown and Sweeney, 2001, Chapter Four.

\textsuperscript{169} Services delivered by private organisations received the highest satisfaction ratings.
and other financial resources. Similar standards of accountability might also be drawn up for the Health Boards’ own services.

The fifth issue is about appreciating the rich resource of services which is currently constituted under the umbrella of family support services. We estimate that around half a million people were in contact with family support services in 2002. For this reason, their potential to affect the well-being of families and children is quite considerable and it is appropriate to ask if this resource is currently being directed and applied in the most effective manner. Given that this study was initiated as part of a broader review of family support services it is timely to address the issue of how to support and develop this sector as part of an integrated strategy to promote the well-being of families and children. That is the challenge and the opportunity.
6.1 Introduction

This chapter draws together key insights from previous chapters in order to identify the core principles which could inform the future development of services for families and children. These principles are shaped by our review of national and international developments (Chapters One to Three), our consultations with numerous stakeholders in each Health Board (Chapter Four), and the census of family support services (Chapter Five). We now identify two key principles which we see as offering a framework for service development into the future. The first principle involves designing services that meet the needs of families and children (Section 6.2). The second principle involves providing a balanced continuum of services involving prevention, early intervention and late intervention (Section 6.3). In considering these two principles we reflect on a wide range of related issues which inevitably arise when these two principles are taken seriously. In essence however the principles for developing family support services are quite simple and, taken together, could be regarded as forming one overall goal which is: design services based on need and provide a balanced continuum of services to meet those needs. In the light of this analysis, we formulate two options which now face policy makers and service managers regarding the future development of services for children and families. The first option is to develop and re-balance family support services (section 6.4.1) while the second is to develop and re-balance all services for families and children (section 6.4.2). We conclude by reflecting on the implications of implementing either or both of these options (section 6.5).

The principles which we propose, like the entire study, are designed to promote discussion and reflection. The study is one element in a larger process designed to formulate a strategy for developing services for families and children. The Department of Health & Children has the lead role in this process with the support of Health Boards, the Eastern Regional Health Authority and the Health Boards Executive. In order to give direction and momentum to the process, the Department of Health & Children has also established a Steering Group to assume overall responsibility for the formulation of the strategy, a Liaison Group which facilitated the
study, and a Consultative Forum to draw upon the views and experiences of all the key stakeholders in the area of family support services. The study therefore has a facilitative role in the deliberations of these different bodies as part of the larger task of formulating and implementing a strategy for child and family services.

6.2 Design services to meet the needs of families and children

6.2.1 Cultivate a system that is needs-led rather than service-led

This principle may appear obvious but the reality in Ireland as elsewhere is that services are often not designed to meet the needs of families and children and are rarely evaluated to see if they are meeting needs. There has been very little assessment of patterns of need among service users based on aggregating clinical data in Health Boards or using surveys of families and children in the community. In practice, families and children are rarely consulted about what they need and are often required to fit into whatever services are available. For these reasons, the present system tends to be more service-led than needs-led.

6.2.2 Adopt a child-and-family-centred approach

The importance of a needs-led approach draws attention to the importance of a child-and-family-centred approach to services given that the well-being of families and children are inextricably linked. The Child Care Act, 1991 requires Health Boards to “regard the welfare of the child as the first and paramount importance” (Section 3, Subsection 2b) while also having “regard to the principle that it is generally in the best interests of a child be brought up in his own family” (Section 3, Subsection 2c). The well-being of each family member is equally important and that is why an approach to services needs to be family-centred as well as child-centred.

Given the diversity of family forms which now exist in Ireland and elsewhere, it is important to cultivate an inclusive concept of the family which focuses on the set of relationships which link parents to each other and to their children, even where the parents are not living in the same household, such as non-resident fathers. In other words, a concept of family is needed which is broader and richer than the concept of household which is currently how most people, including policy makers and family practitioners, understand the family even though experience, and the findings of research\textsuperscript{170}, indicates that this is not always the case.

\textsuperscript{170} See McKeown, Pratschke and Haase, 2003
6.2.3 Understand need from a holistic, multi-dimensional perspective

The requirement on Health Boards to regard the well-being of children as “the first and paramount importance” underlines the importance of defining the needs of children in a holistic way. It is important therefore to define children’s needs in a primary sense rather than in terms of available services. Children need basic physical care, affection, security, continuity of relationships, approval and affection, opportunities to realise their potential, and so on. To define children’s needs in terms of available services runs the risk of obscuring children’s real needs and therefore failing to meet those needs appropriately. The principle advanced here requires that the child and its family is placed at the centre of a consultative process to identify their needs.

Health Boards have been given a specific function under The Child Care Act, 1991 to promote the welfare of those children who are “not receiving adequate care and protection” (Section 3, Subsection 1). In meeting this obligation there is danger that needs assessment may become synonymous with ‘risk’ assessment. This concern is based on the experience of responding to children on the basis of ensuring their safety alone.

Adopting a holistic approach to need also implies a challenge to assess as scientifically as possible the relative importance of the different determinants of well-being including physical and psychological health, family and social relationships, individual and lifestyle characteristics, education and employment, living environment and community networks, social and anti-social behaviour, etc. It is not enough to know that all of these factors are important without knowing which is more, and which is less, important since the design and effectiveness of services depends upon intervening with those factors which are known to be the most important. Too often, services are based on theories and ideologies of need rather than empirical evidence about need.

These considerations have two practical implications for the development of services. The first is that services need to focus on all the factors which affect well-being, both inside and outside the home and this includes housing, the quality of the environment and amenities, pre-school, school and after-school services, sport and leisure, and a range of community-building activities. This means that a wide range of Government Departments and agencies need to be involved and to work in a coordinated fashion at local and national level. This is already happening through RAPID and ClÁR but tangible results are slow to emerge. The second implication is that service providers and professionals need to view themselves in less compartmentalised fashion – such as children in care, child protection and family

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171 See Pringle, 1996; see also the National Children’s Strategy, 2000:38
support - and more in terms of integrating prevention, early intervention and late intervention. An example of how this might be done, as suggested in Chapter Four, would involve the formation of teams based in family centres comprising personnel from Primary, Community and Continuing Care Services such as Public Health Nurses, Social Workers, Community Mothers, Family Support Workers / Home Helps as well as representatives from other agencies and from the community.

6.2.4 Analyse need in terms of risk and protective factors

Children need services if their health or development is impaired or is likely to become so in the absence of services. In assessing the needs of children therefore it is important to assess the overall balance of risk and protective factors which are shaping the child’s well-being, the way in which these different causal factors are linked, and their likely impact on the child’s normal development. This requires an understanding of the multi-dimensional nature of family well-being and, drawing upon good clinical practice and the findings of research, assess the relative importance of these factors in the case of each child and family. In practice this often means identifying strengths within the child and family and, as appropriate, offering services which build resilience and supports. A needs-led approach therefore is sensitive to the specific requirements of the child and family and tailors the service to that requirement. Sometimes when professionals are assessing the needs of families and children, there is a tendency to ask first what can be added from the outside when often the greatest potential is to build on existing resilience within the child and the family and their immediate environment.

6.2.5 Promote a common approach to needs assessment

There is an increasing acceptance of the importance of developing a common framework for assessing needs as a prerequisite to developing a more coordinated and integrated approach to services for vulnerable families and children. Examples of these which have been developed in the UK include the Framework for the Assessment of Children in Need and their Families\(^ {172} \) as well as the Common Language Tools for Children in Need\(^ {173} \). In Ireland a range of instruments have been applied to measure the well-being of parents and children and these have been used with both service users\(^ {174} \) and the general population\(^ {175} \).

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172 UK Department of Health, 2000
173 See Little and Mount, 2003; see also www.dartington-i.org.uk/commonlanguage
174 McKeown, Haase and Pratchke, 2001; 2004a; 2004b; 2004c; McKeown, Lehane, Rock, Haase and Pratchke, 2002
175 See McKeown, Pratschke and Haase, 2003
6.2.6 Assess the needs of families and children who do not use services

Current knowledge about the needs of families and children comes from existing service users. This is a valuable resource albeit one that is still under-utilised by Health Boards. However very little is known about the needs of families and children who do not present for services because no studies have been undertaken of family needs based on community samples. In practice this means that the overall distribution of services throughout the country may not be an accurate reflection of the true pattern of need. This does not imply that existing services are not located in areas where there are high levels of need. However it does imply that more detailed information could contribute to better decisions concerning prioritisation of resources in the future. This is a particularly important consideration from the point of view of ensuring an equitable and efficient use of resources. Given the demographic and socio-economic changes that have occurred recently, it is important to have information on need that is currently relevant.

6.2.7 Keep services outcome-focused

A focus on matching needs to services also implies a focus on achieving better outcomes for the families and children who use those services. It is worth remembering that services are a means to an end, not an end in themselves. Services are a means to achieve better outcomes for families and children. Whether a service achieves its desired outcome is a matter to be determined, not assumed, and this requires some form of evaluation based on agreed performance indicators. In Ireland, as elsewhere, there is a tendency for performance indicators to focus predominantly, if not exclusively, on inputs and outputs to the neglect of outcomes. As a result, monitoring is often given greater importance over evaluation and is sometimes seen as synonymous with evaluation. This is not in the best interests of service users and is not helpful in terms of service development. All services need to address the key evaluation questions raised in Chapter Three above and to set procedures in place for answering them. These questions are:

- Is the service effective in achieving its goals? This involves comparing the objectives and outcomes of that service.
- Is the service efficient in achieving its goals? This involves comparing inputs, outputs and outcomes in similar services.
- Do the outcomes represent significant improvements in the well-being of families? This involves comparing the well-being of families before and after the intervention.
- Would the outcomes have occurred without the intervention? This involves comparing the well-being of families who have received the intervention with those who have not.
• Are the outcomes sustainable? This involves comparing the well-being of families at the end of an intervention and some time later (perhaps 1-5 years) to determine if the improvement was sustained after the intervention ceased.

In addition to evaluating individual services and programmes, agencies should also consider setting some overarching outcome targets to help focus agency as well as inter-agency activity. These targets should be based on a clear understanding of need within the communities being served and have a particular focus on those dimensions of well-being which are known to fall below acceptable levels. In this way, all levels of service provision can be informed by a focus on outcomes and impacts.

6.2.8 Build services which are helpful and supportive

There is extensive research to show that services must be experienced as helpful and supportive if they are to be effective essentially because the therapeutic relationship is central in bringing about change in the lives of families and children\textsuperscript{176}. Some of the qualities normally associated with good therapeutic relationships - emotionally warm, available, attentive, responsive, sensitive, attuned, consistent and interested – are in fact generic to all good relationships\textsuperscript{177}. A growing number of studies\textsuperscript{178} show that service users’ rating of the therapeutic relationship, rather than the therapists’ rating of that relationship, is highly correlated with outcome and this underlines why the personal qualities of the person delivering the service are of key importance. These considerations mean that the services must accommodate to the needs of families and children – rather than the reverse – and this includes adjusting to their motivational level, readiness for change and therapeutic goals. In practice this implies that services need to have acceptability and credibility with the families and communities they serve and this requires working cooperatively and in partnership with all the key stakeholders involved. It also involves offering services which are accessible and flexible in terms of location and hours of opening so that families are willing to use the service and the community is supportive of it.

6.2.9 Ensure services are ethical

The logic informing services is that it is an intervention to alter the balance of risk and protective factors affecting well-being so as to create better outcomes for families and children. This is a complex process due to the natural complexity of family systems and the relatively limited knowledge which we have about how services impact on the well-being of families. These limitations urge caution in deciding if, and how, to intervene in the life of a child and family and to observe the ethical

\textsuperscript{176} Rogers, 1957; Miller, Duncan and Hubble, 1997, Chapter 4; Sprekle, Blow and Dickey, 1999; Howe, 1999
\textsuperscript{177} Howe, 1999:99
\textsuperscript{178} Horvath and Luborsky, 1993; Orlinsky, Graw, and Parks, 1994
principles of: (i) do no harm (ii) prevent harm and (iii) promote well-being. In applying these ethical principles it is important to assess the overall likelihood that the chosen intervention is capable of achieving the desired outcome. Practitioners therefore require a knowledge of ‘what works’ as well as an awareness that some interventions may not have been tried and tested. This implies that care is needed in deciding what services to offer families and children as part of an overall focus on quality. The focus on quality is a central theme in the current health strategy – Quality and Fairness: A Health System for You179 - which states: “Gaining people’s trust in a health system is about guaranteeing quality. People want to know that the service / care they are receiving is based on best-practice evidence and meets approved and certified standards. Improving quality in the health system requires implementation of internationally-recognised evidence-based guidelines and protocols, and ongoing education and commitment from health-care institutions and professionals”180.

6.3 Provide a balanced continuum of services to meet the needs of families and children

6.3.1 Recognise the current imbalance between prevention, early intervention and late intervention

Health and social services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (late intervention, sometimes referred to as treatment). The term ‘continuum’, as normally used in the context of services for families and children, typically refers to the overall balance between prevention, early intervention and late intervention. In defining this continuum, others distinguish between primary prevention (aimed at reducing the incidence of problems in the population), secondary prevention (aimed at reducing the prevalence of problems by shortening their duration or diminishing their impact through early detection and prompt intervention) and tertiary prevention (aimed at reducing impairments and disabilities)181. However the continuum is described, the evidence suggests that the balance of services for families and children in Ireland is now more heavily concentrated on late intervention than on prevention with relatively limited resources going to early intervention. This

179 Department of Health and Children, 2001
180 Department of Health and Children, 2001:19
181 Hall and Elliman, 2003
is confirmed by our examination of expenditure on child and family services in Health Boards which indicates that the largest proportion of expenditure goes to child protection and children in care, both of which are essentially late intervention services (see Chapter Four). Similarly, the results of the census of family support services indicates that those services which involve late interventions are significantly more expensive than prevention and early intervention and also absorb most of the resources available for family support services (see Chapter Five). The underlying dynamic which has brought this about is described in the Health Strategy as follows: “A specialised infrastructure was put in place from the early 1990s where the dominant focus was on child protection and on fulfilling statutory responsibilities to identify children at risk. While these services were both necessary and important, awareness has grown in recent years of the need to target preventative approaches and in particular to develop and expand family support services.”

6.3.2 Invest appropriately in prevention, early intervention and late intervention

It is clear from the health strategy that a more appropriate balance is needed in the overall continuum of services for families and children. This means investing appropriately in prevention, early intervention and late intervention. It also means rebalancing between as well as within the three categories of child care services, namely child protection, children in care and family support. The case for rebalancing rests essentially on the pivotal importance of the early years for children and the cost effectiveness of prevention and early intervention. In other words, the well-being of families and children is best served by a continuum of services which gives appropriate weight to prevention, early intervention and late intervention; finding the appropriate balance therefore, remains a significant challenge. At the same time, the process of rebalancing needs to recognise that the overall package of services for families and children – even given its present imbalanced composition – is inadequate to meet the needs of those families and children who present to Health Boards and other service providers, as the evidence detailed in Chapter Four illustrates. In effect this means that the imbalance between prevention, early intervention and late intervention is compounded by the fact that the supply of services in each of these categories is inadequate. This means that re-balancing will

182 Department of Health and Children, 2001:139
183 Duncan and Brooks-Gunn, 1997; Cameron and Heckman, 1999; Heckman, 1999. According to James Heckman (1999), winner of the Nobel Prize in Economics in 2000, “Policies directed toward families may be a more effective means for improving the performance of schools than direct expenditure on teacher salaries or computer equipment. Policies that seek to remedy deficits incurred in early years are much more costly than early investments wisely made, and do not restore lost capacities even when large costs are incurred. The later in life we attempt to repair early defects, the costlier the remediation becomes.”
184 See, for example, Karoly, et al., 1998 who used US data from the Elmira Prenatal & Early Infancy Project and the Perry Preschool Programme to show that every dollar spent on prevention and early intervention yields 3-4 dollars in return; see also Greenwood et al, 1998; for a review of this literature, see McKeown and Sweeney, 2001, Chapter Four.
need to be carried out in a way which expands the overall package of services rather than developing one set of services at the expense of another. In other words, rebalancing needs to be done within a framework which facilitates expansion rather than contraction of services and this framework will need to inform the selection of performance indicators used to monitor progress towards re-balancing.

6.3.3 Find the right balance between universal and targeted services

All families and children receive support from universal health and education services. The Public Health Nursing service is currently provided universally to all families with young children. All children of appropriate ages are offered school places and those with a Medical Card have free access to health care. This universal provision makes a fundamental contribution to the prevention and early intervention of social need. Effective family support builds on this provision. The challenge for policy makers is to decide on the appropriate balance between investment in universal and targeted services, taking full account of the costs and benefits involved. These decisions apply not only at national level but at local level as well; for example, areas which have intense social and family problems may warrant a higher proportion of universal services than areas which have fewer problems. Naturally, these decisions cannot be made in the abstract but are relatively straightforward when data is available on the costs and benefits of achieving selected outcomes such as reduced educational under-achievement, anti-social behaviour, emotional or behavioural difficulties, etc.

6.3.4 Find the right balance between practical and therapeutic interventions

Services to support families and children typically involve a combination of practical and therapeutic interventions. Practical help includes assistance offered to parents with everyday activities such as cleaning, cooking, shopping, getting children ready for school, child-minding, etc; it may also involve helping children with their homework, including the provision of space for this purpose as well as giving them breakfast before going to school, etc. Therapeutic work also takes a variety of forms such as individual work, group work, family work, advocacy, mentoring, etc. The precise combination of practical and therapeutic work will depend on the assessment of need, the resources available and a knowledge of what works. For the policy-maker and service manager, the challenge is to find the balance which improves outcomes, irrespective of whether the service involves prevention, early intervention or late intervention.
6.3.5 Develop family support in the context of other services for families and children

It is usual to classify the child and family services of Health Boards into three broad categories as follows: (i) child protection, sometimes referred to as child protection and welfare; (ii) children in care, including foster care, residential care, special care, secure units and special arrangements; and (iii) family support services. Increasingly Health Boards are moving towards creating separate management arrangements for each of these categories of service. The extent to which these different types of service are integrated varies and, in general, they seem to work in a more separate than integrated manner.

A strategy for the development of family support services needs to be part of a broader strategy for developing all services for families and children, including child protection and children in care. This is because family support has to be viewed in the wider context of services aimed at improving outcomes for families and children. There is a danger in creating rigid separations between family support, child protection and children in care since this can undermine the role which each can play as part of a balanced continuum of services. It is not difficult to imagine circumstances where the needs of some families and children may require the intervention of all three categories of service since interventions under the rubric of children in care could be part of a family support strategy involving respite breaks and other supports while child protection will almost invariably require the input of family support services. Viewed in this way, the challenge of developing family support services also implies a challenge to develop more fluid multidisciplinary working between existing services for families and children, both within and between agencies.

The need to see family support in the context of other services for families and children is also suggested by the data on children in care for the year 2001. As discussed in Chapter Four, this reveals that the single most important reason why children are in care is: “parents unable to cope / parental illness” (30%), followed by “neglect” (28%). This data provides grounds for suggesting that there may be some scope for expanding family support services to help parents cope and develop their parenting capacity as an alternative to placing the children in care. Interestingly, when the reasons for admission into care are summarised into “child-centred” and “family-centred” reasons, the results indicates that 48% of children are in care for family-centred reasons, a finding which also suggests that family support services may be an appropriate alternative for some of the children who are currently being placed in care.

These considerations draw attention to the importance of family support as a core principle of service delivery as well as being a specific category of service in its own

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185 Department of Health and Children
right. As such it raises the following questions which need to be considered in developing a strategy for family support services:

If ‘Family Support’ is used exclusively to describe one category of child and family services, is there a danger that those involved in other child and family services do not feel that their primary role might also be to support families? This is an important question in that it is generally agreed that families provide the best environment in which to raise children and that child protection is best delivered by supporting families (notwithstanding the minority of children whose families do not provide a safe environment on an ongoing basis). Arguably, supporting families could be regarded as a fundamental principle against which to benchmark all services aimed at protecting children and promoting their welfare.

If ‘Family Support’ services continue to be regarded as relevant only in the context of prevention and early intervention, will children and young people who are particularly troubled be regarded as requiring segregated and / or State care? This seems to represent at least one strand of thinking although there are examples of community-based services for children and young people who are experiencing serious and complex difficulties. One such example is the Youth Advocacy Programme which challenges the notion that ‘serious’ problems cannot be dealt with effectively in the community.

Given the range of needs among children and families, is a more differentiated and flexible range of responses required? The range of services provided to families and children has increased in recent years. However there is considerable scope to extend the flexibility and range of both community-based and alternative care services in order to provide a broader repertoire from which to tailor responses to families in need.

6.3.6 Develop multidisciplinary and inter-agency working

The development of a balanced continuum of services requires an increased use of multidisciplinary and inter-agency working. This is because the needs of families and children are seldom if ever restricted to one area of life and effective responses will cross disciplinary and agency divides. Agencies dealing with health, education, housing, social care, and justice all have a role to play in supporting families and children. Finding the most effective balance between the contributions of the constituent parts of family services is critical to their success. Several types of balancing are required in this context. There is the question of the extent to which various agencies will be the first point of referral. Then there is the issue of which agency will take the lead in managing the support to the child and family. There is also the challenge of identifying the most effective mix of provision at the point of service delivery. The evaluation of Springboard identified a number of key factors
which facilitated inter-agency partnership in different Health Board regions which are worth recalling in this context\textsuperscript{186}:

- Ensuring that all of the relevant agencies and organisations are involved in the partnership process and are aware of its benefits.
- Having regular contact and communication, both formal and informal, through meetings, phone calls, etc, for the purpose of sharing information about each other’s services and promoting clarity about the respective roles of each in working with families, thereby avoiding duplication, overlap and misunderstandings. Shared training events could also contribute to this objective.
- Keeping in mind that the first priority is meeting the needs of vulnerable families.
- Cultivating professional attitudes which place a premium on respect, openness, flexibility, clarity, networking, trust, cooperation, constructive challenge, prompt replies, clear boundaries and good communication.
- Supporting the management committee in Springboard as a key instrument of inter-agency cooperation.
- Ensuring that senior management, especially in the Health Board, show leadership and support for inter-agency cooperation.

6.3.7 Ensure an equitable distribution of services

We have seen that family support services are distributed quite unevenly throughout the country when measured by the number of services per 10,000 population (see Chapter Five). One consequence of this is that families and children with similar needs may be offered very different responses depending on which service, or professional, they happen to encounter and the part of Ireland in which they happen to live. This perception is not unique to services for families and children but extends to health services generally, as the Health Strategy points out: “A perceived lack of fairness and of equal treatment are central to many of the complaints made of the existing system. Improving equity of access will improve health by ensuring that people know what services they are entitled to and how to get those services and that there are no barriers, financial or otherwise, to receiving the services they need”\textsuperscript{187}. A first step in ensuring equity therefore is to develop a range of services for families and children across the country which are based on a careful assessment of need among the different clinical and community groups in each Health Board region. Other considerations mentioned in this chapter about developing a balanced continuum of services also apply.

\textsuperscript{186} McKeown, Haase and Pratschke, 2001:99
\textsuperscript{187} Department of Health and Children, 2001:18
6.4 Options for the Future

The evidence and analysis presented in this report indicates that change is required in the design and delivery of services for families and children. The present system tends to be crisis-driven and services which involve late intervention tend to absorb an inordinate share of resources relative to prevention and early intervention. The system tends to be service-led and output-focused rather than needs-led and outcome-focused. Effective intra-agency and inter-agency working tends to be the exception rather than the rule. The case for change therefore is compelling.

In order to facilitate the development of a strategy we suggest that two options should be given serious consideration. These are:

• Option One: Develop and rebalance family support services
• Option Two: Develop and rebalance all services for families and children.

It is clear that these options are not mutually exclusive since the second is essentially a more comprehensive version of the first. However they are presented as separate options since they allow for the possibility of bringing about the changes required in a manner which can be phased in over time and takes full account of the circumstances likely to affect the change process. It is worth emphasising that implementation of either option will need to be done in a way which expands the overall package of services for families and children rather than developing one set of services at the expense of another. In other words, rebalancing will need to be done within a framework which facilitates expansion rather than contraction of services given that the overall package of services is inadequate to meet the needs of those families and children who presently seek a service.

6.4.1 Option One: Develop and rebalance family support services

This option builds upon an existing commitment to develop family support services which has resulted in the creation of new and promising services for families and children such as Springboard, Teen Parenting Programme, Youth Advocacy Programme, etc. New resources are being targeted at the development of innovative services and there is clear evidence in the case of Springboard that this is an effective service. The use of new resources to trigger a process of service innovation is clearly a positive development and has done much to show the expanding possibilities of family support services. The rationale for Option One therefore is to build on these developments but to do so in ways which are more in line with the principles outlined earlier in this chapter.

The development of Option One requires that two key issues are addressed. The first is the tendency, found equally in other areas of service provision, to develop new family support programmes in the absence of comprehensive studies of need. This
tendency is reinforcing a service-led, output-oriented approach to service development and may also be contributing to an inequitable distribution of services across the country. We have already seen in Chapter One that, although the concept of need is amenable to scientific measurement using standardised instruments to measure agreed indicators of well-being and their thresholds, there has been no systematic study of the prevalence of need among families and children in Ireland. As a result, there is a weak evidence-base from which to identify families and children whose well-being falls below acceptable levels. This is a major obstacle to the development of services – including family support services - as the current Health Strategy makes clear: “An underlying issue contributing to problems in service provision is the lack of good-quality information about the needs of children and the existing capacity of the system to deliver good outcomes”\(^\text{188}\). The National Children’s Strategy also observed that, “despite ... the considerable resources being committed by the Government to children, there continues to be limited empirical data and research-based understanding of their lives”\(^\text{189}\). Prior to this, the Commission on the Family reached a similar conclusion: “The Commission’s examination of the effects of policy programmes and services on families has highlighted the dearth of research into families, family members and how children from different backgrounds fare in the longer term”\(^\text{190}\). This issue needs to be addressed by carrying out a comprehensive study of the multi-dimensional aspects of need among ‘community’ and ‘clinical’ populations using appropriate standardised instruments for measuring the well-being of parents and children.

The second issue is the rebalancing of family support services. Most new developments in the area of family support have involved late interventions rather than prevention and early intervention and this is tending to reinforce the imbalance within family support services as described in Chapter Five. The precise resolution of this issue should be worked out in consultation with the relevant stakeholders but the following challenges should be borne in mind:

(1) the danger of misunderstanding the nature of prevention and early intervention.

When it comes to the well-being of children, prevention typically means intervening as early as possible in the life of the child while early intervention means early in the life of the problem. Rebalancing towards prevention and early intervention therefore means keeping a balance of services for children of all age groups, from infancy to late adolescence.

(2) early intervention can, by its nature, involve the provision of services to families and children who, although they display risks for later problems, do not succumb to that risk. This draws attention to the need for care in early intervention work.

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\(^{188}\) Department of Health and Children, 2001:140
\(^{189}\) National Children’s Strategy, 2000:38
\(^{190}\) Commission on the Family, 1998:504
since there is a danger of inefficiency due to working with families and children unnecessarily; there is also the related danger of ineptness due to interference in the lives of families that have no difficulties or are managing them well.

(3) early intervention may require intense, if short-term, intervention and, as such, should not be regarded as a less rigorous form of intervention than late intervention. A short-term service carefully targeted at a specific pattern of risks in a family may be exactly right for protecting children from neglect or abuse and much more successful than long-term monitoring or separation responses that have traditionally characterised children’s services.

(4) care should be taken to ensure that sufficient services are retained and developed to serve families and children who need late interventions.

(5) rebalancing the continuum of services could have negative effects if it is done without due consideration for the views of children, families and agency staff.

(6) any preventative strategy has to be informed by sound knowledge of the causal processes producing the undesired effects; otherwise there is a danger of giving credence to interventions that are either ineffective or worse, harmful.

(7) no services, whether classified as prevention, early intervention or late intervention, should undermine the capacity of families to cope with their own adversities. This means that services should seek to support families to help themselves and only assist directly where there is good reason to think that this would be more helpful than doing nothing.

It is clear that Option One will require some re-appraisal of how the existing package of family support services are meeting the needs of families and children while also prompting reflection on how new service developments are planned and implemented. This option builds upon the innovative developments in family support services which have occurred in recent decades while also giving it a clearer focus and momentum. As already indicated, this option can implemented on its own or in tandem with Option Two.

6.4.2 Option Two: Develop and rebalance all services for families and children

This option will require the development of all services for families and children and the creation of a sharper focus on needs and outcomes while also re-orienting services towards prevention and early intervention. As such, it poses a major challenge for the reform of all services for families and children. Other countries are going through a similar reform process and we can learn from their experience\textsuperscript{191}. There is no ready-made blueprint for this option and its success will depend on all

\textsuperscript{191} See Axford and Little, 2003c
stakeholders working together to create a framework which integrates needs, services and organisational frameworks. In order to advance this option, we propose the following three steps as a broad framework for implementation.

First, assess the patterns of need in each Health Board region using data from clinical and community populations. Much is already known about the type of preventative services which promote child development and these include the work of Public Health Nurses as well as services which enhance children’s opportunities for play and socialisation while also offering supports to parents; examples of these were cited in Chapter Three. Early intervention will require some screening of children for emotional, behavioural and other difficulties and there are numerous validated instruments which could be used for this purpose. This could be done in schools since these are possibly the closest approximation to a universal access point for families and children. The potential of schools as a base for doing prevention and early intervention work with children in a non-stigmatising setting, using multidisciplinary and interagency approaches, is vastly under-exploited, as the evaluation of Springboard showed\(^{192}\), and could be one of the major opportunities arising from the rebalancing services.

Second, design, implement and evaluate new and existing services. The literature shows that drawing on research is central to most attempts at innovation in preventative services, and that systems for encouraging agencies to share best practice and learn from one another also help. It should be noted that service development need not mean starting from scratch; it can involve adjusting existing services to make it easier for families and children to access them. This is partly about location, but it also demands attention to factors such as the messages given by buildings that accommodate services, the hours of opening, the nature of publicity materials, and making services accessible to all family members including fathers\(^{193}\) as well as creating conditions which are welcoming of particular groups such as Travellers, refugees and families with literacy or mental health problems.

Third, explore the potential of structural reorganisation. Some of the measures to reorganise services that have been tried elsewhere include: better care management and tighter gate-keeping over expensive provision; flexibility so that budgets are managed across a two-to-three year planning cycle, so allowing extra investment early in the cycle; decentralised budgets including pooled funding between agencies; agreed performance indicators particularly for outcomes; improved client and management information systems; staff support and training especially for prevention and early intervention; mandated multidisciplinary teams at both intra-agency and inter-agency level; internal and external performance-related service agreements including agreements which give providers an incentive to change the emphasis of their services\(^{194}\). In choosing from this list of possibilities, it should be

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\(^{192}\) McKeown, Haase, and Pratschke, 2001:121
\(^{193}\) See McKeown, 2001:Chapter 8
\(^{194}\) See Axford and Little, 2003c
remembered that, despite the repeated use of structural reorganisation as a tool for implementing legislative and policy developments in children’s services in many countries, there is little evidence of any impact of organisation *per se* on child outcomes. This is because structural change is only ever part of the solution. As such, structural change should follow careful consideration of the needs of families and children, the kinds of services required to meet those needs as well as the experiences and skills required of staff to do more preventative and early intervention work.

Each of these steps is important but the sequence of steps is also important, particularly in view of a tendency sometimes found among service planners and professionals to begin with the third step rather than the first. In other words, the three steps have a chronological as well as a logical sequence.

### 6.5 Conclusion: A Way Forward

This study was undertaken as a contribution to the review of family support services whose terms of reference require “a clear statement to guide the appropriate development and operation of the broad range of family support services by Health Boards”\(^{195}\). Our analysis, particularly as formulated in this chapter, has outlined the set of principles which should inform the development of these services while also indicating the two main options available for implementing those principles. In this concluding section we look toward the implications of this and reflect on what might be involved in developing and rebalancing services.

It needs to be recognised that an overall strategy to develop services for families and children involves a number of different Government Departments and their agencies, including the voluntary and community sector as well as families themselves. Each Government Department needs to begin that process internally while also taking account of the cross-departmental and inter-agency issues involved. For this reason it is appropriate that the primary focus of the strategy being developed by the Department of Health & Children should be on the services which fall within its remit. Given that context, we suggest that the following points might be considered as requirements for implementing this strategy:

1. Generate a commitment at all levels of the health service - Department of Health & Children, Health Services Executive, Regions - to the strategy and the principles which underlie it. This implies that all staff will need to be given an opportunity to discuss the principles and their practical implications. It is easy to overlook this point given that many of the principles are already familiar but their full and radical implications have rarely been teased out; moreover many of the

\(^{195}\) Department of Health and Children, 2003
2. Appoint a person in each region to lead and champion the implementation process on a full-time basis. This person will require skills to mobilise enthusiasm, promote flexibility and encourage creativity. At the same time, the overall management of change needs to be led and supported at the most senior level in the health services.

3. Draw up a plan for implementing the strategy with a clear timeframe and performance indicators against which to check if targets are being met at key milestones. This plan will involve actions to (i) assess needs (ii) develop services (iii) introduce organisational change. The sequence in which these three actions are undertaken is, as already indicated, important but some flexibility and overlap may also be appropriate. These plans should be formulated according to an agreed template and there should be regular reports on their implementation. The possibility of linking implementation to the overall funding of services should also be given serious consideration.

4. As part of the needs assessment, arrangements need to be put in place so that the views of service users are taken into account on an on-going basis.

5. Ensure that adequate resources are allocated to implement the plan particularly where this involves studies to assess needs, identify services which are known to work, facilitate staff training and development, undertake evaluation of services, etc.

6. Put support structures in place to allow for the exchange of experience among different regions so that each can learn from the other.

7. Draw upon international experience where services for children and families have been developed and rebalanced.

8. The implementation process needs to be tested at every stage to ensure its compliance with the core principles informing the overall strategy. This will be done within each region but will also be an intrinsic part of the reports prepared by each region on the implementation process.

This is far from being an exhaustive list of the issues that need to be considered in moving towards implementation of a strategy to develop a balanced continuum of services for families and children. However they are indicative of the complexity of what is involved and the need for skilfulness in tackling the technical and human issues which arise in moving to a new era of service delivery for families and children. Like all challenges, this process is also likely to be rewarding not only for families and children who will benefit from improved services but also for staff who are directly involved in the design and delivery of those services.


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