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Working for Children and Families

Exploring Good Practice

DEPARTMENT
OF HEALTH AND
CHILDREN
AN ROINN
SLAINTÉ AGUS
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CHILD & FAMILY RESEARCH AND POLICY UNIT
WHB/ NUI GALWAY

Foreword

As Minister for Children, I am delighted to publish "Working for Children and Families: Exploring Good Practice". This publication marks the culmination of an extensive research process carried out on behalf of the Child Care Policy Unit in the Department of Health & Children by the Child and Family Research and Policy Unit.

While the availability of quality research into service provision to families and children in need in Ireland has improved greatly in recent years, it has been acknowledged that ongoing service-based research and wider dissemination of findings are required. In profiling 26 models from health boards throughout the country, this report provides a snapshot of some of the strategies and approaches currently being used in child and family services nationally and encapsulates many of the different elements of how to support children and their families. By identifying a set of good practice principles, the report offers a guide against which those involved in providing services to children and families in Ireland can pursue a good practice agenda, now and into the future.

I would like to thank all those involved in producing this report, particularly the various services who participated – without their co-operation this research would not have been possible. The report is a tribute to their commitment, dedication and excellence in service provision. Special thanks also to the Child and Family Research and Policy Unit, based at Western Health Board / NUI, Galway, for its work in bringing the research to fruition.

This Government is committed to strengthening policies and enhancing services to support families and children. I am confident that this report will prove to be of enormous benefit to both policy makers and practitioners and will play an important part in the ongoing quest to improve the quality of services provided for families and children.

Brian Lenihan T.D.
Minister for State with special responsibility for Children

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The Child & Family Research and Policy Unit (CFRPU) undertakes research and evaluation in relation to the care and welfare of children with the particular emphasis on family support.

It is a joint initiative of the National University of Ireland, Galway and the Western Health Board.

Research undertaken by
Western Health Board / National University of Ireland, Galway
Child & Family Research and Policy Unit

On behalf of
The Child Care Policy Unit
Department of Health and Children

Note on terms used:
Child / Children refers to children aged 0-18 years
Parent refers to parent or carer

The research for this publication was undertaken in 2003
www.childandfamilyresearch.ie

Executive Summary

This document provides a snapshot of some of the models and approaches currently being implemented in child and family services throughout Ireland. Each Health Board was asked to nominate up to three examples of service provision that they feel represents good practice. The 26 models nominated are profiled in this document in order to enable policy makers and practitioners to see good work happening throughout the country and learn from the experiences of others. A set of good practice principles, as identified through empirical research and literature, is presented at the outset. Whilst the services profiled were not evaluated as part of this project, this set of principles can be used as a guide to assist in the analysis and understanding of the service profiles.

Section One introduces the initiative and sets out the policy context within which the child and family interventions profiled in the document have been developed.

Section Two explores the issue of good practice in child and family services. Some of the key theories that have been influential in the development of child and family services are discussed – i.e. intervention appropriate to need, child development, the role of parental care-giving, resilience and the ecological approach. A set of principles of good practice in child and family services is identified and discussed, classified according to management level principles and intervention level principles. These are:

Management Principles

• A range of services is available, targeted at different levels of need, within a framework of prevention
• Services have clear objectives and a management and organisational culture that facilitates their achievement
• The service has a culture of learning and development
• The service measures outcomes
• The service has adequate resources to meet its objectives and offers value for money
• The service has a commitment to effective partnership practice
• Services provide good staff development & support

Intervention Principles

• The service is 'whole child' focused
• The service is accessible and attractive
• Services are integrated
• The service is responsive to need and effective
• The service works in a way that is collaborative and strengthening
• The service is culturally competent
• Staff are interested and able

Section Three contains the 26 profiles, divided into eight categories that emphasise a key focus of the intervention. The categories include:

- Early childhood development
- Parent support
- Community-based family support
- Strategies for working with 'at risk' children and adolescents
- Therapeutic approaches
- Promoting partnership
- Working with children in care and aftercare
- Policy and service development

Section Four offers a range of diverse examples, from the service profiles, of how the good practice principles are being put into practice.

In conclusion, the document illustrates that there is a great breadth and depth of valuable work currently undertaken in child and family services. There are many creative examples of how staff and management are working with service users to design and deliver services that are relevant and effective. Looking to the future, there is scope for networking and further development in relation to good practice in an Irish context.

SECTION 1

Introduction and Policy Context

Introduction

The past decade has seen considerable expansion and development in the range and quality of child and family services in Ireland. As a result, child and family services are now a blend of well-established and proven, and new and innovative interventions and practices. The learning that has emerged from this work has relevance for policy-makers and practitioners engaged in the ongoing process of service development and improvement.

This project was initiated by the Child Care Policy Unit of the Department of Health and Children in order to identify, describe and disseminate a selection of good practice approaches to meeting the care and welfare needs of children and families. It acknowledges that, while there are still many gaps in service provision, there is a considerable amount of very positive work being undertaken in child and family services throughout Ireland. By profiling and identifying good work taking place and disseminating good practice ideas for the benefit of practitioners, managers, policy makers, and service users, this document aims to contribute to the continuous development and improvement of services.

The objectives of this document, therefore, are two-fold:

• To profile and describe current approaches and models in child and family services in Ireland. To this end, Health Boards throughout Ireland nominated 26 examples of current practice that they have found to be effective.

• To identify, from research, a broad set of principles associated with good practice in child and family services, and to highlight examples of these principles in practice, with reference to the services profiled.

It is hoped that this document will encourage readers to reflect on good practice, its many inter-related components and how they can contribute to its development in their own context.   It is also envisaged that this document will form the basis of a process of networking and shared learning between child and family services in relation to good practice.

Methodology

Each Health Board in the Republic of Ireland was invited to select up to three examples of good practice in child and family services from among its range of services. A pro forma was supplied to structure the information provided, with questions relating to aims, objectives, approach, theoretical basis, involvement of service users, outcomes and procedures for evaluation.

The project took a broad view of where the good practice models could be found. Nominations could be drawn from the following domains:
• Prevention and family support – supporting families to deal with problems and difficulties in their daily lives.
• Child protection – responses to concerns about the welfare of children.
• Alternative care – foster care, residential care, aftercare or adoption.
• Cross-domain – models could be located in more than one of the above domains.

In relation to organisational context, the examples submitted could be services or interventions run directly by the Health Board, operated in partnership or sub-contracted to a voluntary organisation. They could be located at all levels of service delivery – for example, practice / individual intervention level, project level, inter-disciplinary / inter-service level or programme level.

All submissions from the Health Boards were reviewed by an Advisory Group, formed by the Department of Health and Children to provide advice to the Project Team on methodology, structure and drafts of the publication. For the Advisory Group and Project Team, the process of getting to grips with the diversity of information and experiences contained in the data was challenging. The original intention had been to short-list the set of case studies. However, it was decided that all submissions would be included in the document, as they had put themselves forward as having experiences that others could learn from. It was not expected that the examples submitted would be 'perfect' models of good practice. Rather, the intention was to profile and learn from what they were doing well. Neither was the overall exercise intended as an evaluation of the models, which the time and capacity of the project would not have permitted. The information put forward was accepted from Health Boards as examples of what they felt worked for them. Some had been evaluated, while others had not.

A set of fieldwork questions was devised and a site visit was made to each of the nominated projects, where the project team met with members of staff, and in some cases management or service users, in order to verify the information contained in the pro forma and to engage in a deeper analysis of the material presented. Following the fieldwork stage, the information was collated, analysed and framed in the context of wider research to produce the final document.

As the aim of the exercise was to allow Health Boards to put forward new and existing work that they have found to be good practice, nominators were not restricted to choosing certain categories. Hence, the group of examples put forward is not, in any sense, a representative sample of all child and family services in Ireland. More than two thirds of the nominations are in the arena of family support, while issues such as foster care, child protection services and disability were not or are less-well represented.

The models submitted did not have to be evaluated, nor was it the intention of the project to evaluate them. Some of the models have been evaluated, while others have not. The information supplied has been accepted on good faith from the managers and practitioners involved. For this reason, the service profiles are not presented as a definitive statement of good practice. Rather, they are illustrations of current practice that highlight how the principles of good practice identified in Section Two are being or could be put into practice in a range of settings and models.

The publication does not aim to be the 'last word' on good practice. It profiles a range of practice taking place at a point in time that has been shaped by recent policy development and the current political climate. Good practice is a contested notion, one that is likely to evolve and develop as policies and research enhance our understanding of 'what works' for children and families. This publication can be seen as both a yardstick to illustrate work taking place in 2003, and a point from which further analysis and development can take place.

Context: Child and Family Policy in Ireland

Article 41 of the Irish constitution (1937) recognises the family as the natural, primary and fundamental unit group of society and guarantees to protect the family 'as the necessary basis of social order'. The care, nurture and protection of children are considered the responsibility of families. In the past 15 years, there has been a policy shift from a 'hands-off' attitude by the state to families, whereby they were largely left to their own devices, to a more interventionist stance. The shift in attitude was primarily inspired by the recognition that children can suffer abuse and neglect within the family, and that support services are required to, where possible, prevent this abuse and neglect from happening and / or to minimise its effects on the child.

The 1991 Child Care Act stands out as the most significant piece of child care legislation in Ireland since the foundation of the state. For the first time, Health Boards were charged with the responsibility of promoting the welfare of children in their areas. The Act is founded on the premise that it is generally best for children to grow up in their own families and favours a preventative approach that prioritises child welfare. The Act was fully implemented by 1996.

However, despite the broad child welfare thrust of the Child Care Act, much of the time and energy of those charged with promoting the welfare of children has been directed into a more narrowly focused child protection framework (Buckley et al, 1997). Revelations of abuse of young children emerged throughout the 1990's, the number of child abuse cases notified rose sharply, while a number of inquiries, such as the Report of the Kilkenny Incest Investigation, highlighted the deficiencies in the child protection system and placed the issue of child abuse in the public and political arena. The outcome, as described by Ferguson and O'Reilly (2001, p.10), was that 'many of those drawn into the child protection 'net' get little more than an investigation into child abuse while their child care problems, often severe as they are, remain under-resourced and children in need receive little or no service.'

To achieve the shift from a child protection to a child welfare focused service, substantial policy development and investment of resources in the child care system has been ongoing since the 1990's, leading to the expansion of personnel and services across all the Health Board areas. According to McKeown (2000), Ireland has advanced quite a distance in developing family services that are concerned with combating social disadvantage, and child poverty in particular. In addition to child protection duties carried out by community care social work departments, family support services typically include pre-school services, community mothers, psychological services, family centres, Springboard projects, Neighbourhood Youth Projects and other services. Practical linkages have developed between child protection and family support, including family support and child care workers who work as part of community care teams and general family support services provided by voluntary groups (Ferguson and O'Reilly, 2001).

The following are just some of the key child and family policies and legislation introduced since the late 1990's:

- **The Commission on the Family (1998) Report, Strengthening Families for Life** recommended the need for public policy to focus on preventive and supportive measures to strengthen families in carrying out their functions.

- **Children First (1999)** is a set of national guidelines to assist people in identifying and reporting child abuse. It emphasises that the needs of children and families must be at the centre of childcare and child protection activity and that a partnership approach must inform the delivery of services.

- **The National Childcare Strategy (1999)** is a seven-year strategy for the development of the childcare sector, including policy recommendations and the structures and mechanisms for a needs-led planning approach at county level, within a national framework.

- **The National Children's Strategy (2000)** is a 10-year strategic plan for children in Ireland, with three major goals: - Children will have a voice, children's lives will be better understood and children will receive quality supports and services. The National Children's Office was established to oversee implementation of The National Children's Strategy, the Children Act (2001), the National Youth Homelessness Strategy and the development of National Play and Recreation Policies.

- **The Children's Act (2001)** provides a juvenile justice framework and includes provision for the establishment of family welfare conferences.

- **The National Standards for Residential Care Services (2002)** and the National Standards for Foster Care Services (2003) were developed to guide the provision of services in these two key areas. A children's version of the foster care guidelines, The Children's Book About Foster Care was also published in 2003.

- Many of the Commission on the Family's recommendations were adopted as part of **The Family Support Agency Act (2002)**, which established the Family Support Agency to provide information, a family mediation service, marriage and relationship counselling, support for the family and community services resource centre programme and to undertake research into family support matters.

- The Best Health for Children Initiative and the National Conjoint Child Health Committee produced a series of policy reports on children's health, including **Get Connected: Developing an Adolescent Friendly Health Service (2002)** and **Investing in Parenthood to Achieve Best Health for Children (2002)**. The latter advocates a society in which children have the right to be cared for by people who are supported in the role of parenthood. The strategy calls for universal and targeted supports for parents, people centred and community development approaches and promotion of children's rights.

Regional Health Boards have also implemented local policies and strategies to address the needs of children and families. This policy and legislative development has changed the landscape in relation to services for children and families in Ireland. The impact of this policy change is reflected in the principles and practices adopted in child and family services profiled in this document.

Report Structure

Following this introduction, the report is in three main sections.

In Section Two, a set of principles associated with good practice in child and family services is identified. These principles were identified from research and theoretical literature and are located at the levels of management and of intervention. At the end of the section, the principles are merged to form a 'model' of good practice. This model provides us with a framework for understanding and relating to the diverse set of information presented in Section Three.

In Section Three, the case material submitted by Health Boards is profiled under eight key categories. The categories are early childhood development, parent support, community based family support, services for children and young people 'at risk', promoting partnership, therapeutic approaches, work with children in care and aftercare and policy and service development. For each category, a brief review of relevant research is provided as a context for the profiles. Common themes emerging from the profiles are identified for each category.

In the final Section, we discuss and highlight where the principles of good practice are evident in the approaches of the 26 case studies profiled. As it is beyond the capacity of the document to refer to every example of good practice emerging from the profiles, a small number of examples are used for illustration purposes.

SECTION 2

Good Practice in Child & Family Services:
Concepts & Principles

Introduction

This section outlines key concepts, principles and a model of good practice in child and family services. The aim of the section is to:

- Collate key theories and ideas regarding principles that contribute to the achievement of good practice;
- Show how the various principles are inter-related, by presenting them in the context of a framework or model;
- Provide a framework with which to identify and illustrate good practice across the 26 services profiled.

Firstly, before looking at the principles of good practice, we look briefly at some of the core theories and concepts that inform, justify and guide child and family interventions. Secondly, management principles that help to create the environment in which good practice can take place are outlined. Thirdly, principles that are considered good practice at the level of intervention are identified. These relate to work at the interface with children and families. Finally, we merge the management and intervention principles to construct a framework that depicts the inter-relationship between these factors. This framework can be used to relate to the profiles that follow in Section Three, and is used in Section Four to review and discuss some of the lessons emerging from the diverse experiences depicted in the service profiles.

Core concepts and theories in child and family services

A number of theories and concepts have had a strong influence on the development of child and family services in Ireland and internationally. Here we briefly describe five such concepts and theories, from which models and approaches to intervention have been derived.

A. Intervention is appropriate to need:

Child care services aim to achieve the correct balance between child protection and family support, safety and prevention. Most child care systems contain a mixture of services with the following objectives:

- **Prevention** – to stop a problem happening in the first place.
- **Early intervention** – to stop those at high risk or those who show the first signs of difficulty from displaying unnecessarily long-term or serious symptoms.
- **Intervention or treatment** – to stabilise or achieve realistic outcomes among those who have a serious problem.
- **Social prevention** – to reduce the damage that the problem causes to the person and/or their family (Little and Mount, 1999).

Hardiker at al (1991) provides a conceptual framework to illustrate how services can be provided at different levels, in response to stages of problem development.

Base level	Universal services available to all children and families
Level 1	Services targeted at vulnerable groups and communities
Level 2	Targeted early difficulties/early risks
Level 3	Established difficulties/serious risks
Level 4	Social breakdown/'in care'

Base Level – Universal services: Universal social services have a preventative role to play in improving quality of life through good quality housing, education, health provision, income support, child care and other services.   General universal services and the family's own efforts will be adequate to meet the family's needs in the vast majority of cases, meaning that additional targeted intervention is not necessary (Hardiker et al, 2002).

Level One - Targeted service provision: Some families will need help in addition to their own resources, combined with universal social services. These services usually aim to promote early child development and compensate for the disadvantages of poverty, as well as personal development, education and guidance for parents. It is envisaged that, by using these services, most parents will be in a stronger position to access other universal services to meet their needs, and will be diverted from child protection services.
Examples - intensive pre-school care and education, parent support, drop-in centres.

Level Two - Targeted early risks: These services are targeted at families with identified risks to try to prevent a temporary crisis or early difficulty from getting worse. Approaches include short-term or task-centred methods or placements. As a result of actions at levels one and two, most children will never have to enter the formal care service.
Examples - Neighbourhood Youth Projects, Springboard.

Level Three - Established difficulties / serious risks: This level targets serious stresses including the risk of significant harm, family breakdown or compulsory entry into the care system. The aim of interventions is to address difficulties, restore family functioning and links between parents and children and facilitate parenting skills. The eventual aim is for all children to be reunited with their immediate or wider families or be helped towards independent living.
Examples - social work services, temporary care placements.

Level Four - Social breakdown / 'in care': If the three other levels are unable to prevent family breakdown, children may have to live permanently away from their family of origin. Services at this level aim to secure the best possible outcomes for the child and family in this situation and plan for the child's future.
Examples - out of home care, supports for parents with children in care.

Such frameworks enable us to see that protection and prevention activities are complementary activities. Investment in prevention and early intervention services for larger populations can reduce need for intensive care and protection services. The savings at a human level, as well as an economic level can be great.

Daro and Donnelly (2002) caution against overstating the potential of prevention, however, as no strategy works with all families and not all child abuse is preventable.   They also highlight the importance of establishing a partnership between child protection service agencies and preventive services to address the problem of child abuse, and avoid a situation where they are placed as alternatives to each other. It is therefore important to be realistic about the need for a framework that incorporates both proactive and reactive services, with clarity regarding roles and relationships between services at all stages of the continuum.

B. Child development and attachment

An understanding of child development is central to the work of child care practitioners, as it enables them to assess if a child's development is proceeding as expected.   Maslow (1968) and other theorists have highlighted the range of needs that children have, including physiological, security, social, egotistical and psychological. Kelmer-Pringle (1974) identified four needs which must be met for the child's satisfactory development: love and security, new experiences, praise and recognition and responsibility.

Bowlby's (1969) attachment theory highlights the inter-dependency of children's care seeking and adult care giving. When children seek care, they expect a comforting and protective response to satisfy their needs and reduce fear. The care-givers who are most likely to satisfy their needs properly are the care givers to whom the child is attached. If care seeking goals are not met, the child's behaviour becomes more intense and the attachment is weakened. Attachment theory emphasises that secure early relationships can produce good emotional, cognitive and behavioural outcomes, while insecure attachments can lead to difficulties in these areas. Early intervention to support primary caregivers, who have difficulty in forming sensitive attachments is important, due to the long-term impact on the child of their experience of attachment (Seden, 2002).

C. Parental care-giving

The nature and quality of family experiences influence not only how a child copes with life growing up, but also help to determine the quality of their relationships, parenting and mental health in adulthood (Gilligan, 1995). Each child has a unique relationship with its parents and siblings. Guralnick (1997) highlights three salient features of the parent- child relationship as important:

•   The quality of parent-child interaction.
•   The extent to which the family provides the child with diverse and appropriate experiences within the surrounding social and physical environment.
•   The way in which the family ensures the child's health and safety.

Belsky (1997) highlights the many factors which can have an impact on parenting behaviour. These include the parents' own developmental history, their psychological resources, the child's characteristics, the marital relationship, social support and occupational experiences. His research found that having just one risk factor did not lead to a child developing an insecure attachment to their parent, because protective factors tend to buffer the parent and child from further risks. Rather, it is a multiplicity of risk factors that appears to negatively influence how a parent cares for their offspring.

Therefore, to make positive changes in a child's life, the overall needs and context of the family have to be taken into consideration. Strategies which do not fully engage with parents and children are less likely to be effective (McKeown, 2001).

D. Resilience

The concept of resilience refers to a person's ability to recover from very challenging life events. Theorists have identified factors that help a person to be resilient – including competent parenting, the availability of close social support, better educational experience and a higher sense of self-worth. Good relationships with pro-social adults and an ability to problem solve and make sense of what has happened are critical factors in promoting resilience (Seden, 2002). While acknowledging that resilience is a complex concept, Rutter (1993) contends that resilience can be promoted and built within individuals, by planning for and supporting children through life-changes and putting protective processes in place. In order to promote resilience, strategies should address the risk factors in a child's life and build on the protective factors (Gilligan, 2001, Little and Mount, 1999).

E. Ecological Approach

Bronfenbrenner's ecological model (1979) provides a framework for understanding how critical factors in a child's environment are inter-related. Families under stress may be contending with the following 'risk' factors at each of these levels:

- At the community level, an impoverished environment with concentrations of poor families and social and environmental problems.
- Poverty at a family and household level - for example, low income, unemployment, poor housing, and/or lone parenting.
- Individual characteristics, including social isolation, poor capacity to deal with stress, and mental health problems.

An ecological approach provides an awareness of the cumulative effects of adverse family circumstances and the potential for their negative impact on children's development through early and middle childhood to adulthood (Ghate et al, 2002, Jack, 2001). It suggests that neglectful and abusive behaviour by parents towards a child be considered within the overall context of the family and the environment of which they are part. The ecological approach also emphasises the correlation between poverty and child maltreatment, indicating that policies which work towards the reduction of poverty should be given priority.

Principles of Good Practice in Child and Family Services

The set of core concepts just outlined have guided and shaped interventions with children and families. From them, and from other theoretical and empirical research, can be derived principles associated with good practice in child and family services. In this section we outline a set of such principles, separating them into the spheres of management and intervention. At the end of the section, both sets of principles are merged to form a model of good practice that depicts the inter-relationship between the principles.

It may be useful to consider good practice principles as being either universal or specific. Universal principles have relevance to all childcare and family services, whether they are a leaving care project or a community based child care project. Such principles include partnership with service users and working with service users in a way that is culturally appropriate.

Specific good practice principles refer to the detail that has been developed to guide how services are provided in a particular sphere or domain. For example, there are clear guidelines on good practice in residential and foster care and in pre-school services. There are also good practice guidelines for holding staff meetings, case conferences and staff support.

Because of the range and diversity of services profiled in this document, we do not attempt to go into detail about specific good practice principles. Rather we identify a set of universal principles and profile how they are being put into practice across a range of settings. These principles have been drawn from research, evaluation and theoretical literature, and underpin Irish child care policy. They are considered components of a system that places effective and respectful support for children and families at its core.

The experience of the services profiled in this document is that good practice is a very dynamic concept. No interventions take place in a vacuum. The nature of work can be affected from day to day by changes in policy, resource cutbacks or increases, staff illness, demographic changes in the target group or the introduction of a new work practice. Like all systems, if one part is under stress or mal-functioning, it has knock-on effects for all the other parts. For example, an individual staff member may be highly skilled and dedicated to the pursuit of best practice, but if he or she is working in a service that does not value and encourage service development, his or her endeavours are likely to be frustrated. Likewise, a service may be well-staffed and resourced, but may not be accessed by families in need due to its location or because they are not aware of its existence. A range of factors influence good practice – staff and management at all levels must work together with service users to create a quality system.

None of the principles outlined in this section exist in isolation, therefore, but are components of a system of effective service provision. It is intended that service providers take the principles and reflect on their application in their own context. From this local experience, reflection and evaluation, further ideas and understanding of what good practice is can emerge.

Principles of Good Practice in Child and Family Services

Management Principles

• A range of services is available, targeted at different levels of need, within a framework of prevention

• Services have clear objectives and a management and organisational culture that facilitates their achievement

• The service has a culture of learning and development

• The service measures outcomes

• The service has adequate resources to meet its objectives and offers value for money

• The service has a commitment to effective partnership practice

• Services provide good staff development & support

Intervention Principles

• The service is 'whole child' focused

• The service is accessible and attractive

• Services are integrated

• The service is responsive to need and effective

• The service works in a way that is collaborative and strengthening

• The service is culturally competent

• Staff are interested and able

Good Practice Principles at Management Level

Adhering to the following principles can help an agency or service to create an environment in which effective intervention with children and families can take place.

1.   A range of services is available, targeted at different levels of need, within a framework of prevention:

The effectiveness of child and family services is likely to be enhanced if a strategic approach to the development of child and family services is adopted, which makes explicit the agency's underlying assumptions about levels of prevention, using a theoretical framework such as the Hardiker or Little and Mount models outlined earlier. Such a framework can assist the linking of practice to the broader policy and legislative agenda and helps to ensure that strategic decision-makers, as well as practitioners, are clear about the levels of prevention at which the service is operating (Higgins, 2000).

The framework should incorporate support for services at the various stages of problem development, demonstrate how linkages and referrals occur between child protection services and preventative services and outline how the various sources of support can best be mobilised in a way that delivers accessible, integrated and effective services.

A strategic framework for service delivery should incorporate a 'mixed economy of help' for parents (Riordan, 2001), that has the capacity to blend a mixture of formal (statutory and voluntary organisations) and informal supports (family, friends, neighbours, communities, churches and other local networks).

2.   Services have clear objectives and a management and organisational culture that facilitates their achievement.

Clearly stated aims and objectives, which the organisation has the capacity to achieve, are one of the criteria for ensuring a quality service (Pugh, 1999).   Fahlberg (1993) makes the point that most agencies have a clear list of the services they provide – such as child protection or respite care. Few, however, have a developed a philosophy that provides a sense of direction for the types of interactions, as opposed to the types of services.   A strong agency philosophy helps to unify administration and project staff and provides guidelines for the staff-client relationship.

Organisational and management culture should reflect the service philosophy. Whittaker (1997, p.137) asks 'can we practice family empowerment / family support in an organisational structure that is top down, non-reinforcing, uncommunicative and sexist?' The answer is clearly no, requiring models of organisation that support and nurture the kind of values embodied in the service philosophy.

For example, studies have shown that children's homes which helped children more than others were those with clear goals and a cohesive staff group operating to openly shared aims (Whitaker et al., 1998). Sinclair and Gibbs (1998) found that residential homes where staff are on good terms with each other and agree on the homes' philosophy of care are among the factors that make it easier to establish reasonable order.   They also found that heads of homes with a thought-through philosophy for dealing with family relationships were more likely to have residents whose relationship with home improved.

3. The service has a culture of learning and development

Canavan and Dolan (2000) make the point that there is no one family support approach that will be successful in all cases. Different contexts will require specific responses and therefore, for successful family support intervention, a guiding principle of continuous innovation, evaluation and research should apply.   This can be a time consuming process, as Pinkerton (2000) highlights - it can require patience over hours, weeks and months from an individual worker and consistency over years from a service. Improvisation and experimentation with new approaches, including learning from users, also involves taking risks and learning from the experience.

Research and evaluation are crucial elements of a learning and development culture, helping to ensure that resources are deployed in a way that best serves the needs of the client group and offers value for money. There should also be mechanisms for staff, service users and other interested parties to provide feedback on service performance on an ongoing basis.

It is also important for staff to have clearly documented policies and procedures describing how the service will approach key service delivery issues. Practitioners and their managers must ensure that practice and its supervision are grounded in the most up-to-date knowledge and that they make use of relevant research findings, local statistical data, national policy and practice guidance, evaluation, inspection and audit reports and lessons learned from inquiries and reviews of cases of child maltreatment.

4. The service measures outcomes

A culture of learning and development must prioritise the measurement of outcomes. Service delivery must be linked to concrete change and positive outcomes in the lives of children and families, which highlights the importance of measuring outcomes (Higgins 2000). Interventions should be planned and delivered in a way that facilitates ongoing and systematic evaluation, which may lead to the culling of practices if their outcomes do not hold up under evaluation.

5. The service has adequate resources to meet its objectives and offers value for money.

Daro & Donnelly (2002), reflecting on some of the lessons learned from decades of prevention work in the USA, comment that some agencies have focused on breadth of services rather than depth.   In a rush to develop a greater number of services, too little attention was paid to ensure that programmes have adequate paid staff, sufficient partnerships with other key service providers and a service engagement process that potential participants find sufficiently attractive to accept and remain in services. This emphasises that quality prevention work, whether reactive or proactive, requires adequate resourcing.

Value for money is also an important criterion in the development of good quality services. Essentially it means that public resources are being put to the most effective use possible. This is not to say that services cannot be expensive, but that the investment of resources results in the delivery of a quality service. Other good practice principles, such as a strategic framework for service delivery, a culture of learning and development and integrated service provision, can help an agency or service to achieve value for money.

6.   The service has a commitment to effective partnership practice

A commitment to partnership practice underpins all Irish child care policy and legislation, including the Child Care Act (1991) and the National Children's Strategy. Partnership in this context has two key dimensions; the relationship between the service and families, and the relationship between agencies and disciplines engaged with a role in helping to meet the needs of the family. With regard to the former, effective partnership practice involves a commitment to the provision of information, practical arrangements and emotional support to parents engaged with services, as well as formal mechanisms to enable the input of children and families into the design, delivery and evaluation of service provision.

In order to provide integrated and user-friendly services, professionals from a range of agencies and disciplines must work in a co-ordinated way in response to assessed needs.   One factor that works against the development of family-centred service provision is conflict and lack of communication between professionals from different agencies and disciplines. As Jordan (1997) states, despite the rhetoric of partnership, conflict is endemic in inter-agency work where some professions are more powerful than others and because of poor communication between members of the professional network. It is important for each member of the expert system to share goals, make explicit assumptions about what is being attempted, through what practice model, and how realistic are such goals, given the resources and philosophy of each agency (Ferguson and O'Reilly, 2001).

7.   Services provide good staff development & support

Staff and volunteers can only be expected to work in an empowering fashion on behalf of an agency if it is in keeping with their own experience as employees (Pinkerton, 2000). Staff support and retention is important in child and family services because it takes time for clients to develop relationships with key workers in frontline services and the work is more likely to be effective if there is a good level of trust established. The work can be very challenging, especially in settings such as residential care. Organisations must have the capacity to support staff as individuals with personal, professional and training needs and offer them a humane and family friendly workplace from which to work. It is also important that reasonable steps are taken to create a safe physical environment for staff and clients.

An integrated, well-trained staff team can also have a positive impact on morale, increase the support network of staff and be a forum to facilitate the emergence of new ideas and approaches.

Good Practice Principles at Intervention level

There are a number of factors at the interface between service users and services that affect whether the service will have the positive outcomes intended for it by management. These principles relate to how people are engaged with and view the service, and its capacity to work with them to achieve positive outcomes. As we have seen, a supportive culture at management level and a commitment to good practice is needed to enable the service to adhere to these principles.

8. The service is 'whole child' focused

Numerous research studies have called for an integrated model of childcare dedicated to the promotion of safety, welfare and healing of the 'whole child'. Buckley's (2003) research into child protection practices found evidence that the child protection system defines children's protection and welfare in terms of future risk and past incidences rather than their current emotional and psychological well-being. Moreover, childcare needs tend to be defined in terms of agency functions and categories, rather than needs of the child. The whole child perspective, according to Daro and Donnelly, (2002, p.739) offers the hope that: ' ….parents will understand that their child's ability to develop to his or her full potential depends not only on their actions as parents but also on the supportive efforts of others such as school teachers, coaches, ministers, youth leaders and parents of their children's peers'.

The National Children's Strategy advocates the adoption of a 'whole child approach'. Its three national goals are that children's lives will be better understood, children will receive quality supports and services and that 'children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity'. To achieve this goal, age, gender and culturally appropriate methods for ascertaining the wishes and feelings of children and of understanding the meaning of their experiences to them should be used (Department of Health, UK, 2000). Children's views as to what information will be used and in what manner also need to be respected.

9. The service is accessible and attractive

Early intervention and preventative services are the building blocks of a healthy and safe environment for children. For families to engage with services voluntarily, it is important that services are accessible and attractive. According to Gilligan (1995), family support services should be responsive and accessible and connect with families when they need the support. They must be low key, local, unfussy and 'user friendly'. Families should perceive the support as enticing and attractive and they should be left with a clear sense of benefiting. The issue of accessibility also applies to alternative care services. Families in O'Connor's (1995) research highlighted their difficulty in visiting their children and maintaining a role in their lives if they are in care away from home.

As well as the issue of accessibility, how clients perceive the physical and social environment of services affects their willingness to engage with the service. For example, the more trendy and 'cooler' the service in the eyes of young people, the more they will be prepared to access it (Osborne, 1999).

In working with parents, child care and family support services tend to work predominantly with mothers or female carers. There are few strategies and interventions to involve and support fathers / male carers.

McKeown (2001) suggests that the low uptake of services by fathers may indicate that they are not appropriate to their needs, so it is important to find out what the needs of fathers are. A possible solution is that services undertake an audit of existing attitudes to the involvement of fathers in the service and develop a concrete strategy for father involvement; which includes:

- creating a father friendly environment,
- recruiting men to work in the services as both volunteers and staff,
- designing and delivering programmes of shared and separate activities for fathers, mothers and children as appropriate,
- sustaining fathers' involvement through positive feedback, regular reviews of progress, cultivating leadership and building networks.

10. The service is integrated

Delivering services that are family centred requires that they be integrated and sequenced according to the developmental needs of the child and family. Yoshikawa (1994) suggests that it is not the number of services offered to families that has an impact on family wellness and child maltreatment, but the way the components are integrated and sequenced. MacLeod and Nelson (2000) found evidence to support the role of multi-component programmes, such as family resource centres, in providing integrated and sequenced responses to the needs of children and families at different stages of their developmental pathways.

There has been a tendency for programmes, agencies, disciplines and departments to function in isolation, even when multiple agencies work with the same family. This has resulted in service inefficiencies and costs, and confusion on the part of families about who was doing what and why. Integration does not automatically improve services, but it can be a facilitator of improved quality if it is used to deliver services in a more 'useful' way. As Knitzer (1997) points out, the most crucial test of service integration is how the family experiences the help offered. Models of integrated service delivery should be the norm, rather than 'isolated pockets of excellence' within a context of traditional structures and policy.

11. The service is responsive to need and effective

Plans and interventions should be based on a clear assessment of the developmental progress and difficulties a child may be experiencing and ensure that planned action is timely and appropriate in terms of the child's developmental needs (Department of Health, UK, 2000). For example, the early years are vital to physical and speech development and to the development of strong attachments.

In making an assessment of a child's needs, a profile of the individual child, the adults who determine their upbringing and the social environment in which they live must be taken into account. As Seden (2002) stresses, the course of action decided on will be the result of a careful analysis and judgement about the interactive dynamics of these three constituents. Pinkerton (2001) makes the point that those looking for a service should not be placed into set, routine categories. While some degree of consistency and categorisation may be necessary, needs boxed in this way are needs only partially understood.

It is important that staff identify the deficits in assessing a family situation, but also make a realistic and informed appraisal of the strengths and resources in the family and the relative weight that should be given to each. These can be mobilised to safeguard and promote the child's welfare.

Staff should be able to elaborate the logic of the chosen intervention, relating it to a theoretical approach where possible. This is not to suggest that there should not be room for innovation and experimentation. If staff understand the reasons for the chosen approach, can critically assess its outcomes and can explain why a certain intervention or approach has been chosen, it is likely to be more effective.

12. The service works in a way that is collaborative and strengthening

Delivering services that are family-centred and family strengthening represents a change from the traditional model of service delivery, wherein professionals are experts and families are clients. Involving parents in service concept, planning, delivery, management, monitoring and evaluation can yield positive results, as can involving parents as collaborative partners in determining the types of interventions they themselves receive. Interventions should address the family's definition of the need or problem concerned and make sense to the target users (Gilligan, 2000). Interventions should draw upon parent's existing knowledge and experience and recognise that many parents, regardless of socio-economic environment, are competent and effective caregivers (Riordan, 2001). As well as being a core element of family support practice, residential and foster care principles also emphasise partnership with parents and continuity of experience and identity for children (Chakrabarti and Hill, 2000).

MacLeod and Nelson (2000), in a review of 56 programmes, found evidence to support the view that an empowerment approach is critical in interventions for vulnerable families. A strengths perspective shows how the practitioner can work positively towards partnership, by building on what parents already possess. Key elements are; giving pre-eminence to the client's understanding of the facts; believing the client; discovering what they want; using understandable language; avoiding blaming; reaching a mutual agreement and making assessment a shared activity (Saleeby, 1997, pp. 3-17). In a residential care context, parental involvement can take place at intake, through sharing information, clarifying expectations and developing a plan; treatment – through contacts routines, training, and support and finally; through preparation for the child leaving care and aftercare (Smit and Knorth, 1997).

Chakrabarti and Hill (2000) suggest that a persistent orientation by staff to inclusion of parents and other family members is needed. This requires support in agency policy and in the unit's stated objectives, with management and front-line staff negotiating a shared approach. Training, support and role clarity for staff are important to enable them to undertake planned and consistent support for families. While this point is made in relation to residential care, it can equally apply to other services.

13. The service is culturally competent

Since discrimination of all kinds is a reality for many children, agencies responses should not reflect or reinforce that experience – in fact they should counteract it. Knitzer (1997) refers to a concept known as cultural competence – delivering services in a way that is respectful of the cultural values and traditions that families bring with them. As well as upholding the human rights of all clients, the emphasis on cultural competence reflects the recognition that, unless services are sensitive to the culture and traditions of consumers, they are unlikely to be effective.

Samantrai (2004) suggests that cultural competence includes acknowledgement and acceptance of cultural differences, and equal respect for all cultures. Workers should understand how culture has shaped their own values, practices and beliefs and have a basic understanding of the client's culture and the dynamics of 'difference' and power in helping relationships. The skills of cross-cultural communication, engagement, interviewing and assessment are also important.

Equality proofing of services raises awareness of how they may be excluding certain groups and can highlight where there may be a need for tailored or additional services. The nine grounds on which discrimination is unlawful under the Equal Status Act (2000) are gender, marital status, family status, age, disability, race, sexual orientation, religious belief and membership of the Traveller Community.

14. Staff are interested and able

Service users can tell if a staff member or volunteer is genuinely interested in their welfare and this is likely to affect their relationship and ultimately the outcomes of the intervention. McKeown (2000) points out that in therapy, the quality of the client-therapist relationship is one of the key factors influencing success. Some of the characteristics of the therapeutic relationship - emotionally warm, available, attentive, responsive, sensitive, attuned, consistent and interested – are applicable to staff working in child and family services.

Riordan (2002) highlighted the personal qualities and characteristics of project staff as a key strength of the Teen Parents Support Initiative. Young parents suggested that staff need to be friendly, easy to talk to and good listeners, down-to-earth, non-judgmental, helpful, with a wide range of knowledge on relevant topics, and trustworthy. Similarly, one of the messages from Sinclair and Gibbs's (1998) research in residential homes was that adults should listen harder, pay attention to the things that trouble young people and recognise and encourage those activities in which they take pride. Staff and services should also be there for the long haul, willing to stick with a child or family through thick and thin.
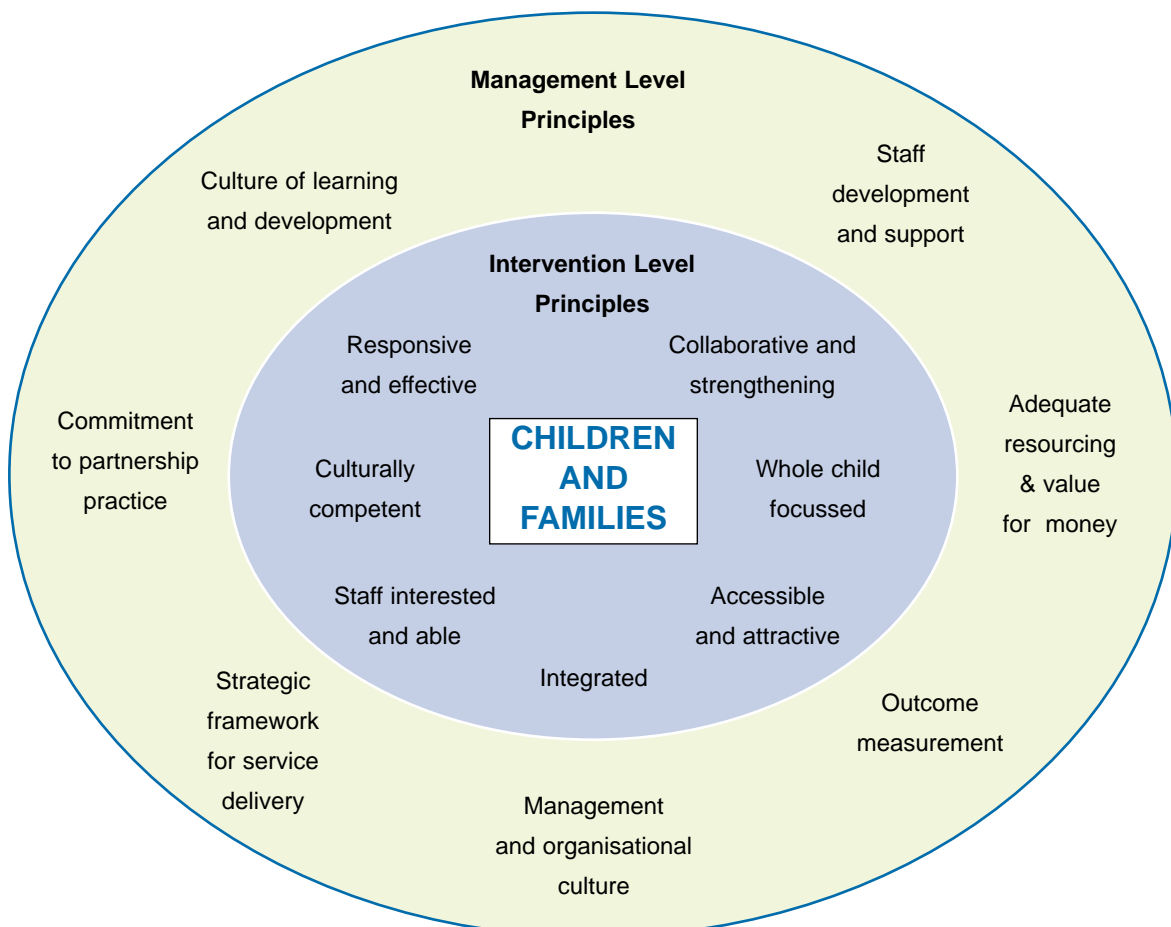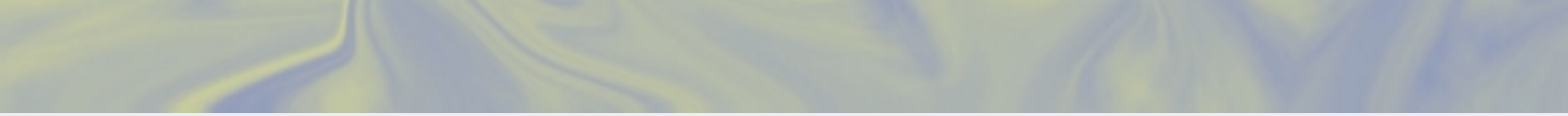
Towards a model of good practice….

The development of good practice in child and family services is informed by a set of core concepts that have emerged from theoretical and empirical research. Knowledge and understanding of these concepts is important for all staff involved in child and family service provision, be it at intervention, agency or policy level. The ultimate test of any intervention or service is if it achieves positive outcomes in terms of the welfare, safety and development of children and their families. This is the measure against which good practice development must be assessed.

In relation to practice, a distinction can be made between principles that guide service delivery at management level and at intervention level. The intervention level principles, such as staff interest, accessibility, integration and cultural competence, are important but they cannot exist in a vacuum. They are dependent upon a service and agency environment that creates the climate in which these principles can be effectively put into practice. Conversely, neither will a 'perfect' agency or service climate produce good practice if the principles at intervention level are not adhered to.

The model below brings together management and intervention level principles in a single system, built around the needs of children and families at its centre. It highlights the interrelationship between the principles both within and between levels and provides the backdrop against which the interventions profiled in Section Three can be considered. In Section Four, we highlight a number of examples drawn from the profiles to illustrate more explicitly how these principles are manifest in practice.

Principles of good practice in child and family services

Management Level Principles

Culture of learning and development

Staff development and support

Intervention Level Principles

Responsive and effective

Collaborative and strengthening

Commitment to partnership practice

Culturally competent

CHILDREN AND FAMILIES

Whole child focussed

Adequate resourcing & value for money

Staff interested and able

Accessible and attractive

Integrated

Strategic framework for service delivery

Outcome measurement

Management and organisational culture

SECTION 3

Profiles of Child and Family Interventions

Introduction

This Section describes twenty-six current child and family interventions and services. As outlined in the Introduction, the information was supplied by Health Boards, who were asked to nominate models that they experienced to be good practice. In profiling the models, particular reference is made to aspects of the intervention that practitioners have found to work well. The intention is not to portray these services as ideal embodiments of the good practice principles just outlined, but rather to give a flavour of current strategies, actions and approaches. In Section 4, aspects of all the profiles are discussed in relation to the principles of good practice.

For presentation purposes, the profiles have been separated into eight categories that describe a central focus of the intervention. Common features and approaches from each of the categories are summarised at the end of each section. These eight areas are:

1. Early childhood development
2. Parent support
3. Community based family support
4. Work with 'at risk' young people
5. Therapeutic approaches
6. Promoting partnership
7. Work with children in care
8. Policy and service development

It will become apparent to the reader that the categories are not mutually exclusive. For example, services that offer community-based family support also offer early intervention, social support and therapeutic approaches. Early childhood development services have a strong focus on parent support. Likewise, promoting partnership is something that is not confined to the three profiles in that category, but it is a common feature across the range of models. The categorical division is used to emphasise and clarify particular approaches and aspects of the interventions, in order to make it easier for the reader to relate to and make sense of the breadth and diversity of information.

Contact details for each of the organisations is listed in Appendix Two.

Profiles included under each category are as follows:

1. Early childhood development

Three profiles of intervention with children and parents in the early years are:

• **Kilkenny Community Early Years Project** provides quality childcare to help break the cycle of disadvantage for pre-school children in Kilkenny city.

• **Sligo Family Support** promotes early childhood development and parent support through home visiting (Lifestart) and centre-based activities in Sligo town.

- **The Marte Meo Project**, Dublin 7 uses a therapeutic approach to strengthen parents' capacity to promote child development and build relationships.

2.   Parent support

Strategies to enhance parental capacity through social support are the focus of the three profiles in this category:

- **Home-Start,** Tullamore, Co. Offaly matches the skills and interests of volunteers to the needs of isolated families with its home visiting programme.

- **The Post-Natal Distress Group**, Tallaght, Dublin was a pilot initiative that sought to mobilise peer support to help women cope with post-natal depression.

- **The Mid Western Health Board** developed a universal strategy for parent support to meet parents' support and information needs 'from the cradle to the grave'.

3.   Community based family support

These four profiles relate to the work of community based family resource centres:

- **Whitefriar St. Community Education and Development Project**, Dublin 2 is a community education project providing education, childcare and developmental opportunities to an inner-city community.

- **Geraldstown House,** Ballymun offers a holistic response to the needs of children, adolescents, adults and families, through group work, education, social support and other means.

- **The Family Resource Centre**, Tallaght is a preventative social work service that works on a pro-active basis in a community setting with vulnerable families.

- **Muirhevnamor Springboard Project**, Dundalk is a community based Springboard project working closely with schools, community and families to develop an integrated response to family needs.

4.   Work with 'at risk' young people

These four services provide a diverse set of interventions targeting 'at risk' children and adolescents.

- The **'Big Deal' Contract** - Westside Community Services, a Galway-based Springboard project, developed this child-led approach to dealing with difficult behaviour.

- **Gorey Youth Needs Group**, Co. Wexford, as well as its core youth work services, works with home, school, community and state agencies for the benefit of young people at risk.

- **The C.R.I.B Youth Project and Café** in Sligo town, offers universal and targeted services to young people.

- **Granard Action Project**, Co. Longford is an example of a family support service working with children and young people in a rural town.

5. Promoting partnership

The three profiles in this category are pro-active regarding the development of partnership with service users.

- **The Family Welfare Conference Project**, Dublin mobilises the support of the extended family to develop a plan for family support.

- **The Family Rights Group**, Limerick was established by the Mid-Western Health Board to address the powerlessness of parents who have children in care.

- **The Western Health Board** developed a strategy to promote parental participation at child protection conferences.

6. Therapeutic approaches

Two examples of therapeutic approaches used in child and family interventions are:

- **'Back to Basics'**, Midland Health Board is a social model of occupational therapy / speech and language therapy for children with autism and their families.

- **The Integrated Model of Self Regulation** (IMSR) for children in care, NWHB, Donegal has been operational for more than two decades and combines sensory integration with attachment theory.

7. Work with children in care and aftercare

The four profiles in this section relate to assessment of children's needs, approaches to working with children in care and a model of aftercare support:

- **The Airne Villa Resource and Assessment Unit**, Co. Kerry is an example of a dedicated unit that assesses the needs of children entering care.

- **The Amiens St. Childcare Centre**, Dublin has several decades experience of caring for children in their own community, while maintaining the child's links with home, community and their sense of identity.

- **Gleann Alainn**, Glanmire, Co. Cork uses a behavioural approach to deal with difficult behaviour.

- The **Aftercare Programme** was developed by the Mid Western Health Board to provide planning, support and guidance for young people leaving care and includes a supported lodgings scheme.

8.   Policy and service development

This final set of profiles relate to Health Board policy initiatives designed to develop more effective service provision.

- **The Children Services Forum**, Carlow is an inter-disciplinary South Eastern Health Board initiative developed to tackle the issue of non-attendance at early years services and generally improve the co-ordination of such services.

- The North Eastern Health Board strategy in relation to developing a comprehensive **Family Support Policy Framework** is outlined.

- **A Quality Management System**, accredited by ISO 9002 was implemented by the Roscommon Social Work Team of the Western Health Board.

1. Early Childhood Development

'Just as early insults may have long-term effects, early interventions enable children and young people to accrue some of the social capital needed for good long-term outcomes' (Roberts and McDonald, 1999).

McCain and Mustard's research (1999) found that the nurture, care, nutrition and stimulation received by a child from their parents (or primary carer) is a key factor in the child's development, regardless of their socio-economic group. The way parents care for their children, teach them skills and values, and guide them in their encounters with the world outside the home lays the foundation for childrens' later emotional, social and intellectual development (Riordan, 2001). Not surprisingly, therefore, a growing body of research evidence suggests that intervening with parents and children in the early years can be very valuable in terms of stimulating children's intellectual, physical and social development (Johnson et al, 2000; Ghate et al, 2002). Some of the areas of intervention, identified as effective by Roberts and McDonald (1999), include:

Education – A number of US and UK studies have demonstrated the value of structured, participative pre-school programmes. These programmes, such as the Perry Pre-school, High Scope and Head Start Programmes, combine a variety of methods – high quality day care incorporating aspects of pre-school education, parent education, home visiting and other methods to improve outcomes. Evaluations showed that children who attended these programmes had significantly better outcomes than those who did not - for example, better academic achievement, less teenage pregnancy rates, higher earnings later in life (Yoshikawa, 1994; Hertzman and Wiens, 1996).

Physical Health - Children born into poverty are at considerably heightened risk of poor health. Therefore, optimising growth and development before birth and in early childhood is an important goal for intervention.

Social Support - Research into social support interventions for new mothers, including home visiting, has shown positive results in terms of parenting behaviour compared to parents who did not participate in the interventions. MacMillan et al (1994) concluded that long-term home visiting was effective in the prevention of child physical abuse and neglect among families with one or more of three risk factors; single parenthood, poverty and teenage parent status.

Parent Training - Training for parents can emphasise the importance of establishing the ground rules and boundaries of acceptable family behaviour, help parents to acquire an understanding of what they can reasonably expect from their children and teach parents to give clear, unambiguous instructions to children.   In general, studies indicate that parent training has good results with a wide range of child behaviour problems and can form an important component of community based approaches.
In an Irish context, evaluation of the Teen Parents Support Initiative showed that the project, which assessed and responded to the needs of young parents was successful in helping them with parenting, helping them as young adults and in making their lives better (Riordan, 2002).

McKeown (2001) highlights that home-based early intervention programmes for vulnerable families can reduce the barriers to service provision that arise due to childcare, transport or motivation and provide a source of social support to the parent and family. The Eastern Health Board's Community Mothers Programme, which is based upon a sharing of experiences between the parent and the home visitor, called a Community Mother, was considered by evaluators to be 'sound, practical and effective' (Johnson

et al, 1993). As a result of the programme, children were more likely to have received all primary immunisations, to be read to daily and to have a better diet.

The profiles in this section are examples of early intervention services in an Irish context that aim to improve developmental outcomes for disadvantaged children. The services profiled all undertake education, health promotion, social support and parent training, albeit in different contexts and using different approaches. **The Kilkenny Community Early Years Project** promotes early years development through provision of a community based pre-school childcare facility. **Sligo Family Support** strengthens parents' ability to facilitate their children's development in the early years through a home visiting and parent education service. Both of these services have also evolved into broader family support provision, in response to the needs of parents and children. **The Marte Meo Project** in Dublin 7 also works through home visits to enhance parent-child communication and raise awareness of the child's developmental needs.

Quality childcare to help break the cycle of disadvantage: Kilkenny Early Years Project

South Eastern Health Board

The Kilkenny Community Early Years Project (KCEYP) opened in 1996 as a cross-community childcare project, targeted at families in five disadvantaged areas in Kilkenny city. The project is guided by childcare and family support principles, endeavouring to support children and their families to develop skills that will help them to break out of the cycle of poverty. It is managed by a partnership of statutory, voluntary and community representatives.

The KCEYP is a high quality childcare facility with a weekly attendance of 23 pre-school children. Participants are children who, due to adverse personal or family circumstances, would benefit most from the experiences of an early years project. Participants are selected from Health Board, community and self-referrals, with one third of participants coming from each source. The length of service provided to each family averages two years. The full day pre-school caters for children aged 2-6 years, from Monday to Friday and a hot meal is provided at lunchtime (by meals on wheels).

The project places a strong emphasis on the achievement of high standards of quality childcare provision. It operates as a child-centred facility where the needs of each child are paramount. The curriculum is planned with all aspects of development in mind and with a strong emphasis on play. A key worker is assigned to each child. At least 4 workers are on the floor with children at any one time, as some children need one-to-one work. Children's progress is monitored on a continuous basis and discussed at team meetings.

As well as providing childcare, the project supports children and families in a number of other ways. Active parental involvement in the project is encouraged and parents are facilitated to identify and meet their own needs, to join groups in their own communities, undertake education and training or access employment. The KCEYP has recently employed a liaison person to provide a link between the home and the project, with the aim of providing continuity between the support the child receives at the project and in the home – for example in relation to toilet training, speech therapy or nutrition. It also enables the project to be aware of the family's needs so that it can support them as best they can, using both their own resources and linking the family into the wider statutory and community supports. For example, if a parent is going through a stressful time, the project can offer extra childcare hours to give them respite. Having worked in the project for many years, the liaison worker is well placed to undertake this work, as she has a strong relationship with many of the families.

The project recognises that the provision of quality childcare is just one element in an integrated approach to breaking the cycle of disadvantage. Thus, it ensures that there are inter-project links and structures between community facilities and other projects targeting similar groups.   There is close co-operation with health professionals such as social workers, speech and language therapists, public health nurses and psychologists, thereby ensuring that children's needs are addressed at as early a stage as possible and that follow-up support is provided to the child and family to maximise the effectiveness of these interventions. Three-way meetings between the social worker, parent and the project staff have proven to be a very supportive and successful means of working with vulnerable families.

Partnership with parents is key in all the work of the project. Bi-annual meetings are held for parents to discuss their child's progress in the pre-school. The parent is recognised as the primary educator and the project works in equal and respectful partnership with parents in supporting their child's progress. Events like birthdays, weddings and festivals are celebrated by staff, children and parents together.

Some of the outcomes of the project are:

- Staff and parents can see progress in children's development from when they first come to the project. Regular progress reports on each child help to assess their overall development.

- Parents have been supported to deal with stresses in their lives and find solutions to issues and problems.

- Parents have been facilitated to participate in VTOS and other education, training and employment through having support with childcare.

- The project has been a resource and a model to other community childcare facilities in the county and beyond.

KCEYP identifies the following strengths in its approach:

- High quality childcare is provided for children.

- There is close attention to and monitoring of children's developmental progress.

- The project demonstrates respect for and partnership with parents.

- Home-project links ensure that the child's needs are understood and addressed in the context of his / her family.

- There are strong linkages and referrals with statutory and community services.

- The project benefits from its accessible location in close proximity to education and development services.

- There is an openness to sharing learning and networking with other childcare and family support projects.

Early intervention through home visiting and centre-based activities
Sligo Family Support Ltd.

North Western Health Board

The mission of Sligo Family Support is to educate and empower the parents of children from birth to age five so that these children are enabled to reach their full potential. It was established (as Lifestart) by a Mercy Sister, who, as a result of her teaching experience in junior primary school, identified a need for a parent education and early intervention project in urban Sligo.

While the Sligo Family Support model of early intervention involves the provision of pre-school, full day care, out of school and drop in childcare facilities, the core element of the approach is a Lifestart home visitation child development support programme. Over 300 families are visited each month by a Family Visitor, who introduces the developmental issues arising within the month that are relevant to the child's age. The family visiting service is available in Sligo Town's north, west and east wards. In the east ward (an area of higher socio-economic disadvantage), it aims to reach all mothers and in the north and west wards, all first-time mothers. Mothers are referred by Public Health Nurses and over 95 per cent avail of the service. The project recently adapted the parent education materials for use by Traveller families.

The home visiting programme is complemented by activities at the centre, which is conveniently located in the grounds of a local primary school. An affordable, quality childcare service is provided for 46 children, including full day care, pre-school, out of school and drop-in services. Parents can meet at the Lifestart centre to get a break from parenting and participate in courses, which promote self-awareness and social and personal development. Public Health Nurses from the North Western Health Board facilitate sessions on health and social issues. A community outreach programme brings the parent and child programmes to parents in outlying areas, for whom the centre is not so accessible.

An evaluation of the home visiting service in 2003 found the following:
- The majority of parents felt that the best aspect of the service is the one-to-one visit of a supportive, non-judgmental and experienced mother.

- 94 per cent use the programme materials, 'The Growing Child', and find that they are accurate and realistic in terms of their child's needs.

- Mothers find that the family visiting programme benefits their child directly through the suggestions for play and activities, as well as the indirect benefits of their being calm, relaxed and knowledgeable about child development.

- There were differing perceptions about who Lifestart is 'for'. Some parents felt they were targeted because of their disadvantaged status. As the visiting service extends beyond areas of disadvantage, the evaluation concluded that there may be merit in promoting the service more visibly as being 'accessible to all' to prevent any possible stigma.

The Sligo service identifies the following strengths in its approach:

- Home visiting has been proven as an effective strategy for social support and parent education.

- The centre-based child care and family support services add value to the home visiting service by providing a social and educational outlet for parents.

- The composition of the management committee reflects a broad range of relevant skills and the participation of parents ensures that services are in direct response to needs.

- Collaboration with the NWHB Public Health Nursing Service helps to ensures that Sligo Family Support services are complementary and relevant.

- Lifestart staff are trained to a high standard and are committed to their work. Family friendly working arrangements are promoted by management.

- The project involves a number of volunteers, harnessing their contribution and representing good value for money.

- The project aims to respect cultural diversity, as seen in their adaptation of material for Traveller families.

Strengthening Parent-Child Communication
The Marte Meo Project, Dublin

Northern Area Health Board

The Marte Meo Project provides training and clinical supervision in the Marte Meo method for health professionals within the three area heath boards in the Eastern region, who have been using the Marte Meo method since 1995. This case study refers to Area 7 of the Northern Area Health Board, where there are currently 35 public health nurses (PHNs), 30 social workers, 12 family support workers and 1 community Marte Meo Therapist involved in implementing the programme.

The words Marte Meo are derived from the Latin "Mars Martis" to express the idea of "on one's own strength". The Marte Meo method is a video-based interaction programme that provides practical information on supporting the social, emotional and communication development of children, adolescents and adults in daily interaction moments. It is mostly used with children under three years, but can also be used for older children or a child returning home from care.

Public health nurses and social workers refer vulnerable families to the Marte Meo therapist. After discussing the approach with the therapist, the family can choose if they would like the intervention. As a basis for the work, the therapist focuses on a specific problem or question that is raised by the family. A ten-minute film is made of the family in an everyday situation (for example, mealtime or playtime) that shows how they are currently dealing with the specific issue. The film is reviewed with the parents, during which time problems are re-presented as opportunities for development.   This process is repeated until intervention is complete. The family completes an evaluation form and a follow-up session is held after three months to see how the family is progressing.

"It made me realise I can make everyone's life a lot easier in the home"
> *Quote from a parent who participated in the intervention.*

The Marte Meo Project also provides training in the method to child care workers, residential care staff, family support workers, public health nurses and social workers, which ensures that there is continuity in the approach of professionals and families to promoting the development of children in everyday situations.

'One of the things I found most surprising was that how you deal with situations in small ways can completely change the outcome of a situation…. seeing the children and staff on video highlighted all the positive things that the staff do, while giving simple things that we can do to improve our relationships with children'.
> *Quote from a child care worker who completed training in the Marte Meo method.*

Some of the outcomes of the project are:
- Families who completed the programme reported that changes in patterns of communication have taken place in their families and that their well-being is better than before they started the programme.

- In their work with vulnerable families, family support workers have become more aware of ways to strengthen the parent-child relationship and avoid taking action that may inadvertently be disempowering for the parent.

- Public health nurses have welcomed having a solution-focused rather than a problem-focused approach in their work and having an established framework for identifying risk.

Staff of the project feel that its key strengths are as follows:
- As a solution-focused method, it starts where the family is at and seeks to build upon their strengths to support their children's developmental needs.

- It is a home-based intervention model that can be used with the most vulnerable groups. Members of the extended family can sit in on the therapy sessions, including siblings and grandparents.

- The intervention is preventative as it enables problems to be tackled in their early stages. Risk to children is reduced through addressing current difficulties being experienced by children and families.

- The video-based method is useful for parents with literacy or learning difficulties.

- There is continuity in how the parent, pre-school workers, family support workers and public health nurses communicate with the child, as almost all have been trained in the approach.

- Training in the Marte Meo method facilitates professional workers to analyse and develop their own practice.

- It represents good value for money as it can be implemented by existing staff as part of their work.

Case Study: Marte Meo in Practice

A mother with learning disabilities found it difficult to form an attachment with her first child. The child was placed in care aged three as a result of serious concerns about her care and welfare while living with her mother. On the birth of a second child in a subsequent relationship, a case conference agreed that every possible support should be made available to facilitate the baby to remain in the care of her parents.

It was agreed that a multi-disciplinary approach would be put in place, including the Public Health Nurse, Family Support Worker (both of whom were trained in Marte Meo Methods) and Marte Meo Therapist.

It was clear from the films made by the Marte Meo Therapist that the mother needed basic information at every stage of her baby's development. Eighteen films of the mother and baby were made and reviewed. In this way, detailed and concrete step-by-step information regarding the child's needs (social, emotional, physical, intellectual and language) was transferred to her mother. This was further reinforced by the Family Support Worker who was present at review sessions, and by the Public Health Nurse.

After 14 months, the baby remains in the care of her parents and is of normal development. The multi-disciplinary team involved in the intervention report that there are no concerns about the care and welfare of the baby at this time.

Summary: Common features of the three case studies of early intervention work

Some of the common features of these three case studies in early intervention are:

- The parent is recognised and supported as the key facilitator of their child's development.

- Information about child development is imparted to aid parents' understanding of their child's needs and capabilities.

- An emphasis is placed on strengthening parent-child communication and parenting skills.

- Practice is informed by research and theory.

- The assessment and monitoring of children's progress is undertaken on a systematic basis.

- Proven international models and approaches have been adapted for use in an Irish context.

- Where the home is the primary focus for intervention, complementary services are provided in the community and vice versa.

- There is close partnership with community and statutory service providers.

- Work proceeds from awareness that every child has a unique set of needs and that cultural differences have to be taken into account.

- Services for children are also used as an opportunity to engage parents in developmental activities that can enhance their own resources and skills.

- From small acorns ..... most of the projects started small and developed additional services organically by responding to the needs of service users.

- All recognise the importance of starting where a child or parent 'is at' and working from there.

2. Parent Support

Changes in society have meant that parents often don't have access to a supportive social network of family and friends, and can be quite isolated. Thompson (1995) identifies some of the negative effects of social isolation of parents as:

- Increased loneliness and depression;
- Diminished opportunities to obtain emotional sustenance from others;
- Limited chances to exchange assistance (such as baby-sitting) that reduce the demands of child-rearing;
- Undermined sharing of knowledge about child development and child-rearing;
- Diminished integration into a supportive community or neighbourhood network
- Reduced access to or knowledge of public resources to assist families economically;
- Limited effective monitoring of parenting behaviour;
- Heightened risk of child maltreatment.

Research studies have shown that the social isolation of families can be combated by enlisting the assistance of either formal (e.g. social services) or, preferably, 'natural' helpers (e.g. neighbours, family) in the neighbourhood who can provide affirmation, information and practical help on a long-term basis (Cutrona and Cole, 2000). Such support may also reduce the likelihood of child maltreatment in high-risk families (Gardner, 2003). The functions of social support can be:

1. Emotional sustenance: The sense that one is not alone and that others are emotionally 'on your side' in coping with stress can enhance confidence and provide outlets for the release of tension and anxiety that might otherwise find more unfortunate victims.

2. Counselling, advice and guidance: Support can provide the recipient with guided direction in challenging life events.

3. Access to information, services and material resources: Support agents can act as brokers between the recipient and others who can provide tangible aid.

4. Skill acquisition: Social network members may assist in personal or job related skills, parenting or financial planning. (Thompson, 1995)

In addition, Ghate and Hazel (2002), Gardner (2003) and Dolan and Holt (2002) all highlight the importance of the availability of tangible support as a key resource to successful parenting.

Gardner (2003) in a large study of family support needs in the UK found that the greater the informal support network, the lower the degree of difficulty parents perceived as regards vulnerability, stress and ill health. Conversely, the weaker their informal network, the greater their degree of difficulty. Parents who had a higher level of vulnerability in past life experiences (such as early parenthood, violence) had greater stress and health problems, greater behavioural difficulties in a child and lower levels of informal support.

Frost et al. (1996) in a study of the effectiveness of a Home-Start scheme in England, found that over half of participants saw an improvement in emotional well-being and thought that their informal network had been extended, while a similar percentage experienced a shift for the better in relation to their parenting difficulties. McAuley's (2000) study in respect of the programme in Northern Ireland found similar results. The **Home-Start** programme in Tullamore is a good example of how the isolation of parents can be reduced by offering them the support of a weekly visit from a volunteer, alongside access to a weekly family morning where they can meet other parents. The high demand for the services of the project underlines the value that people place on this type of support.

Social support interventions are also valuable for women suffering from post-natal depression. Sheppard (1994) in his review of research on the subject, found evidence of high levels of depression among mothers with children aged 6 and under; that depression is related to deprivation and social problems amongst young mothers and that depression has an impact on women's child caring ability. Furthermore, there is a close connection between the mental health of mothers and the long-term emotional well-being of their children. He concludes that there is a vicious circle, in which depression reduces the capacity of women to care for their children, and added behavioural difficulties make the problem of childcare even greater. Brugha's (1995) and Dolan's (2000) research on the relationship between perceived social support and mental health also linked the presence of responsive social support to good mental health and improved parenting capacity. It follows that interventions which detect and work with 'at risk' groups of women may not only contribute to prevention or treatment of maternal depression but also enhance their capacity to care for their children. The case study below of the Post-Natal Distress Group, which ran in Tallaght, highlights positive outcomes for the 14 women who took part in a peer support group for women with post-natal depression.

The **Mid Western Health Board Strategy for Parent Support** is an example of a policy initiative designed to harness the contribution of professional and informal sources to meet the information and support needs of parents. It is a universal strategy that aims to address parenting needs on an ongoing basis, with the aim of preventing or reducing the need for intensive support at a later stage of problem development.

Tackling Parental Isolation: Home Start, Tullamore

Midland Health Board

While a child's formative years are vital to their future well-being, parents' ability to nurture their children can be hindered by the stress of sleepless nights, financial worries, relationship problems and the needs of their children. In Tullamore, a large number of young families have moved into the area in recent years. Public health nurses found that many mothers are home alone with their young children, while the father is away long hours at work, and as they are new to the area, they do not have a social network as a source of mutual support. This situation can lead to loneliness and depression, which has a negative effect on the child and family, as well as the parent.

In 2000, a Midland Health Board commissioned parenting study recommended that a pilot parenting support programme be initiated in the Tullamore area. The model chosen was Home-Start, a family support initiative that originated in the UK. Volunteers work alongside professionals, providing emotional and practical support for families with at least one child under 5 years.

Volunteers visit families in their own homes, where they share parenting experiences, listen to, encourage and enable parents. They work on the family's strengths, reassure parents that have challenges in bringing up children and encourage them to use the support and services available in the community.

All volunteers attend an 18-hour preparation course and receive additional information and support to meet needs that develop in the course of their work with Home-Start. The training enables the Home-Start organisers to assess if the volunteer is suitable, while giving the volunteer a chance to see if Home-Start is for them. Volunteers have to have two references and must be reliable. After they have started working with families, volunteers come together every six weeks to share experiences and offer mutual support.

Families either refer themselves to the service or they are referred by a General Practitioner or Public Health Nurse. The Home-Start organiser visits the family to match the volunteer with the family. In less than 10 per cent of cases, the volunteer and family are not suited. The organiser makes a follow-up visit after three weeks and again after three months to make sure that the family is satisfied with the level of service it is receiving. The family can withdraw at any time.

A weekly family morning is run for families who are being visited by volunteers and also for parents who feel isolated and lonely but do not require a volunteer. It is run as a group, not a drop-in and there are a core group of 15 families availing of the service. This has proven very popular and the waiting list is more than double the number of places available.

All Home-Start schemes conform to the 'Home-Start International Statement of Principles and Practice'. Information about parents and families is confidential, to be discussed only as necessary with the organiser in support of the volunteer and to assist the family. Health professionals working with the family are notified when they join the scheme.

Some of the outcomes of the project are:

- An average of 14 families currently receive weekly visits, which has reduced their isolation and linked them in with community services and supports.

- The project has found that the need for social support crosses class and cultural boundaries and there is a huge demand for this type of service. They respond to needs across all socio-economic groups.

- 90 per cent of the referrals are due to isolation and loneliness, which can lead to depression if not tackled.

- Volunteers have derived great personal satisfaction from being involved and many have made lasting friendships with the families they have visited.

Home-Start has identified the following strengths in its approach:

- It is focused on early intervention and parental support, which can prevent serious problems developing for isolated families.

- It is a community owned project that is available to people on a voluntary basis, meaning that the community will decide its success or failure.

- It is cost effective as it matches the skills and interests of volunteers with the needs of families.

- It is a simple model that can be easily adopted by a community.

- Systems are in place to monitor quality and outcomes. Projects must abide by the Home-Start constitution, which is designed to ensure that high standards are maintained.

- Parents who have received support from Home-Start can become volunteers, if they wish to do so.

- Home-Start offers a unique service but also complements professional services, such as public health nursing, social work, general practice and psychiatry. There is good communication between the project and these services. In Tullamore, the Home-Start organiser also works part-time as a Public Health Nurse, which ensures that she has an insight into the evolving needs of families.

Peer Support to Counter Post-Natal Depression: The Post Natal Distress Group, Tallaght

South Western Health Board

A Public Health Nurse working in the Jobstown area of Tallaght found that a significant number of women were suffering from post-natal depression, but often did not recognise it as such. She felt that a system of supporting mothers in the post-natal period was needed. A support group to address the identified need was put in place on a pilot basis. The rationale for the intervention was that group processes and peer support can have a therapeutic effect and that early intervention and treatment can prevent problems escalating.

The Post Natal Distress Support Group was established to:
- Offer friendship, fun and reduce the mothers' sense of isolation.

- Allow mothers to talk through their experience in a group setting with a strong sense of safety in expressing these feelings.

- Validate the mothers' range of emotions and problems, and to reassure them that they are not alone in this experience.

- Refer the women to relevant agencies as needed.

Recruitment - Verbal approaches were made by the PHN to her colleagues, GP Practices, social workers, family resource centres and schools. Flyers were posted in the local shops, churches, schools and community centres advertising the proposed group. Fourteen women were recruited.

Facilities - The group met at An Cosan, a local community education centre and availed of its crèche facilities. five child minders took care of 50 children in total, aged from 3 months to 8 years. A group facilitator led the group for 14 weeks.

Approach - A decision was taken that it should be a closed group from the outset to facilitate group cohesion. A trusting environment was established and a person-centred model of good practice was used. The women followed their own agenda. Self-empowerment was encouraged, which promoted independence and reduced the risk of group dependency developing. Two treats were included – an image consultant and a pampering day with massage and crystal healing.

The pilot initiative had the following outcomes:
- All 14 women completed the programme, with full attendance over 24 weeks.

- Seven women were referred for counselling.

- Participants reported needing less time with GP's and social workers, thereby reducing health costs, both personal and financial.

- The women reported that the group helped them to develop independence, self-confidence and a positive feeling towards themselves and their children.

- A number of women have engaged in further education – including parenting, personal development, computer skills, childcare and addiction studies.

'I used to bottle it all up, now I can let it all out, as a result I'm not exploding at home.'
Quote from participant

The experience of the pilot project is that there is a need for pre-screening of applicants as the degree of need in one or two cases was profound. A subsequent support group was run for another group of women, but without childcare facilities, which had a negative impact on participation.

The SWAHB identifies the following strengths of this approach:
- Early detection of isolation and depression, with ongoing support, reduces the prolonged effects of undiagnosed depression and family stress.

- Positive support enhances developmental progress in the infant and improves parent-child relationships.

- Meets the participants where they are at and goes with their agenda

- Confidentiality and trust are created in a specific healing environment

- Having a balanced, multi-skilled facilitator with a good referral network.

- Childcare provision is crucial to facilitate the attendance of mothers.

- The facilities used, a women's education centre, were attractive and welcoming and enabled women to become aware of other courses and opportunities open to them.

From the Womb to the Tomb: A universal strategy of parent support

Mid-Western Health Board

Focused intervention with parents in the Mid Western Health Board region began in 1992 when the MWHB began piloting a Community Mothers Programme in partnership with Limerick Social Services Council, with support from the Bernard Van Leer Foundation in The Netherlands.

The programme was evaluated in 1998 and subsequently two parallel initiatives linked to the Community Mothers Project were developed. These were the Teen Parenting Project, which became part of a national pilot, and the Parenting Initiative Group, which sought to support parenting in general across the region. In 2003, a universal Parenting Support Strategy was developed by the MWHB.

The Strategy Statement on Parent Support is focused on developing generic parent support as an effective early intervention strategy that will reduce the need for intensive specialist parent support interventions at a later date. It recognises that there is a continuum of need, from generic supports that employ a preventive approach at one end to specialist intensive problem oriented supports at the other.

In order to support parents effectively, generic interventions must recognise that parents are concerned with all areas of their children's lives – health, educational, social, emotional and spiritual. This requires the adoption of a holistic approach.

The goal of the strategy is that all parents will have access to flexible, life long supports in their tasks of parenting. Some of its strategic objectives are:

• Develop information on parenting – including creating a central point of contact on all parenting issues and supports, developing training materials and information for all parents on parenting 0-5 year olds.

• Develop parent support activities and services – this includes recruiting parent support workers and course facilitators, and increasing the numbers of parent support groups.

• Develop a dialogue with parents – structures will be put in place at local levels that encourage parents to exchange information and share their views on parent support.

• Develop effective structures for the implementation of the strategy – ensure that the needs of parents are met throughout all Health Board services, that there is effective inter-agency work and that high quality monitoring and evaluation systems are in place.

• Develop services and models of good practice – evaluate and disseminate results of MWHB models of support.

The initiative is strategic at a regional level and operational at a county level. A full-time co-ordinator has been appointed on a regional basis, while parent support workers have been appointed in each county to implement the strategy in co-operation with local statutory, community and voluntary groups. A regional research and information co-ordinator has been employed to develop leaflets, performance indicators and evaluate the programme.

The MWHB is aware that delivering effective lifelong parent support is highly complex, as it is difficult to achieve and maintain high take-up levels. A key challenge will be to develop agreed and reasonable performance indicators and to quality assure both the strategy and the individual work.

The strengths of the approach, as identified by the MWHB are:
- The strategy represents a positive preventative approach to family support

- Representatives from a range of agencies and perspectives agreed a common vision and strategy for parenting, which while challenging, makes it likely that the strategy will gain acceptance from a broader audience

- Parents are seen as experts and the strategy has a focus on facilitating peer support

- It builds on and complements existing services

- Constant review and feedback will be encouraged from parents

- Research and evaluation were and will be used strategically to develop the service

- It advocates a universal approach complemented by targeted services

Summary: Common features of Parent Support initiatives

Some of the common themes emerging from the three case studies are:

- A recognition that parental isolation and lack of social support can have a negative impact on a family's welfare.

- Facilitating the development of peer networks can be an effective way to support parents and relieve maternal depression.

- Social support services include practical help, emotional and skills support and referral to other sources of formal and informal support in the community.

- Parent support is seen as an essential part of a wider preventative strategy for children and families.

3. Community Based Family Support

Family and community resource centres are designed to provide community-based support for families in disadvantaged areas. The centres are generally universally available to people living in these communities - families are encouraged to drop in and see for themselves if they would find the services of benefit. Whereas such services are universal in that they operate an 'open door' policy, most also specifically target vulnerable families. Typically, community based resource centres provide classes and groups for parents, with childcare provided, to increase parents' skills and give them 'time out' for their own development (Rylands, 1995). They offer information and referrals to a wide range of statutory and community services. Some provide groups, such as pre-school or after-school facilities for children. The Commission on the Family (1998, p.16) stated that the approach of Family and Community Services Resource Centres is '.. empowering of individuals, builds on family strengths, enhances self-esteem and engenders a sense of being able to influence events in one's life'. They conclude that such centres have significant potential as a primary preventive strategy for all families facing the ordinary challenges of day-to-day living.

Four fifths of parents in the 'Supporting Parenting' study (Riordan, 2001) favoured open access support services for parents and children that meet parents needs as defined by parents themselves. On a similar vein, Ghate et al's. (2002) research among parents in poor environments in the UK, found that parents want services that allow them to feel 'in control', meet their self-defined needs and build on the existing strengths of parents and their communities. This suggests that service providers need to consider ways of improving access to support for all parents, regardless of income or family structure. This view was also strongly echoed in 'Investing in Parenthood: The Supporting Parents Strategy' (2002).

Community based family support and resource centres generally embody the aims of family support services, as outlined in the National Guidelines for the Protection and Welfare of Children (1999), including; responding in a supportive manner to families where children's welfare is under threat; reducing risk to children by enhancing their family life; developing existing strengths of parents / carers and children who are under stress and providing an accessible, realistic and user-friendly service. This is done on the basis of early identification of problems, interventions based on accurate assessment of need and due consideration to the views of service users.

By offering a universal service to all families in the catchment area, community-based family resource centres can identify families in need of targeted support, build up trustful relationships with needy families and are well placed to co-ordinate the provision of specialised support to meet families individual needs. Gardner's UK study of NSPCC family projects (2003) found that the majority of parents came to the family support project on a friend's recommendation or by informal contact with the project's staff or users. Through the project, many had obtained confidence and active support to use local resources, including professional help. Professionals said they received more appropriate referrals if they had good links with one another and with community groups. Gardner believes that this important transfer of skills and knowledge between the levels of the support network potentially improves the 'community climate', the safety and supportiveness of the community for children.

Community and family resource centres are well-placed to offer opportunities for parents to engage in personal development, education, job placement and training. Gilligan (2000) points out that parents are likely to be depressed and low on morale if they have no other roles apart from being a parent, and therefore, it is important to enhance the number of identities available to parents with constrained opportunities. Similarly, Featherstone (1999) argues that it is in the interests of good child protection for professionals to help women to develop their own sense of self outside of the lives of their children. Therefore, linking children and parents into community groups and organisations benefits the individual, the family and the community (Weiss, 2001).

Whitefriar St. Community Education and Development Project is a community run initiative that gives parents options to socialise, acquire skills, manage stress, reduce their isolation and become involved in their community, mostly, while having their children cared for in a quality child care facility. Education and training are an acknowledged route out of poverty and community education has proven very successful in providing outlets for people who have had negative experiences in the formal education system.   The project is firmly located within a community development framework, and the principles of open access, self-referral and user participation are fundamental to its approach.

Geraldstown House, Ballymun and **Family Resource Centre, Tallaght** combine a community development approach with a social work model, which encompasses the provision of universal and targeted services. They offer a drop-in service, a range of courses and supports, as well as intensive supports to families in difficulty, both on a group and individual basis.   An important role of these services is acting as a referral source to other services.

The Muirhevnamor Springboard Project, Dundalk offers similar services to the Dublin-based projects, but differs in other ways. It is one of the organisations that make up the national Springboard family support programme and works with families of children aged 0-10 years.

Community education and development in the inner city: Whitefriar St. Community Education and Development Project

South Western Area Health Board

Whitefriar St. Community Education and Development Project is based in Aungier St. in the centre of Dublin, working with a community living in 600 City Council flats and houses. The area experiences the social problems that affect many inner-city areas such as drug and alcohol abuse, poor housing, lack of play areas and insufficient child care options. The project was initially established in 1989 as a facility for young women in the area to meet. The focus of the centre has since broadened considerably, to incorporate a wide range of programmes and activities for all members of the family.

The overall aim of the Whitefriar Street Community Education and Development Project is to empower local people through a process of participation, support and development, to effect change in their own lives, in their families' lives and in the lives of the community. Its objectives are to establish supportive networks (formal and informal), to bring people together to create support and solidarity, release new energy and effect change. The Project takes the clients of the community as they are and not where they might be, believing that 'here' is the only starting point from where we can set out.

The following is just some of the work undertaken by the Whitefriar St Project:

- First Step educational courses have been organised to involve local people in education and training. Participants are encouraged to pursue further studies. The principle of life-long learning is promoted. Courses have included creative parenting, personal enrichment, health, literacy, development through play, food hygiene and cookery. An average of 25 courses a week are run through the centre, involving 250 or more participants.

- Child care is provided to 42 children aged between three months and three years on a daily basis.

- A locally based counselling service has been established, involving four qualified counsellors working with an average of 22 people every week. Much of this work is related to grief, bereavement and loss.

- Participation in the DIT Digital Community Project – which provides state of the art computers on an open access basis for the community and computer classes for all age groups.

- Input into policy development, such as the Dublin City Development Board strategy, the Community Forum and the City Childcare Committee.

- Family outreach workers have been employed with the assistance of the South Inner City Drugs Task Force to work with families affected by drug misuse.

- Courses targeted specifically at men and door-to-door visits to encourage men to attend have yielded positive results in terms of increasing men's participation in the project.

The target area is expanding as new flats (both private and local authority) are being built. While its primary target group are residents of local authority flat complexes and housing estates, the Project encourages people moving into private accommodation to become involved, either as volunteers or participants, in order to encourage community integration. Refugees, asylum seekers and non-nationals account for an increasing number of project participants.

Some of the outcomes of the project have been:
- Quality childcare is provided to 43 children on a daily basis.

- Through provision of childcare services, parents have freedom to attend courses, which has resulted in some taking Junior and Leaving Certificate, while others have progressed to third level education.

- Through many of the project's programmes, people experience befriending and contact, which allows their confidence to develop sufficiently to move towards personal development.

- Participants have assumed leadership roles in the Project and the community.

- The counselling service has helped people to reduce stress, tension and in some cases, reduced dependence on prescribed medication.

The Whitefriar St. Project feels that its approach has the following strengths:
- The Project is child and family orientated and friendly.

- A broad range of options for development are available to people of all ages, which offer respite from stress as well as potential progression routes.

- It is led by the needs expressed by the community and has an advisory group of project participants.

- It is a non-judgmental, respectful place for people of all genders, creed, race or ability.

- High standards are pursued in the management of a quality childcare service.

- The project works closely with statutory and voluntary organisations as part of an integrated response to the needs of this disadvantaged inner-city area.

A holistic response to family needs - Geraldstown House Family Resource Centre

Northern Area Health Board

Geraldstown House is a community-based project in Ballymun, established in 1987, focused on helping vulnerable families and children cope with particular adversities. The aim of the House is to mobilise all resources to facilitate, empower and support families in the many challenges they may experience and bring about meaningful change. This intervention, where possible, aims to keep the family intact and prevent children from entering custodial or residential care. Over the years, Geraldstown House has developed a wide range of initiatives aimed at children, adolescents and adults. Many of the groups offered at the House are in place since the House first opened. Other groups have been discontinued as the focus has always been on meeting the evolving needs in the community.

Current areas of work include:

Children's and teenage groups:
- After school groups aimed at primary school children with an emphasis on life skills, social skills, creativity, teamwork and play.

- Teenage groups: single sex groups aimed at adolescent boys and girls with an emphasis on life skills, social skills, creativity, teamwork and also a focus on Relationships and Sexuality Education (RSE).

- RSE delivery in second-level schools.

Adult groups:
- Parent and child group – focus on support, play and guidance on child development matters.

- Young parents group: provides support throughout pregnancy, support and guidance regarding parental skills and child development matters.

- Health and relaxation for adults.

Multi-agency work:
- Co-facilitating groups with multi-disciplinary teams in primary and second level schools: Working with groups of young people with particular adversities as identified by schools.

Crèche provision:
- Quality child care provision to enable parents to access the above groups.

- Drop-in crèche morning for service users.

Other areas of work:

- **Summer project:** aimed at service users and involves entire families. Parents are involved at a planning level and staff provide training to enable parents to co-facilitate activities.

- **Individual and support work** with children, teenagers, adults and families: This involves focused work on a one-to-one basis or with families around particular issues, court accompaniment and advocacy.

- **Coffee shop:** this is a non-profit making service that offers wholesome food to the adults and young people that use the services.

Features of the model:

The model is based on a social work code of ethics, a community development approach and the Children First guidelines. The team aspires to create a warm, friendly, safe and non-stigmatising environment where participants can become involved at their own pace. The relationship established with users of the service is of crucial importance and is based on respect, understanding genuineness and care. Importance is placed on staff sharing common basic assumptions regarding the work, maintaining a consistent and fair approach and high professional standards. There is emphasis on groups being structured and equal importance is given to planning, evaluation and contact with groups.

Client self-determination is also to the forefront of the approach. Consistent dialogue with and feedback from parents and young people is used to structure the activities at the House. Integral to the facilitation of adult groups is the provision of quality childcare. There is an open and transparent team structure where all team members contribute on an equal footing. Decisions are reached by consensus, which stimulates motivation, fosters a sense of ownership and helps staff feel valued. There is a willingness to question practice and embrace new ideas and staff are involved in ongoing training.

Project outcomes

- Prevention of teenagers entering the juvenile justice system.

- Early school leavers have been supported to return to school or take up alternative further training.

- As a result of participation, users of the service have experienced increased self-worth, empowering them to move into further training and employment.

- Staff and service users have a sense of ownership of the service.

- Children and adults with very challenging behaviour remain engaged with the services and often request additional services.

- As a result of working with teachers in multi-disciplinary groups within the schools, teachers have reported positive changes in teacher-child relationships and improvements in children's behaviour.

- The team established a model of working with early school leavers and the Department of Education and Science has adopted this model for a local project.

- Local schools have requested that staff co-facilitate the Geraldstown House model of RSE delivery with teachers.

- Local schools and voluntary / statutory groups have requested training and support input from the team.

The strengths of Geraldstown House's approach, as identified by staff, are:

- It provides a holistic response to the various needs of children, adolescents, adults and families.

- Groups are initiated and developed in response to the evolving needs of the community and a partnership approach is adopted with participants with regard to programmes and group guidelines.

- There is a common, consistent approach from staff and services are person centred.

- Staff have been invited to share experience and skills through involvement in multidisciplinary groups in schools demonstrating transferability of the model.

- There is an emphasis on quality as opposed to quantity.

- Integral to the model is regular supervision and support for staff on the team.

A preventative social work service - Family Resource Centre, Tallaght

South Western Area Health Board

In 1983, a drop-in service was established in Tallaght by a member of the social work team to respond to an identified gap in services for parents, who were attempting to cope with the demand of parenting in difficult circumstances. The drop-in service has evolved into a multi-layered service, the Family Resource Centre (FRC) supported by a multi-disciplinary team of childcare, social and project workers.

The families involved with the FRC Tallaght are very vulnerable, isolated and disadvantaged, and typically they have little or no involvement with other community based services. In many cases, they themselves have been the victims of poor parenting, abuse and / or poverty, which has damaged their capacity to offer a better future for their children. The strategy used by the centre is very much based on making parents feel welcome, encouraging them to drop in and undertaking developmental work in a gentle, non-threatening way.

The FRC, Tallaght service differs from other Family Resource Centres in that it involves social workers and child care workers working with families around identified issues. Parents are aware that the project is attached to the social work service and that any child protection issues that arise must be dealt with by the social work service. Where there is a child protection concern or a risk that a child may be taken into care, it is referred to the duty social workers, but the project staff offer additional support to the family to help them to cope and to keep the child at home, which is in line with their role as a preventative service.

People attend on a voluntary basis, with supports from the FRC such as home visits to introduce staff, telephone calls when they haven't seen a family for some time and regular letters updating clients on events / activities. Staff use courses that have popular appeal, such as health and beauty, as a means of introducing more sensitive topics such as hygiene and self-esteem. Likewise, a course called 'parenting' will have few subscribers due to the perceived stigma of admitting you need such a course, so parenting tips are included in open discussion parents have about their children.

The core activities of the FRC are:

- A drop-in is held 3 mornings per week, at which there is a mixture of structured activities, for example, personal development, parenting, health & hygiene, domestic violence services and free discussion. Parents can see a social worker or childcare worker individually if they need to. A healthy breakfast and snacks are provided.

- A playroom is available on the same days as the drop-in to facilitate parental attendance and provide a structured environment for children.

- Group work is undertaken with children, usually in response to a specific issue. Assessments are undertaken to ensure that services are targeted effectively at children's needs. Groups have been run for children with speech difficulties and for children in care.

- Group work has been done with parents and children together, which has proven very successful.

- A summer project is run every year for 6 weeks, consisting of a day trip twice a week for six weeks. An average of 40 families take part. Families fund raise for the project and teenagers act as volunteers in helping to get it organised. Families also go on a week-long holiday to the Cavan Centre, which is for most, their only opportunity to have a holiday.

The experience of the project has been that it takes over a year for a parent to relax and feel at home in the centre. After this time, trust has been established and more targeted work can take place. When they feel ready, parents are introduced to other community services. For example, staff bring women up to An Cosan, a community education centre for women, to enable them to see the centre, meet the staff and consider doing a course. The average duration of involvement with the FRC is 2-3 years, after which time, parents are linked in to other services. A small number have been involved with the centre on a long-term basis, some of whom have taken on leadership roles in relation to organising the summer project or other activities.

Domestic violence is a prominent issue for many of the women involved with the service. In response to this, a group for women experiencing domestic violence was run at the FRC. Participants were recruited through referrals or self-referrals. The co-facilitators (social worker and Barnardo's worker) made visits to the each woman's home to discuss her participation. A 12 week course was held to explain reasons for domestic violence, enable women to tell their stories and look at issues of safety. There was 100 per cent attendance and women reportedly found it very useful. For the FRC, it highlighted the value of inter-disciplinary working and the need for support groups such as this one to run on both an introductory and a long-term basis.

While it has been almost all women who have attended the service over the years, in the past year a number of men have been coming to the drop-in. Staff feel that this could be due to a number of factors, including the increased number of men who are primary carers and / or the fact that there is now a male staff member.

Some of the outcomes and strengths of the work, as identified by the FRC are:
- Families feel more supported and are less isolated.

- Families appear to have an improved sense of agency involvement and engage differently.

- Children engaged with the service typically don't come into care.

- There is evidence of improved self-esteem in children and adults and coping skills are developed and enhanced.

- Families are more integrated into the local community, have made friendships and are linked with progression routes.

- Uptake of services is consistent - families generally attend regularly and they bring issues and concerns to staff regarding particular circumstances they may be having difficulty with.

Targeted Family Support - Muirhevnamor Springboard Initiative

North Eastern Health Board

The Muirhevnamor Springboard initiative is a community based day care family support service operating in an urban area on the outskirts of Dundalk Town. The project is part of the National Springboard Family Support Programme established by the Department of Health and Children in 1998. In line with its sister community based family support projects, the aim of Muirhevnamor Springboard is to provide an integrated and co-ordinated response to the needs of families within the local housing estate, with particular focus on the development and well-being of children. The priority of the service is to work directly with young and latency aged children aged 0-10 years old and their parents.

The service was designed and developed from a 'local identification of social need', whereby the North Eastern Health Board invited all voluntary, statutory and community organisations operating in Muirhevnamor housing estate to formulate a vision, ethos and direction for developing a different and innovative family support project. The purpose of the service is to match interventions with both the needs of service users and within the context of the local area. At the time of establishing the service, the following gaps in service provision were identified:

- Lack of family support services generally.
- Few and inadequate services for families with children aged 0-10 years.
- Supports for vulnerable families.
- Inadequate training for parents.
- Inadequate educational and social supports for children and parents.
- Lack of community-led sports initiatives.

In response to these identified needs, the objectives of the service were developed as:
- To respond in a supportive manner to families where children's welfare is under threat.
- To address current problems being experienced by children and families.
- To develop existing strengths of parents / carers and children who are under stress.
- To provide an accessible, realistic, integrated and user-friendly service.
- To connect families with supportive networks within the community.

One of the key strengths of the project is its location, in that it is based on the grounds of the local primary school situated at the heart of the local estate. Additionally, the project staff have an excellent relationship with the staff and management of the school. This means that families have easy and immediate local access to the project in the context of a school environment which is presented in a way that is non-stigmatising for them. The project operates a timetable of activities and work plan which includes:

- Individual and group work with children.
- Individual and group work with parents.
- Family Work.
- Community Initiatives.

Importantly, as with other Springboard Projects, the programme operates very much from a 'child and family strengths perspective'. In order to do so, the project strives to:

- develop a bottom-up approach to its work, which involves acknowledging and developing the skills, knowledge and resources that exist within families.

- work in a flexible, creative and inclusive way, incorporating honesty, openness, approachability in a non-threatening, friendly and relaxing environment.

- promote change at a personal and community level, empowering families to make informed choices.

- create a service that is based on equality, and that meets the needs of users of the project.

- work in partnership with families and agencies, ensuring an effective use of resources.

Outcomes

The national evaluation of the Springboard Programme (McKeown, 2001) suggests a positive outcome for service users, for example, a strengthening of parents' social network ties, a reduction in their sense of being burdened and an enhancement in their parenting capacity. Some of the positive outcomes highlighted by Muirhevnamor Springboard Initiative in relation to its work are:

- Since the inception of the project, the numbers of children going into care from the Project's catchment area have been reduced by 62.5 per cent.

- 48 families to date have received a service from the project.

- School attendance levels have increased.

- Feedback from children, parents and agencies has been extremely positive.

- When the project has closed cases, these families have not been re-referred to the project or the social work department.

- Inter-agency co-operation in the area is excellent.

- Extra resources have been brought to the estate – for example, a computer project (CAIT).

Muirhevnamor Springboard initiative identifies the following strengths in relation to the project:

- Location and accessibility.

- Relationship with local schools and families.

- Direct and focused approach towards working with parents and children in helping them overcome adversity.

- Inter-agency co-operation.

- A programme which matches interventions to need.

- A stable team and positive staff culture.

Summary: Common features of Community Based Family Support Services

Some of the common features of the four community-based family support service case studies are:

- All are based in communities that experience grave socio-economic disadvantage.

- They provide a safe outlet that enables family members to spend time away from the family, which can be a source of stress.

- They have a focus on personal development, education and training.

- Childcare is provided to enable parents to participate.

- Families are encouraged to see their strengths, identify solutions and work at their own pace.

- While the primary work might be with young people or children, they work with parents as part of an integrated family support strategy.

- Services are universal but families in need are provided with additional support.

- All recognise the importance of inter-agency and inter-disciplinary work, and make use of their referral networks.

- Working with families is a slow process but it can yield very positive results.

4. Work with 'at risk' young people

'The more direct services intervene with children's distress and provide direct assistance to parents in the care and management of children, the more children's welfare will be promoted and the ultimate goal of child safety and healing for parents as well as children will be achieved.'

(Ferguson and O'Reilly, 2001, p.270)

One of the main challenges facing welfare states in the developed world is how to cater more effectively to significant minorities of adolescents who face serious adversity in their daily lives (Canavan and Dolan, 2000). The term 'at risk' is used to refer to adolescents in a range of settings, including early-school leavers, young people involved in crime and young people growing up in difficult personal and family circumstances that puts them in danger of being taken into state care.

The case studies in this section relate to interventions that seek to improve the educational, health and personal outcomes for young people at risk. Like all early experiences, a child's experience at school is very important in terms of their subsequent life experiences. Gilligan (2000) points out that a sense of 'membership' of a school may have great psychological and social value for a vulnerable child, including children that find it hard to fit in. Yet, children who grow up in difficult circumstances can experience stress, a poor environment, inadequate support with homework or poor confidence and self-esteem. There can be a lack of congruence between the child's home circumstances and the requirements of schools (Boldt, 1997, Ryan, 2000). The stress children experience may be internally directed, resulting in depression or externally directed, manifesting itself as difficult behaviour (Hoghuchi, 1999, Herbert, 2000). As a result, these children can find it hard to fit in or progress at school and, in cases of difficult behaviour, face expulsion from school or legal sanctions, which will inevitably lead to further problems and increased social exclusion. In some cases, they may simply drift out of school (Bell and Bell, 1993).

Dryfoos (1990) makes the case that tackling youth problems on a fragmented basis is not powerful enough to tackle high-risk behaviours. In order to address the root causes of the child's behavioural problems as well as the symptoms, interventions that work in a co-ordinated way, providing a range of therapeutic and social supports with the child, his / her family and school are likely to be more effective.

The 'Big Deal' Contract is a behavioural model that was developed by a community based Springboard project in Galway in response to the threat of a child's expulsion from school due to difficult behaviour. It primarily involves the child's key supporters in tackling the issue of the child's behaviour, but support is also provided to the family to deal with other issues, which may be affecting the child's environment. Crucially, the school is centrally involved in supporting the child to manage his / her behaviour and remain in the school system.

The Gorey Youth Needs Group have developed an inter-agency approach to working with young people at risk, and provide a range of supports to children, young people and parents in project, school and individual settings.   This case study focuses on one aspect of their work - inter-agency work with young people at risk that aims to keep young people in the school system and address their difficulties. The Granard Action Project provides community based activities for young people in the town, and also runs more targeted interventions with young people 'at risk'. Inter-agency work is a core element of both approaches.

The broad aim of youth work is the personal and social development of young people in preparation for a successful transition to adult life (Kennedy, 1999). Bradford (1999) found that, while there is no definitive evaluation of its effectiveness, more 'impressionistic' evidence suggests youth work can be well placed to work with young people at risk, who are otherwise difficult to engage. Among the factors which contribute to effective work with 'at risk' young people are secure and informally organised accommodation, supported by outreach work which can provide opportunities for advice, counselling and the provision of information; networking with other professions and agencies, which offers opportunities to link young people in with other specialist services that they may not otherwise have accessed and; an approach which emphasises informality. Youth workers should be willing to engage with young people on negotiable terms and recognise young people's status as active partners rather than passive consumers.

C.R.I.B., Foroige Sligo Youth Café is an example of a universal service for young people, that provides targeted support to young people at risk. A notable feature of this model is how it promotes the leadership of young people in designing, planning and managing the service, thus ensuring that the service is relevant to them.

In common with other target groups, there are no simple solutions or strategies that are designed to work with young people 'at risk'. Each area and situation will require a response that makes sense in that context. There is a need for careful evaluation and the use of research, which acknowledges the complexity of the issues and includes the views of all stakeholders.

A child-led approach to dealing with difficult behaviour - The 'Big Deal' Contract

Western Health Board

Westside Family Services in Galway is a Springboard Project, which works on an intensive basis with families in difficulty. A local primary school contacted the service seeking support with two children who were about to be suspended as a result of their behaviour. Project staff met with guardians (parents / grandparents) of these children. Anger management and other programmes were tried, with little success. Then a model was devised involving the child, the school and the project staff, (one child called it the 'big deal' contract). It consists of a contract that is agreed to by the child, parents, school and project staff. The child decides what sanctions s/he will endure for breaking the contract, while rewards are offered for positive behaviour outlined in the contract.

The aim of the model is to keep the child in school and to help and support teachers and parents. It also enables the child to identify feelings of anger and frustration and deal with these in a constructive way. The model is based on positive reinforcement, is child-centred and works from a strengths perspective. The child is not only a focus of the work, but is a major player in devising and implementing the contract.

The 'Big Deal' contract works as follows:
- The project staff meet with the teacher who is experiencing difficulties with the child.

- The child, parent, teacher and project staff meet to explain the contract and seek the child's views. A final contract is drawn up and signed by the child, teacher and project staff member.

- The child is listened to – any difficulties that may arise during the week are discussed when the child meets for individual work with project staff.

- The child can leave the class, where necessary, with the teacher's permission, using a code or signal.

- The child is rewarded for keeping his / her promises under the contract. Each time the contract is broken by the child, a meeting takes place. The contract is reviewed monthly by all parties and may need to be adjusted.

Project outcomes:
- The model has been used with five children to date and all have remained in school so far.

- Very positive feedback from parents and teachers.

- Children's behaviour in school improved dramatically, as did school attendance.

- Parents' involvement with their child's education increased.

- Parents learned different, more positive ways of dealing with their child's behaviour.

Westside Family Services identifies the following strengths of the approach:

- It is child-centred and empowering.

- It makes school a more positive place for the child.

- Teachers, parents, project staff can develop a greater understanding of the child and his/ her needs.

- It represents good value for money – little or no extra expense is involved and preventative work can result in savings from dealing with major difficulties later in life.

- The project makes a holistic assessment of the needs of the family and responds in an appropriate manner.

Gorey Youth Needs Group - working with home, school and community for the benefit of young people at risk.

South Eastern Health Board

Gorey Youth Needs Group (GYNG) is a community based youth project, which aims to support young people, particularly those who are or who may be at risk of experiencing social exclusion. It provides a range of community based child and youth groups for young people between the ages of 6 and 18 years, particularly those experiencing real exclusion and disadvantage. The Group is core funded by the South Eastern Health Board.

Because children's lives are influenced by a wide variety of experiences and individuals, a partnership approach to supporting children at risk is very important. The GYNG sought to support children and young people by bringing together those who have a role in influencing and nurturing children – peers, parents, school, community and statutory agencies. Their work in this regard had a number of components:

- Home school community initiative: A home school community initiative was developed to target interventions at young people currently in difficulty or who are at risk of getting into difficulty. The initiative is a partnership of personnel in key agencies – including community care, gardai, schools and the project. This group identifies young people at risk, develops a co-ordinated response to their needs and monitors their progress.

- In-school support and intervention work with 'at risk' students: Project staff facilitated a number of groups of students who had been identified by school staff as causing and experiencing difficulties at school. Issues such as non-attendance, behaviour in class, negative attitudes to school and unwillingness or inability to take responsibility for behaviour were identified. The support groups aimed to increase children's self-esteem, equip them with skills for managing behaviour and help them to explore their attitudes to school. A ten week programme was initially run, followed by ongoing work throughout the school year.

- Support work with Traveller students: As Travellers are a group at risk of leaving school early, an in-school support group was also established for young travellers to explore issues that make it difficult for Travellers to come to and stay in school. The group also focused on building confidence and self-esteem.

- The Gorey Youth Needs Group also runs a range of after-school and drop-in programmes for this target group. They also ran an intensive parenting course for parents of children who were in contact with the project.

- Counselling is available to children or young people who express a need for it.

As a result of the work, there is evidence of improved school attendance and retention, uptake of second chance educational opportunities and professional support and increased self-awareness on the part of young people.

Gorey Youth Needs Group sees the following strengths in its approach:

- The project works in an integrated way with the school, children and other service providers to aim to understand and respond to the issues that children are experiencing.

- It facilitates young people to express themselves and understand their own and others behaviour.

- Young people can build up a relationship with the youth project from an early age and use it as a source of stability and support in their lives.

- Working with parents is a means of supporting the parent-child relationship to function in a healthy manner.

Universal and targeted family support in a rural town - Granard Action Project

Midland Health Board

Granard is a disadvantaged rural town in County Longford. In 1997, there was concern that a number of young people were becoming involved in crime and that there were a high number of physical assaults. This project was initiated in 1997 in response to these concerns, and to increase the range of preventative services available to families.

The aim of the Granard Action Project is to support vulnerable children and their families by identifying and providing a range of integrated and targeted family support services to referred families and the wider community.

As Granard is a rural town, one of the key concerns of the project is to target children and families 'at risk', but to do so in a non-stigmatising manner. To achieve this, most groups run for children and young people are open to all. The open access groups for children are based around arts and crafts, sports, play and drama. The Project produces a large float for the St Patrick's Day parade every year, which has been an important focus for all participants of the project to work together. They also run a summer camp in July and August.

A smaller number of groups are targeted at disadvantaged children and individual work is undertaken with children where necessary. The 'copping on' programme is run to raise awareness of crime among children at risk. Childcare workers work with children at risk, using a set programme, often in partnership with the Midland Health Board psychology department. They also do some anger management programmes with children, or refer them for treatment if necessary. Project staff also work with young mothers participating in Youthreach around childcare and parenting issues. The Project has a close relationship with social workers. Staff attend case conferences and participate in inter-disciplinary work.

Like other childcare and family support projects, Granard Action Projects' experience has been that, to work effectively with children, is also necessary to work with their parents. A recent departure for the Project has been to employ a family support worker. She works directly with parents in their homes in the mornings and runs groups at the Project in the afternoons. Courses have included home management, budgeting and cookery. Intensive one-to-one and small group work was required in some cases. Parents are also helped with queries, filling forms, making housing application and other needs. The Project also facilitates a women's group. Through this work, the Project's awareness of the needs of children is also enhanced, which puts the Project in a better position to offer children and families the support they require.

One of the main challenges the project has faced has been to overcome the social divide and promote integration between disadvantaged and non-disadvantaged families. Poor self-esteem and cultural differences have made it difficult for some mothers to overcome this barrier. The project finds that it is easier for children to work together than their parents.

Granard Action Project has identified the following strengths in its approach:

- Universal and targeted services are delivered in a way that attempts to avoid stigma and promote integration.

- Children and adults are supported to develop personal life skills.

- High profile community events such as community games and St Patrick's Day parade are a focus around which all families can participate together.

- Targeted family support is a positive means of supporting parents in the home, assessing their needs and tailoring support to their needs.

- Group work and education is used as a means of diverting young people from crime.

The C.R.I.B. Youth Project and Health Café
(Choices, Responsibilities, Ideas, Belonging)

North Western Health Board

In the main, services to young people in Ireland have traditionally been delivered through youth and health services that have been club or project based and / or linked to education (Burke 1999). However, within the North Western Health Board area there was a recognised need for a service in Sligo aimed at young people who are isolated from mainstream health and youth services. More specifically, it was recognised that there was a noticeable number of young people from the town and environs who were to varying degrees at risk of social exclusion and in some cases, homelessness. The Youth Homelessness Strategy, developed by the North Western Health Board, in 2002 identified a need for a creative response to meet this identified need.

In response, Foroige developed a proposal for a health café, similar to a model developed in Galway (the GAF Youth Café). Given that Foroige had earlier worked in partnership with the NWHB in the provision of three Neighbourhood Youth Projects (day care support programmes for adolescents) in the region, they were ideally placed to develop a youth café with an emphasis on adolescent mental and physical health. Funding to develop the café was secured in May, 2002.

The café (called C.R.I.B.) is a youth-friendly and relaxed social setting in the town which provides support to young people on social and health issues and a cup of coffee in an alternative venue in a drug-free environment. Based in the centre of the town, C.R.I.B. is open after school and at occasional weekends and offers both a drop-in and group work facility. The project comprises a coffee shop, high profile drug-free entertainment (live music, DJ's, etc), health information and youth homelessness prevention. Importantly, a youth committee directs the service through other user consultation on the running of the café. There are also a range of individual and group work programmes offered in the café, including group interventions with a mixture of generic and special interest topics and individual work where required.

The café's approach is based on the key principles of the 'Get Connected: Developing an adolescent friendly health service' strategy (1999), namely:

Accessibility – The café is safe, accessible, and open at evenings and weekends.

Appropriate staffing – Staff have a variety of skills in relation to working with young people.

Informativeness – The café offers information to young people in a variety of formats.

Flexibility – Support and advice is available through a range of services.

Partnership – Service users are encouraged to become involved at every level of service delivery and management.

Since its inception, the engagement of young people in the design and implementation of the C.R.I.B. Youth Project and Health Café has been a central feature. Thus far, the in-house layout and programmatic work has come from young people. It provides a model as to how in practice, adults can give a proper 'voice to service users' in the development of a youth service in a community. While the project is still at an early stage, it feels it is well on the way to achieving the following outcomes:

• User-friendly one stop shop for young people.
• Provision of alternative venue to licensed premises for young people's entertainment.
• Service development led by the stated needs of young people.
• Café offering an opportunity to services working with young people to meet them in a non-threatening, non-stigmatising manner.
• Targeting vulnerable young people through universal service provision.
• Specific programmes for young people in crisis.

The strengths of the C.R.I.B. Youth Project and Health Café approach, as identified by the project are:
• Targeted delivery within universal provision
• User consultation and planning in service delivery
• Community based
• Non-threatening, non-stigmatising, attractive base for service delivery
• Value for money
• A service for young people which is accessible outside of 9–5 and open occasional weekends

Summary: Common features of interventions with young people 'at risk'

These models of work with children and young people 'at risk' have some key features:

• The child / young person is facilitated to take the lead in identifying actions and solutions.

• The work is preventative in that it aims to tackle problems at an early stage.

• They provide young people friendly outlets and meeting places.

• Staff are skilled in working with young people and listening to what they have to say. They are thus able to tap into their interests and motivations.

• Services are community-based and accessible.

• Inter-agency work and work with parents is a common feature.

5. Promoting Partnership with Families

Child care legislation and policy is based upon the concept of partnership between the state and the family, in situations where families are in need of assistance in bringing up their children. This commitment to partnership is based on an acknowledgement of the rights of children and parents and the realisation that working in partnership with parents and children is more likely to yield positive outcomes.

Despite a high level of commitment to the principle of partnership, there can be confusion regarding what exactly it means in practice and how best achieve it in children's services (Pinkerton, 2001). Some of the factors that can frustrate partnership working are power relations and an inability to appreciate what the other person has to offer.

Fahlberg (1993) says that every effort should be made to treat parents and children as collaborative partners in the identification of problems, in planning and in treatment. She stresses that the nature of the contact with parents is important – workers should 'model' good parenting techniques. As opposed to being power based or adversarial, healthy family relationships are reciprocal in nature. It is important that staff model this in contacts with both parents and children.

Thoburn et al. (1995) identified some of the actions that service providers can take to develop better partnerships with children and families. While these relate to the child protection process, they are applicable to all services:

• The provision of leaflets and other information that helps them to understand the service

• Clarity regarding their rights

• Preparation for meetings, including being informed of what information or reports will be considered

• Resources to facilitate participation and attendance at meetings

• Attention to ensure that cultural differences, such as language, are not a barrier to participation.

Pinkerton (2001) suggests that individual workers identify their values in relation to working in partnership with children and families. While the rights are formalised in law and in agency procedures, it should not distract from the need to also address them within personal belief systems, so that each worker is aware of what he or she is bringing to the relationship. A knowledge of how to negotiate is also required, in order to manage the relationship and work towards an agreed outcome. The worker also has to be able to appreciate, clearly identify and positively reinforce what it is that family members are bringing as resources to the partnership (Pinkerton, 2001).

The three profiles in this section relate to projects and approaches that are designed to support parents and families to become more active partners with professional service providers regarding the care of their children.

The Family Welfare Conference Project in the Eastern region is an example of how service provision and planning can be user-led. It is based on the belief that solutions to family problems are likely to be more relevant to needs if found within the family, than if externally decided. A family welfare conference

mobilises the social support of the extended family to respond to a family's needs, by coming together to agree a family support plan. This model acknowledges that the family is a source of important support, that can be complemented and encouraged by professional support.

The Family Rights Group was established by the Mid Western Health Board in response to local research which found that the parents of children in care are a very isolated and vulnerable group, and that many don't have continued contact with their children.   The group aims to break down isolation and facilitate these parents to assume a more active role in the lives of their children. Like other peer support interventions, this group highlighted significant social and therapeutic needs among participants that impact on their own physical and mental heath and parenting ability.

The final case study relates to the Western Health Board's efforts to improve the level and rate of participation of parents in child protection conferences. The provision of information, both written and verbal, better organised and chaired conferences and support to parents from social workers were among the actions the Board took to improve participation.

A family-led approach to planning family support - The Family Welfare Conference Service

East Coast Area Health Board

The Family Welfare Conference Service is a service of the three Area Health Boards in the Eastern Region. The Family Welfare Conference model originated in New Zealand. In 1999, the Eastern Health Board initiated a one-year pilot project to apply the model in an Irish context. Following an evaluation, the project was mainstreamed in the Eastern region and was used as the basis for the national roll-out of the model by the Department of Health and Children, as provided for in the Children Act 2001.

The Family Welfare Conference (FWC) model is based on the belief that support for and solutions to family issues are best found by mobilising the ideas and resources of the extended family.

A Family Welfare Conference is a meeting of an extended family and professional workers, at which the family is facilitated to independently devise a plan for the care and welfare of their child. The professionals agree to accept and resource the plan, providing it does not place the child at risk of significant harm. A FWC may be convened where a professional worker or a family member has a concern about the care, protection, welfare or placement of a child.

Families have the right to agree to a FWC. They also have the right to be consulted about who attends the FWC, to invite whatever family members they wish to attend and they can also decide when and where the meeting will take place. Some take place at weekends or in the evenings. There are three stages at the meeting:

- Information giving time – professionals outline their concerns for the child to the family

- Family private time – the family have an opportunity to devise a plan in private

- Plan and agreement – the plan as outlined by the family is agreed by the professionals and issues and resources are discussed.

There is a review of the plan three to six months after the FWC, which is attended by those who attended the original conference. All involved can see the files at any time. The content of meetings and plans is non-judgmental – it just focuses on who will do what and when. Information is given clearly and without jargon.

Evaluation of the pilot project showed that families were willing to become involved in the process and that they came up with plans that were acceptable to professionals. Families reported that they felt listened to and 'they didn't talk down to you'.

As with any new model, many issues and challenges have had to be addressed as part of the implementation process. These included:

- 'selling' the idea to professionals and families.

- defining the role of FWC co-ordinator vis-à-vis social workers and other professionals.

- letting the family know they have the power without being disrespectful to the agency and vice versa.

- resolving disputes over attendance, especially where there is conflict between parents.

In line with its participatory ethos, the service is currently examining ways to enable families to become trainers of the FWC model in the future.

The FWC Project feels that the key strengths of the model are:
- The term 'family' is interpreted widely and includes relatives, friends and other significant people. It allows the family to define who in their network could be a potential source of support in times of stress and provides a formal mechanism to secure this support.

- It ensures that the plan devised is logical from the family's' perspective and is not perceived as being imposed by others. Often family solutions can be simple and inexpensive.

- It is preventative in nature – it supports the family to specify what it needs to be able to function better as a family unit and support its children.

- It promotes partnership between the family and the state, and moves away from an interventionist approach with the professional as 'expert' to one that is more empowering for families (O'Brien, 2001). Families come up with the plan and take the lead in its delivery, but professionals are needed to support it.

- The principles of the model are consistent with Government policy and legislation, which emphasise the rights of the child, such as the Child Care Act (1991), Children First (1999) and Children Act (2001).

Family Rights Group

Mid Western Health Board, Limerick

O'Higgins research (1993) found that families in the MWHB area who had children in care were likely to feel excluded and marginalised within their own communities and lacked kin and neighbour support. Two fifths of children in care in the Mid Western Health Board area in 1989 had either no contact or very poor contact with their parents.

The Family Rights Group was established to provide a voice and support group to families with children in care. It was initiated by the MWHB in 1991 in conjunction with PAUL Partnership, as part of the Poverty 3 Programme. Limerick Social Services agreed to act as the host organisation for the project and provided the services of a part-time worker to work directly with the group.

The objectives of the Family Rights Group are:
- To establish an independent forum for families who have children in care.

- To promote the rights of families who have children in care.

- To input into policy and practice regarding children in care and their families.

- To establish links with similar projects throughout the EU with a view to drawing up an agreed charter of rights.

- To encourage the development of support services and other preventative services for families at risk.

A support group, facilitated by a staff member of Limerick Social Services, is run on a monthly basis for parents. This group is attended by a core group of 8-10 parents, most of whom have children in long-term care. Parents can talk openly about their difficulties in the support group and these issues are communicated to the Core Group (discussed below). One-to-one support is provided, as is support to parents meeting with social work staff. Parents are assisted in preparing for and may be accompanied to care reviews, court hearings and case conferences. This group has also been assisted by a psychotherapist. An Information Pack for Parents with Children in Care was published in 1998.

An inter-agency and inter-disciplinary core group was set up as a vehicle through which policy and practice issues raised by parents could be addressed. This group is composed of representatives of the Limerick Social Services, PAUL Partnership, MWHB Social Work Department, residential care services, Irish Foster Care Association and parents with children in care. Parents bring the issues raised at the support group to the core group for discussion.

The reaction of those actively engaged with the group is positive. The group has regular attendance and parents have found it valuable to be able to discuss their issues and problems with people who have had similar experiences, rather than being isolated. In an evaluation of the project, O'Connor (1995) found that the 'support group provided a forum in which parents felt accepted, their self-esteem enhanced, their rights as parents were validated, and informal access provided to senior social workers' (p.74). As the

group is independent of the Health Board, it is 'an arena where the difficulties as regards access, reviews and generally dealing with unequal power relationships with social workers could be ventilated and in many cases actually resolved'. The group raised awareness of the importance of parents' rights.

'It's the only place I can talk – you are heard, you are not shut down – they can understand'

Quote from participant in O'Connor (1996)

The evaluation also found that it is necessary to address people's individual therapeutic needs as well as support their rights as parents. In Limerick, participants were parents who had regular access to their children, but would have liked more. O'Connor suggests that in order to attract parents who are more needy, an initial focus on their needs as individuals rather than as parents would be more fruitful.

Similar projects have been established in Clare (2001) and in North Tipperary (2003), by the Mid Western Health Board, each supported by one full time staff position. These projects are also located in and run by voluntary organisations, Clarecare and North Tipperary Community Services respectively, on behalf of the MWHB.

The evaluation findings (O'Connor, 1995) highlighted the following outcomes and strengths of the approach:

- It's a support group where parents feel accepted, which validates their rights as parents and develops their self-esteem.

- The group is independent of the Health Board, and thus is an arena where difficulties can be aired and many cases were resolved.

- Parent's capacity to understand the system and participate more equally in it is developed and strengthened.

- It engages in positive networking with groups in other areas.

Improving Parental Participation at Child Protection Conferences

Western Health Board

A child protection conference (CPC) is an inter-agency and inter-professional meeting which is convened by a Child Care Manager/designate when concerns arise about a child's care and protection. The Children First guidelines (1999) state that the child's parents / carers should be included where appropriate and sets out four reasons why parental participation at child protection conferences should be enhanced:

- **Effectiveness:** Co-operation is more likely to be achieved if parents / carers are encouraged from the outset to participate in decision-making about the protection of their child.

- **Source of Information:** Families have unique knowledge and understanding of the child's situation.

- **Rights:** Family members have the right to be involved in decision-making and to have their views represented.

- **Empowerment:** Involvement in decision-making helps parents to build up self-esteem and encourage them to feel more in control.

Prior to the development of this initiative in 1998, Child Protection Conferences in the Western Health Board region lacked direction and focus. Parents were not routinely invited, nor were there clear expectations of multi-agency participation. Consequently, preparation of participants and their understanding of the process were weak.

In response to this, management decided to adopt a more strategic approach to ensure that parents could participate adequately in child protection conferences. Given that the vast majority of children in the Child Protection Conference system remain at home, it was important that effective child protection plans would be in place to significantly reduce any risk to children. It was felt that increasing parents understanding of and participation in the process was an important element in reducing risks.

Key activities
- Good quality assessment of risk to child.

- Production of summary guides for participants and parents, which includes the function of the conference, who attends, agenda, explanation of plans, parents' role, opportunity to bring a supporter.

- Social work report structure sent to participants in advance.

- Copies of minutes and plan given to parents.

- Policies and protocols were agreed in relation to issues such as parental interviewing, investigative interviews, anonymous referrals and working with An Garda Siochana locally. Such protocols would ensure a consistent approach to child protection and accountable practice.

- Training for chairs of child protection conferences.

- Preparation of parents by social worker prior to the case conference.

Since the development of this initiative, there has been an increase in parental and professional attendance at initial and review conferences. Parental participation is now the norm in most cases. Conferences are more streamlined and structured, with greater direction and focus. Accountable decisions and plans are agreed. While attendance at conferences has improved, there remains room for progress in relation to parents' ability to participate at the actual conference. Research is currently being undertaken by the WHB to identify the current level of participation by parents, explore the quality of participation and to identify further areas and issues for improvement.

Staff feel that some of the of the arguments which can be made in favour of a strategy such as this are:
- Effective and accountable child protection processes assist children in remaining at home or alternatively returning home as soon as possible.

- There is multi-disciplinary ownership of the model.

- It shows adaptation to the principles of partnership with parents.

- Staff are better trained to encourage parental participation.

Summary: Common features of projects designed to improve partnership with parents

Some of the common features of the three case studies in relation to participation are:

- Parents' rights are recognised and steps taken to translate them into policy and practice.

- There is an acknowledgement of how vulnerable families can be disempowered by the child protection system and the power imbalance between parents and professionals.

- It is recognised that most parents are interested in their children's welfare but may need support to understand and input into childcare services.

- It is in children's interest that their parents can take an active role in care services.

- There is an awareness that Health Boards can function in an exclusionary manner and that this needs to change.

6. Therapeutic Approaches

As McKeown (2000) points out, research has consistently highlighted the importance of the therapeutic or helping alliance in effective interventions. A review of the literature, based on over 1000 studies, recommended three ways for improving outcome effectiveness through the therapeutic relationship:

• Treatment should accommodate the client's motivational level and state of readiness for change.

• Treatment should accommodate the client's goals for therapy.

• Treatment should accommodate the client's view of the therapeutic relationship.

In practice, professionals in the child care and welfare fields often work from a variety of theoretical bases, applying a variety of techniques. A concern to do 'what works' with children and families results in practice that is best described as eclectic in nature. Many of the ideas and techniques adopted in this eclectic practice are rooted in the disciplines of psychology and psychiatry. Approaches are often an amalgam of psychoanalytic, psycho-dynamic, behavioural, cognitive behavioural, social learning and other key theories. But it is also the case that some techniques adopted in work with children and families retain stronger connections to the theories on which they are based, and are implemented in a more 'pure' form. In this section, two such approaches, which work to relatively tight therapeutic models, are described.

Both of the case studies use sensory integration (SI) as part of the therapeutic process. **Back to Basics**, a recently piloted model in the Midland Health Board region, combines SI with psychodynamic theory and practice in working with young children with autistic spectrum disorders. Therapy takes place in the home, facilitating the parent to undertake exercises that enhance the parent-child attachment.

The Integrated Model of Self-Regulation has a long track record, having been practiced in Donegal since the 1980's. It is a therapeutic intervention for children in care who have experienced abuse and trauma, that aims to improve their attachment patterns to parents / carers and to regulate their emotions through sensory integration.

'Back to Basics' - a social model of intervention with children with autism and their families

Midland Health Board

'Back to Basics' is a family centred, non-directive, play-based treatment for children with autistic spectrum disorders and their families. It supports the 'social model' of disability, which emphasises the inclusion of children in their natural environment, rather than the 'medical model', which focuses on what the person's impairment prevents them from doing.

Autistic children have developmental difficulties, affecting play, communication, imagination and emotions. This can affect the developing 'attachment' relationship with the primary carer and needs to be addressed in therapy. Traditionally, an occupational therapist undertakes sensory integration therapy with the child, in a clinical setting, observed by parents. 'Back to Basics' mixes sensory integration with play therapy and is undertaken in the family home, engaging parents as co-workers. It was introduced to the Midland Health Board by an Occupational Therapist, dual trained as a Play Therapist, who combined sensory integration theory and practice with psychodynamic attachment theory and practice.

Following formal diagnosis by the Childhood Autism Team of autistic spectrum disorder, children aged up to six years are offered 'Back to Basics', a joint Occupational Therapy / Speech and Language Therapy intervention package. The programme begins with a non-directed play-based assessment, undertaken in the child's home. The programme links in with the child's developmental level, rather than his or her chronological age. The child's spontaneous behaviour / play leads the intervention. By accepting, waiting, watching and offering choice, the child will respond, and make developmental and emotional progress.

Home visits are undertaken at weekly intervals with parents observing and participating in play where confident. Simplified verbal and written explanations of child development, sensory integration and child centred play are provided for parents. Following eight initial home visits, progress is reviewed and a further block of treatment may be offered, and / or other supports. The model promotes independence by having faith in the parent's ability to continue treatments after three to four months of intervention.

The Back to Basics Programme does not suit all parents or children with autism as some prefer a more directed behavioural approach. It is an additional treatment and parents can choose if the programme 'is for them'. The model operates within the framework of the Board's autism service, with full recognition of the roles of other professionals.

Back to Basics is at 'pilot' stage in the Midland Health Board and has not been formally evaluated. However, staff and parents have observed the following outcomes:

- Those parents who continue beyond the first five demonstration sessions are positive and actively involved. Treatment sessions are fun, playful and energetic.

- Play skills, communication and sensory / motor skills have improved and parents report a positive change in attitude.

'My son had few single words and little eye contact. He did not know how to play. Now he uses sentences, he enjoys play and whinging has stopped.'
> Quote from parent.

Staff highlighted some of the strengths of the Back to Basics model as:
- It is child centred.

- The approach is rooted in child development theory.

- The professional works in partnership with children and families.

- It involves building on strengths as well as identifying difficulties.

- It is grounded in evidence-based knowledge.

Integrated Model of Self Regulation (IMSR) for Children in Care

North Western Health Board

Research undertaken in Donegal indicated that children in care experience high levels of unresolved loss and trauma. The Integrated Model of Self-Regulation was developed in Donegal in order to meet the therapeutic needs of children in care who have had such experiences. It is comprised of three elements:

• Sensory integration and neuro-development

• Attachment theory

• Jungian sandplay and symbolic play.

While the individual components of the model are in use all over the world, to the knowledge of the team, this combination of all three is not in use anywhere else.   The model is based on the vision of Bowlby, CJ Jung and Jean Ayers, suggesting that both the body and the psyche have the capacity to heal in the right conditions. It is a holistic mould, which treats the psyche and the body simultaneously. The vision and aim of the Integrated Model is to enable children who have suffered trauma and loss to recover and heal. Importantly, the model offers young people clinical support in order to address trauma through the use of self-expression within a non-clinical strengths perspective. Its objectives are:

• To assess the attachment patterns of children in care, how they are processing stimuli and current experiences through their senses, their emotional and physiological development and their imaginative capacity.

• To work with foster and birth parents in order to strengthen healthy attachments and development.

• To facilitate the child's capacity to regulate their emotions through a Sensory Integration programme, which is personally devised.

• Through play therapy, to enable children to remake attachment patterns so that they can make more secure relationships.

Children with attachment and sensory difficulties are identified by individual Social Worker's reports or through the Care Planning system. They are then referred for assessment of attachment to a Social Worker trained in assessment of attachment patterns, and/or sensory profile by a qualified Occupational Therapist specialising in Sensory Integration. Some children receive all three aspects of the model as outlined above, others receive one or other component of the model according to need and the availability of resources.

A team leader, from the Foster Support Team, and four therapists staff the service. It is managed by a steering committee and a referral committee.

Foster parents and care staff are directly involved in the Sensory Integration and neuro-developmental programmes, assisting the children to do the physical exercises and sensory programmes and sitting in on therapy sessions, which can be extremely supportive to children with attachment difficulties.

Results are assessed through:
- Changes in the child's attachment pattern, as assessed through child observation with foster parents and carers.

- Reports from social workers.

- Analysis of a child's sandplay processes and symbolic play which reveal their level of emotional integration, re-organising attachment patterns and emotional security over time.

- Sensory integration and neuro-developmental re-assessments which indicate the child's level of progress from a sensory and developmental perspective.

Work is currently underway to develop an objective measure of the effectiveness of the Integrated Model.

At the time of this research, 12 children have been treated with the integrated model. Foster parents and birth parents have reported very positive results, stating that Sensory Integration is very successful at helping to calm very distressed children. Sandplay helps children to develop more secure attachment to their Foster parents but it is a slower process. When all three components of the model are combined, the results are more positive. According to foster parents, the children can express aggression in the Sandplay, and as a result it is not then projected into the foster family.

Staff feel that the strengths of the approach are:
- It has a sound theoretical base.
- The programme has been evaluated.
- It is a direct child focused intervention.
- It integrates the physical and emotional aspects of development.
- It is capable of reaching children in their own language - play.
- The model is inter-disciplinary.
- It is capable of adaptation to different settings, for example, family support.
- This model offers an innovative way of working with children experiencing a wide range of traumas and adversity and has potential to be used in many clinical and non-clinical settings.

7. Children in Care and Aftercare

Triseliotis (1993) uses the term 'permanence' to refer to promoting a child's physical, social and psychological well being through providing consistent care, stable relationships and a social base in life from which to face adulthood.   The preferred place for the achievement of permanence is in the child's own immediate or extended family. There are times when it is in the child's best interest for permanence to be achieved outside the original family through permanent care or adoption. Such arrangements need not result in the child losing meaningful links with members of his original family.

The latest national figures suggest that the number of children in care is 4,424, a number that has risen substantially over the past 30 years, from 1,665 in 1970. Children who need long-term or permanent substitute parenting are now usually fostered or adopted. Just over three quarters of children in care (76.5%) are in foster care, (18% with relatives), 14.4 per cent are in residential care, with the remainder in other care, including pre-adoptive care or at home under supervision (Department of Health and Children, 2003).

Children's care services in Ireland are guided by the National Standards in Residential Care and Foster Care, which set out good practice that must be adopted in their work with children. Within this framework, services have adopted differing emphases and models of work that aim to respond to the needs of the children they work with. All models endeavour to strengthen the coping and resilience of children in care in a way that will endure when they leave the care system. This section profiles the work of four services that work in different ways with children entering, living in or leaving care. Two of the four profiles refer to a residential care setting; one refers to an assessment unit and another to an aftercare service. Together, the profiles provide just a taste of the broad range of work and good practice development taking place in services for children in care.

Child care planning is about bringing together information from children and young people, their families, carers and professionals in order to plan for the care of the young person and to review that plan on a regular basis (Grimshaw and Sinclair, 1997). **Airne Villa** in County Kerry is an example of a specialised assessment unit which aims to ensure that the needs of children are adequately assessed and an accurate and realistic care plan is drawn up. Children are then offered services that are appropriate to their needs.

In relation to residential care, Bullock (1992) concluded from a review of the research that the following conditions were necessary for successful residential centres.

- The young people feel enriched by their residential experience and perceive the staff as caring.
- The young people acquire skills during their stay.
- The institution addresses the needs of the child that led to their being placed in care, not just their needs as a result of being in care.
- There is consensus between staff, children and parents about what the goals are and how they should be achieved. Leadership is clear and consistent.
- Child and staff cultures must be prevented from cohering in a destructive way, by encouraging small group work and sensitive relationships.

The profile of **Gleann Alainn**, in Glanmire Co. Cork, a residential centre for children with behavioural problems, focuses on their approach to dealing with difficult behaviour.   Staff support young people to develop their self-esteem and deal with the root causes of their challenging behaviour. This is done in conjunction with their families and statutory and community services.

A study by Millham et al. (1986) highlighted that some parents experience great difficulty in maintaining contact with their children in care. Families are poor, disrupted and continuing to experience many of the pressures that caused their children to be placed in care in the first place. Their research indicated that most children's well being is enhanced by contact with home, and that strong links with parents increase the child's likelihood of leaving care. **The Amiens St Child Care Centre** has over two decades experience in caring for children from the inner city, and is rooted in a particular philosophy which emphasises the value of protecting and nurturing the child's sense of home, community and identity. Its ecological approach means that it works with children in their own environments, linking them in with schools, peers, health and therapeutic services, youth services and crucially their family members.

While many care leavers are in work and training, managing their income and accommodation and being successful parents, the undeniable evidence is that a very large proportion of care leavers face major difficulties at the point when they leave or shortly after they leave care (Action on Aftercare consortium, 2000). A study of young people leaving care in Ireland (Kelleher and Associates, 1998) illustrates their disadvantaged status, with a low level of educational qualifications, low prospects for training and employment, vulnerability to drug and alcohol use and ultimately, homelessness. Research from the UK also shows that the transition from a structured care environment to living independently can be stressful and that young people leaving care are at higher risk of early pregnancy, homelessness and ill health. Hutson and Liddiard (1994) highlight that, while less than 1 per cent of young people are ever taken into care, the proportion of homeless young people with a care background was 22 per cent in their 1991 study.

The Kelleher and Associates (1998) study showed, however, that children who have had a planned and supported exit from care are less likely to experience these adversities. In Ireland, there is no legal obligation for Health Boards to provide aftercare services. Under Section 45 of the Child Care Act (1991), Health Boards have discretionary powers to assist persons who have left the care of the Board up to the age of 21 years, (or beyond 21 years until they complete their education), if the Board establishes a need. The Child Care Regulations 1995 state that the Board is required to give consideration to the needs of children due to leave care two years prior to the date of discharge. The fact that Health Boards are not obliged to provide aftercare services has led to a situation where aftercare services in Ireland are patchy, inadequate and not prioritised for resources. Research studies by Ritchie and Nee into young people leaving care (cited in Buckley, 2002) recommended that the Child Care Act, 1991 be amended to make after-care compulsory.

The **Mid Western Health Board** established the After Care Programme with the objective of improving outcomes for young people leaving care. It provides after care services to help young people to make the transition to independence, including a supported lodgings scheme. Sinclair and Gibbs (1998) in a study of residential homes, found evidence to support the development of supported lodgings as most care leavers want to live near their families, but not with them. They conclude that a system which provides them with a variety of adults to whom to turn is less likely to fail than a system in which they are dependent on one.

Aime Villa Assessment & Resource Unit

Southern Health Board

In 1993, a review of childcare services in Kerry commissioned by the Sisters of Mercy recommended the establishment of an assessment and resource unit. A joint working group of the Mercy Sisters and the Southern Health Board oversaw the development of the unit, which was opened early in 2000. In 2001, services were transferred to the management of the Southern Health Board.

Airne Villa is a six-bed unit, the main function of which is to provide an assessment function to children and their families in the Southern Health Board area. The focus of assessment is to develop an understanding of the child and the family's situation in order to formulate a plan of intervention to meet both sets of needs.

The aim of the centre is to work in partnership with the child's family to provide a comprehensive team assessment report which will guide the community care teams in providing the best possible care to young people. The assessment model is child centred and builds around the child's needs with regard to his/her wider social networks and interests. The key philosophy in Airne Villa is empowerment with compassion – the Unit works towards providing safe and compassionate services, respecting those they work with and empowering them to achieve their potential for personal fulfilment.

Based on research to date, the centre identified key principles, which are associated with good practice in assessment. These include the need to be flexible, evidence based, accountable, collaborative, constructive, child centred, context based and adopt a developmental perspective.

Assessment in Airne Villa is conducted through a team process. The three phases are as follows:

Phase 1:
Establishing presenting problem parameters
Identifying key issues – generating initial hypothesis

Phase 2:
Exploration of individual characteristics of child and carers
Exploration of family functioning and relationships

Phase 3:
Exploration of availability and appropriateness of possible resources, supports and interventions likely to be considered in formulating recommendations from assessment.
Children and young people and their families are encouraged to voice their concerns, views, opinions, likes and dislikes, through consultation at various fora, including family engagement meetings, feedback meetings and house meetings.

Some of the outcomes of the work are:
•   A comprehensive team assessment report with a very specific set of needs and recommendations is provided, which guides the community care team in providing the best possible care to the young people that have been assessed.

- Social workers have given positive feedback regarding the development of their cases following implementation of recommendations from the team assessment report.

- Young people and their families have also given positive feedback with regard to feeling included and being supported through the process.

Airne Villa identifies the following key strengths in its approach:
- It offers a multi-disciplinary approach to assessment.

- There is direct family involvement throughout the process and engagement with extended family.

- A comprehensive team assessment report guides community care teams in providing the best possible service to young people.

- There is engagement with previous school / workshop placement or any other significant people that may inform the assessment process.

- Young people and their families feel listened to through being treated with dignity and respect.

- Multi-disciplinary staff are on hand as part of the assessment team and not a separate entity.

- Recommendations are based on the 'real world' needs of young people which advocates matching the needs of young people to any potential interventions by informal supporters such as extended family and friends and formal support services.

- Through in-depth holistic assessment of service users, recommended pragmatic interventions are matched to need (e.g. what can be done now) with the child as the central focus at all times.

Responding to Challenging Behaviour through one-to-one positive relationship building: Gleann Alainn

Southern Health Board

Situated on the outskirts of Cork City, Gleann Alainn is a high support residential unit for children and adolescents with challenging behaviour. The unit is staffed by a team of committed professionals who agree on the crucial issue of 'successful relationships' as central to positive interventions. Additionally, the unit does not see itself as working in isolation with the young people in residence but rather operates ongoing life and social skills through community and social activities. The programme model operated by the unit staff focuses on understanding the root cause of challenging behaviours and addressing matters 'there and then'. This is done positively in a way that improves the young person's image of him or herself. Whereas the programme operates a strengths perspective approach, more specifically, it attempts to assist service users in re-learning positive and appropriate responses that have been initiated in early childhood. For example, project staff actively encourage young people to re-engage positively with key people in their social networks, even where those current relationships may be estranged.

Work practice model
The model makes a link between early life experiences (such as child abuse and neglect) and challenging behaviour. Such behaviours may also be manifested in the young person through low self-esteem and poor self-image /sense of self. The programme operates on the simple but clear principle that, in order for young people who are experiencing severe adversity to value others, they must firstly learn to value themselves. The Unit sees this as the root cause of challenging behaviour and works on the assumption that, by addressing their sense of self, the service users' challenging behaviour will correct itself over time.

Key activities
The interaction between staff and young people in day-to-day residential living situations is exploited (positively) as a powerful therapeutic tool. The staff seek to give children a new message about themselves by the way they interact with them, from 'dawn to dusk', for example, in how the young person is called in the morning to how he or she ends the day. To this end, staff are strongly supported in the function of supporting the young person in their care.

On the basis that the programme offers (on a daily basis) intensive therapeutic support to young people known to be in severe difficulty, there is potential for 'strain' on staff, which are the key asset in the unit. Cognisant of this, management see the importance of support, supervision, staff meetings to debrief workers and an ongoing awareness of staff needs as crucial to the programme. One of the key benefits of the programme is that staff 'stick it out' by continuously reassuring young people that things can be okay for them despite their difficulties. The programme goes to great lengths to ensure that a difference is made between the negative behaviour of a person, and the goodness of the young person. Staff and service users are consistently reminded that whereas the behaviour of children who are out of control is bad, it does not mean that they are bad people. Given that other services may have given up on the young people who attend Gleann Alainn, this is seen as a vital part of the culture of the centre.

Staff and management in the unit feel that this approach brings a number of specific benefits:

- It gives a good explanation for challenging behaviour.

- It empowers staff to empower young people.

- The programme is simple and easy for all to understand.

- It addresses challenging behaviour in a real world positive and non-threatening way.

- By positively changing young people's view of themselves, it improves their self-esteem, self-confidence and resiliency.

Amiens Street Child Care Centre: Caring for Children in their own Communities

Children in care who are sent to residential or foster homes away from their own families and communities can find it very difficult to maintain relationships and a sense of identity and belonging. This has the potential to add further instability to the lives of children already experiencing chaos. According to Gilligan (2001) being in care should not dominate the young person's sense of self to the extent that it erases other facets of the young person's identity and 'story'.

In recognition of this fact, the Amiens St Child Care Centre was established in 1980 as a community based child care unit, designed to cater only for children from the surrounding North East Inner City Community. The Centre believes in the tremendous importance of continued family and community contact and involvement in the lives of children. Its ethos is that families consist of individuals who have natural potential and strengths to communicate and interact in positive and constructive ways but who may have been damaged and dis-inherited through negative and destructive experiences in their lives. While the child-family relationship is supported, the welfare of the child is of paramount importance in consideration of any decisions that need to be taken in relation to the child's circumstances.

Ultimately, the aim is to enable the child to regain their place with their family on a relatively stable and problem-free basis or, if the objective of returning home proves unattainable, exploring suitable alternatives.

Children are considered for placement where it is reasonable to assume that continued family and community contact would be beneficial in terms of the child's sense of security and future welfare. A child is only admitted when alternatives to full-time care have been exhausted. Prior to admission, the parents must agree on a voluntary basis to the placement of their child and demonstrate their commitment to co-operate with the goals and objectives of the centre.

The Centre has realised the following outcomes throughout its many years in operation:

• Strong local awareness and support for the centre, resulting in a co-operative model of working with families / extended families. The centre is viewed as a community resource – families with no connection to the care system often ask for parenting advice from staff.

• Young people settle into placement in a more accepting fashion. Parents are actively involved in daily routines such as accompanying their children to school, preparing meals and other activities.

• Evidence exists in a high number of cases of the stabilisation both during and after placement of children who are referred from a chaotic and unsettled background.

Amiens Street Child Care Centre staff have identified the following strengths in their approach:

- The unit is based in the community, which enables children to retain and develop their links with family and community.

- Great emphasis is placed on the quality of the relationship that the project develops with children and families. This is the key to progress.

- There is a strong commitment to children's rights.

- The centre works on a concept of 'shared care' and children frequently spend large amounts of time at home.

- Families are consulted on a continuous basis and are involved in activities organised by the unit. No appointment is necessary to visit. It is not seen as an alien or outside resource, which is separate to their daily lives.

- Children and young people are consulted in both the day-to-day issues and the long-term planning for their own lives.

- There is a continuum of care before, during and after placement in the centre. Past residents will often link in with the Centre for a number of years after discharge.

- The Centre is strongly linked to local community services and organisations, which has enabled it to work in partnership for the good of the children in its care, their families and the community.

Some of the challenges experienced have included:

- Balancing the child's right to protection with parental involvement in a process that creates least harm to everybody concerned, while acknowledging a primary duty to protect the child.

- A high level of flexibility is necessary to allow for the multi-faceted nature of the difficulties which many of the families are dealing with.

- Protecting the community-based ethos of the project can be difficult if children from outside the community are in need of a care placement.

After-Care Programme

Mid Western Health Board

The Aftercare Programme was established by the Mid-Western Health Board in 2001 to develop a formal framework for the planning and delivery of aftercare services for young people in the care of the Board. It aims to maximise each young person's levels of independence and life skills based on clear assessment and planning processes. Its objectives are to:

- Engage with young people aged 16-17 years who are preparing to leave care;

- Undertake an assessment of need in partnership with the young person, residential workers, foster carers and his/her family;

- Contribute to the development of appropriate, effective and realistic individual care plans;

- Assume primary responsibility for the provision of supports to young people aged 18 and over in aftercare.

Leaving care is defined as the planned transition to independent living and is incorporated into the care planning process. Aftercare is defined as the provision of practical and emotional support to young people aged over 18 years who have left care.

The service starts to work with the young person from age 16-17 to prepare them for when they leave care at age 18.   A key worker is assigned to each young person. A needs assessment is undertaken, which incorporates a comprehensive look at the young persons skills and needs. Based on this, a plan is developed, which is broken down into manageable tasks. The plan can be amended or updated if the young person wishes, and is used as a guide for reviews which are held every 6 months. The programme refers the young person to other services, and aims to co-ordinate the supports for the young person to ensure a holistic response to their needs. Co-operation with the service is voluntary after age 18 – some young people choose to get on with their lives without the service, while some leave but may come back if they have a problem.

The Programme has developed a supported lodgings scheme, which is a type of 'bridge' between care and independent living. Accommodation providers are assessed and must be approved by the Health Board. Young people must be aged 16-21, and have to be in training, education or employment to avail of the lodgings, which provides bed and breakfast and an evening meal. There are currently 9 places available under this scheme. The experience of the project is that the young person must want it and 'buy into it' if it is to work.

Young people have experienced many difficulties during and before care, which may negatively impact on their progress post-care and on their own ability to offer their children a better future than they have had. Thus, the programme aims to be preventative by providing as much support as possible to the young person if they become a parent. For example, when a young girl with learning difficulties had a baby, the project linked her in with the Community Mothers programme and other services and so far, she has managed to keep her baby, against the odds.

The Programme allows the young person to see their file at any time. A log of all events and outcomes is kept, which is signed by the young person to show they have read and agree with the description. The young person also decides who gets a copy of their plan. The programme supports young care leavers to become involved in the Irish Association of Young People in Care and has looked into the feasibility of establishing a local representative group for children in care.

An audit of the Limerick service found that generally young people were positive about what the service was doing for them, its impact on their lives and the way the service linked in with them and the focus the work gave to their future (Child Care Inspection Service, MWHB, 2003). Carers were also happy with the service, saying that it made them feel less 'abandoned' once the young person turned 18. One challenge the service faces is that young people with learning difficulties can need long-term intensive support, for which additional adult services are required. Also, demands on the caseload mean that the programme with young people commences at age 17 years and not at 16 years as is preferable.

As aftercare in Ireland has little national coherence, with different approaches in different areas, the MWHB has taken a lead role in establishing a national forum for aftercare workers with the aim of developing a framework for aftercare in Ireland and developing resources for project workers.

The Aftercare programme staff feel that the service has the following strengths:

- The programme focuses on a continuum of care approach and sees a throughcare perspective involving family and key service stakeholders as the most holistic way to support young people.

- There is a commitment to best practice through ongoing inspection and evaluation, in which young people and families have input.

- It works from a strengths-based focus.

- There is a clear and agreed philosophy, policy and procedures.

- It has strong links with community-based services.

- The supported lodgings scheme offers a bridge between care and independence.

Summary: Work with children and young people in care

Common themes and approaches among these four case studies are:
- The need for quality relationships between staff and children.
- A desire to achieve the best possible outcomes for children in the care system.
- A focus on tailoring services to meet the unique needs of each child and family, taking their context into account.
- Inter-agency co-operation and referral to a range of services.
- The need for a range of approaches and models that are appropriate to the diverse needs of children and families.

8. Policy and Service Development

On a wider level, interventions for children and families can only be enhanced when they occur within a clear organisational service framework that is based on sound policy. Just as children and parents need the support of practitioners, so also do services need systemic clarity and sustenance in order to provide for service users. The Commission on the Family (1998), the National Children's Strategy and Best Health for Children reports (1999, 2000, 2001) all provide such clarity at national level. These final three profiles tell of the experiences of Health Boards in developing local policy initiatives designed to improve the quality of their practice and ultimately to enhance outcomes for children and families. These diverse profiles involve the following:

- Improving the co-ordination of service delivery: The South Eastern Health Board established a **Children's Services Forum** to improve the take-up of health services among children aged up to four years.

- Developing a vision and framework for service development: The North Eastern Health Board engaged the relevant stakeholders in developing a **Family Support Policy Framework**.

- Adopting quality systems for service cohesion and development: The Roscommon Social Work Service of the Western Health Board achieved ISO 9002 certification for their **Quality Management System.**

Children's Services Forum, Carlow

South Eastern Health Board

The Children's Services Forum was developed by health professionals in Carlow to tackle the issue of non-attendance at vital health service appointments by children aged up to four years. There is an average non-attendance of 13 –14 per cent across the South Eastern Health Board region. After repeated non-attendance, children were being discharged from various child health services. The children's needs would be later identified through school checks, meaning that vital years of intervention had been missed out on. Each discipline has its own procedures for making appointments with families, and there was no forum where professionals could communicate with each other regarding families that are difficult to engage or improve co-ordination of appointments for families. The Forum was formed to improve communications between disciplines and encourage vulnerable families to engage with services and to make use of appointments.

The disciplines involved are Public Health Nurses, Area Medical Officers, Speech and Language Therapists, Social Workers, Psychologists, Community Welfare Officers, Dental Services and others, where necessary.

When a child / family repeatedly fails to attend specific or various services, the health professional for that service may refer that case to the Children's Forum for discussion. Other disciplines can relate if they have had a difficulty in engaging with this particular family. A key worker is then identified, who will confirm the families details. A letter may be sent to the family informing them that, due to non-attendance, their case will be discussed at the Forum meeting.

Outcomes

- One third of families referred to the forum did engage with services. One third are still in the system, albeit with ongoing difficulties. One third remain non-compliant.

- Families and staff felt greater importance was attached to attending children's services.

- Professionals using the forum reported feeling better supported and satisfied that something constructive was being done to prevent babies being discharged from services without having received adequate care.

- As a result of the forum, services began to operate more at a system level, rather than as discrete isolated units. Where a number of disciplines were involved, interventions were planned in a way that was more suitable for the family. There was more cohesiveness in the Health Board's approach to vulnerable families who had contact with a wide variety of professionals.

- Some families gave reasons for the failure to attend and staff had the opportunity to respond to their medical needs. It highlighted the importance of supportive relationships (e.g. fathers, extended family) to enable the mother to bring the child for appointments. It also showed that there is a need for parents to be educated about their child's developmental stages as some parents did not understand why the children had to go for appointments. Speech and Language Therapy have since developed a leaflet explaining their service.

- Families were traced where addresses had been incorrect.

- In one instance, a case was re-opened in the social work department.

- It prompted a re-examination of how the Board delivers services to vulnerable families.

There were also a number of challenges in developing this forum. Firstly, to protect the confidentiality of families, initials rather than names were used when discussing them at the forum. However, this was awkward and the issue is one that requires further analysis. Secondly, the role of chair of the forum was rotated between the disciplines. However, the Carlow experience is that there is a danger that the forum will lapse if it does not have somebody to drive it. Thirdly, attempts to initiate a similar group in Kilkenny were not successful. It is thought that Carlow lent itself to the forum as all health professionals were located in close proximity to each other, which eased the process, whereas in Kilkenny they were more spread out.

Professionals involved with the Children's Services Forum identified the following strengths in the approach:

- It's a simple model that tries to address the fact that certain families can become lost in a complex system.

- It leads to improvements in customer service. Unsuitable or non-consumer friendly timing of appointments was highlighted, as was the need to make waiting environments friendlier.

- Good value for money is offered in that time spent pursuing clients who do not attend is reduced and better use is made of appointment times.

- The model could also be used for other groups such as adults or the elderly.

Family Support Policy Framework

North Eastern Health Board

The North Eastern Health Board (NEHB) identified the need for a clear policy framework for Family Support Services in the region in 1999. It was felt that such a policy would enhance existing family support services to children and their families by developing a framework to facilitate the provision of such services across disciplines, programmes and agencies, while at the same time acknowledging the importance of informal support networks.

In 2000, a Family Support Working Group was established, comprising of NEHB practitioners and managers across a range of disciplines and programmes, to develop a family support policy framework for the Board. The Development Officer for Regional Child Care Services chaired the Group. This group undertook most of the work, with external assistance and expertise provided by Queens University Belfast and NUI, Galway. The terms of reference for the working group were:

- To review existing understanding and practice in relation to family support / prevention.

- To consult with local community care teams and voluntary agencies concerning this issue.

- To map existing services, statutory and voluntary and to assess the need for the service throughout the region.

- To examine different models / frameworks for family support / prevention.

The working group set about achieving its overall aim by addressing its terms of reference in as comprehensive a way as possible. Questionnaires were designed by the working group for consultation with Board and non-Board services. NEHB services consulted included child psychology, child psychiatry, community physiotherapy, health promotion, child health, paediatric services, drug addiction services, social work, speech and language therapy, counselling and home visiting service. General Practitioners were consulted with the assistance of the Board's primary care unit.

A total of 35 voluntary and community services were consulted, including pre-school providers, Springboard projects, services for young people, domestic violence services and disability services. A group of 11 children, service users in an after-schools club were also involved in the process. A drama in education methodology was used to consult with children.

Following collation of materials from the consultation process, a policy framework and supporting documents were printed. The policy was adopted by the Board's Strategy and Policy Advisory Forum and launched by the Chief Executive Officer. An implementation strategy has been developed. Eleven agreed indicators of need were identified.

The outcomes of this initiative to date have been:

- The policy sets out a new way of working together across disciplines, programmes and agencies.

- The policy places the needs of children and their families over professional departmental and agency boundaries.

- It provides an integrated model of family support prevention that encompasses universal and targeted services.

- It maps out what will be different for children and families.

The NEHB feels the development of the strategy had a number of key strengths:

- There was an extensive consultation process.

- The voices of children were included, using child-friendly methods of consultation.

- It sets out a new way of working that puts the needs of children and families first.

- It maps out what is required to commence the process of policy implementation.

- The strategy develops a basis for needs-based planning.

8 principles underlying the NEHB's approach to family support

- A strengths based perspective which is mindful of resilience as a characteristic of many families lives.
- Aims to build capacity amongst children and families to maintain and promote their own health and well being by increasing their self-esteem, self-competencies and self-efficacies.
- An ecological approach that understands the interacting relationships between child, family and community and their stage of development.
- Aims to promote social inclusion and counteract inequalities by ensuring issues of disability and rural and urban deprivation are given centrality in all initiatives.
- Responsive to identified needs of children and families.
- Involves children, families, communities and service providers in the planning, delivery and evaluation of family support services.
- Informed by ongoing evaluation, family support services are based on what is known to make a difference to children and families.
- The needs of children and families should take precedence over professional, departmental and agency boundaries in order to achieve planned, co-ordinated and integrated services.

Quality Management System - Roscommon Social Work Team

Western Health Board

ISO 9002 is an established and internationally recognised quality model. While the model has had some use in the health care service throughout Ireland, the Social Work team in Roscommon was the only community care team in Ireland to have received certification for their established system at the time of this research.

Prior to the introduction of the Quality Management System (QMS), the Roscommon social work team had few written policies and procedures regarding how the work should be done and social workers in various teams had different ways of doing some things, which could lead to confusion and make induction difficult. They wanted to develop and implement a systematic approach to service delivery that would be clearly defined and understood. The system would help them to attain high standards of practice and focus on the process of continuous improvement. It would provide high levels of accountability by ensuring practice and services are in line with statutory and legal requirements and guidelines.

In implementing the model, the focus was on improvement, not certification. The question 'will this be helpful?' was asked of every procedure. All members of the team were involved in researching and writing the policies and procedures, which, while tedious and time-consuming, helped to ensure common ownership. Standard operating procedures were developed and implemented, based on best practice and in line with legislation and guidelines. Policies were developed in areas such as quality, complaints system, staff training, maintenance and storage of records. Systems of internal and external audits were implemented, including the training and involvement of all staff in audit tools and procedures. The policies and procedures can be easily updated to keep them in line with emerging legislation and best practice.

A Management Review Board reviewed all elements of the system. In July 2000, the National Standards Authority of Ireland (NSAI) undertook the first external audit and certification was secured. It carries out regular audits and to date, its findings have been very positive and encouraging, highlighting the fact that the system is operating successfully. The audit consists of a thorough evaluation of case files to establish whether or not documented procedures are being followed. This audit also involves an evaluation of staff training, complaints management, administration and other areas. Internal regular audits are also carried out - all staff in the department are trained to do this and are involved in the process.

Service users are involved through specific user-friendly information leaflets, a complaints procedure, register and leaflet and written practice procedures. The next priority for staff will be the development of service user feedback mechanisms.

SECTION 4

Principles in Practice

Principles in Practice

In this Section, we return to the good practice principles identified in Section Two, in order to highlight how the principles are reflected across the 26 profiles presented in Section 3. As this project did not evaluate the models profiled, the analysis is not the outcome of a systematic process but is based on an interpretation of where the principles were clearly represented in the data submitted. Space does not permit us to refer to every example of where good practice was found, so if services are not referred to under a particular principle, it does not necessarily mean that their work is not in line with that principle.

Management Principles

Good practice principles relating to service management are evident in the work of the profiled organisations, as follows:

Strategic framework for service delivery:

- The North Eastern Health Board's Family Support Policy Framework is an example of how a Health Board agreed a set of principles and objectives in relation to family support in the context of a strategic framework for service delivery. Similarly, the MWHB Parenting Strategy was developed from a process of consultation and planning and sets out a strategic and operational framework for parent support. The strategy is explicit about the level of prevention at which it aims to operate.

- As mentioned in the outset, being explicit about the links between preventative work and child protection is important as is clarity regarding the role of each service or intervention. People attending the Family Resource Centre, Tallaght are clear about the service's role in relation to prevention, but are aware that any child protection concerns must be dealt with by the duty social work service. This clarity of roles and relationships is conducive to the development of trust between staff and service users.

Management and organisational culture

- For Geraldstown House Family Resource Centre, the culture of the organisation is very important. Importance is placed on staff sharing common basic assumptions about the work, maintaining a consistent and fair approach and high professional standards. There is an open and transparent team structure, a willingness to question practice and embrace new ideas.

- The experience of the Roscommon Social Work team was that introduction of its Quality Management System improved management and organisational culture. It made induction easier, clarified procedures, ensured that practices were in line with national and regional policy and has created a better environment for staff to work in.

- A number of services have clearly articulated the theoretical position and ethos from which they work, which helps to guide staff in terms of interactions with users of the service. For example, Kilkenny Community Early Years Project is very clear regarding its role as an anti-poverty project, is run according to family support principles and respects the parent as the primary carer of the child.

A Culture of learning and development

- The Mid-Western Health Board's Parent Support Strategy demonstrates a commitment to create a culture of learning and development in relation to delivering parent support. The Board is aware that parenting training is a complex issue, which is difficult to target and evaluate. For this reason, they have committed themselves to developing performance indicators to evaluate the parenting strategy, in the awareness that it will take refection, rigorous examination and adaptation to ensure that the strategy is bedded down in each county and effectively meeting parents needs.

- Likewise the MWHB's Aftercare Programme has a commitment to continuous self-reflection and learning from its work. Close attention is paid to the outcomes of audits and staff are open to feedback from young people regarding their experience of the programme. The service is also taking a lead role in developing coherence and good practice in aftercare nationally.

- As an emerging service, the C.R.I.B. Youth Project and Health Café in Sligo town recognises it is in somewhat 'unchartered waters' in trying to design a new type of youth health café. Cognisant of this position, the project leader was explicit about ensuring that, from the outset, the project should grow in a culture of learning. In practical terms this includes the staff and manager acknowledging mistakes and changing as required, while at all times acting in the best interest of service users.

Outcome measurement

- While not all of the organisations profiled have procedures in place for evaluation, a number of the services profiled have evaluated or measured the outcomes of some or all of their work. These include Sligo Family Support's evaluation of its home visiting programme, evaluation of the Family Rights Group and The Family Welfare Conference Pilot Project Evaluation. The Marte Meo practice of having a routine follow-up with families three months after the intervention is a simple way of assessing whether the intervention has had a lasting impact, as well as checking if other needs may have arisen in this time.

Adequate resourcing and value for money

- The issue of resources is obviously important to all the services profiled. For most, additional resources would be welcome to enable the service to expand its remit or improve quality. A number highlighted that they would like extra resources to enable them to undertake an evaluation of their work. While they acknowledged that additional resources would be valuable, they felt that they were achieving good value for money in their use of existing resources. The message from services is that good quality intervention with children and families does not come cheap. Also, creating a good practice environment, including making services attractive and accessible, staff training and evaluation involve extra costs. However, investment can be justified on the basis that good quality prevention and protection services can yield savings at a human and economic level in the long term.

- A common feature of the profiles was their emphasis on promoting the parents understanding of their child's developmental needs and then providing them with the means by which they can help them to develop into emotionally and physically strong children and adults. As the parent is the key educator of the child, imparting this information and skills to the parent is likely to have long-term benefits. The

experience of parents, including the parents of children with autistic spectrum disorders in 'Back to Basics', the parents trained in the Marte Meo method and the parents participating in the Sligo Family Support Lifestart programme is that acquiring information and tools to communicate with their children can radically alter the quality of their relationships. While it is difficult to state with certainty that these services are preventative in nature, research indicates that such models of early intervention represent good value for money in the long-term.

- There are examples of where resources are used creatively to come up with new solutions to old issues. Models such as the 'Big Deal' Contract and the Children's Services Forum were developed by existing staff to use existing resources in a way that represented value for money and provided better outcomes for families. The Family Welfare Conference project points to the fact that plans made by families under the project can be less costly and represent better value for money than a plan devised by professionals for the family. For Homestart, Tullamore, matching the skills and interests of volunteers to the needs of isolated families represents good value for money.

A commitment to effective partnership practice

- All of the profiles involve practitioners working in partnership with other disciplines and agencies. It is considered an essential part of the work, in order to address the needs of children and families in an integrated manner. The Children's Services Forum in Carlow proves that working in an inter-disciplinary manner can improve the targeting of children's services and ensure that needs do not go unmet. Staff derived greater job satisfaction from having a co-ordinated approach and knowing that cases were not falling 'through the net'.

- Other models in which inter-disciplinary and inter-agency work was strong were the Kilkenny Community Early Years Project, Amiens Street Childcare Centre and Granard Action Project.

- In the context of a more formal 'clinical' approach provided through direct work with children, the IMSR Programme in Donegal town clearly saw its role as one player in the consortium of agencies and disciplines who work with people in need. The worker on the project, whilst advocating the importance of the service offered to children, specifically around the issue of attachment, was still very clear that no one professional, programme or project could adequately meet the needs of children. In fact, the need for connectedness between families, professionals and agencies alike was seen as crucial to the success of the one-to-one intervention.

Staff Development & Support

- Services were aware that work with vulnerable children and families can take its toll on staff and it is essential that personal and team support is given to staff. Ongoing training and staff development enhances staff capacity and can improve the quality of the service. A number of services mentioned that they encourage staff to undertake regular training.

- Sligo Family Support Ltd. has a management culture that reflects its objectives as a family support project. For example, family home visitors work a 20-hour week, which is compatible with their own responsibilities as parents.

Intervention Principles

Good practice principles relating to direct interventions with children and families are evident in the work of the profiled organisations, as follows:

Accessible and attractive:

- The community based family resource centres are all locally based and accessible for families. The organisations profiled in this document, including the C.R.I.B. Youth Project and Café, Geraldstown House, Family Resource Centre, Tallaght and Whitefriar Street Community Education and Development Project highlighted the importance of creating an attractive and welcoming environment for people to come to.   The involvement and input of service users is vital in designing and creating such an atmosphere.

- The location of services such as Muirhevnamor Springboard Project and Sligo Family Support in the grounds of a primary school is an example of how services can be accessible and increase their profile by having a strategic location. Westside Family Services (The 'Big Deal' contract) has an accessible base in a community resource centre, which also avoids any possible stigma for families involved due to the high throughput of visitors to the centre.

- In terms of making services more accessible for fathers or male carers, two particular examples were raised in the profiles. Whitefriar Street Community Education and Development Project made a specific effort to target men, by visiting their homes and asking their views on what types of courses they would like. This yielded results in that more men are now participating. The Family Resource Centre, Tallaght has had a small number of men attending, where before it was mostly women. It attributes this to the fact that there is now a male staff member, but also that there are more male primary carers. There is an acknowledgement among many of the services that it is an area that needs further attention.

Integrated:

- Sligo Family Support's home visiting service gets in touch with all first-time mothers in its target area to deliver home-based social support and parent training. A centre-based service is available for parents to access childcare on a full-time, part-time or sessional basis, to undertake courses, meet other parents and participate in other initiatives. Furthermore, the NWHB public health nurses are closely linked to the centre and outreach courses and sessions are run. This is just one example of the many models of integrated service provision profiled in the document that offer a range of choices to families in an accessible and user-friendly manner.

- As part of its role as an assessment unit, the Airne Villa service in Killarney saw integration with other service providers as central. Whereas the residential assessment process included a range of professionals who work 'on-site' with the service directly, the wider family, community and other professionals are also integrated into the assessment process.

Responsive to need and effective:

- A cycle comprising assessment, intervention and review / evaluation in collaboration with the service user is the mode of operation among many of the services profiled. For example, the Aftercare Programme works from the basis of an in-depth assessment of need, followed by appropriate intervention and review. In other cases, such as in universal community-based services, the assessment of need may not be formal, but through use of the service, service users and professionals can gain an understanding of where each is coming from and what type of intervention is required. Intervention is more likely to be effective if based on a shared understanding of needs and goals.

- Paying close attention to children's developmental needs is a core element of the approach of many of the services profiled. Given the importance of the early years in terms of speech and language development, as well as general health, a number of interventions place an emphasis on ensuring that children from vulnerable families receive the health and therapeutic services they require. For example, the Kilkenny Community Early Years Project works closely with health professionals to ensure that any health needs that emerge for children in their care are addressed. The Children's Services Forum, Carlow was established to tackle the issue of non-attendance at young children's services, which can result on children missing out on vital health interventions.

- Where children have been damaged by abuse or insecure attachments in their early years, therapeutic interventions can support healing and recovery. The Integrated Model of Self-Regulation is a specialised approach for children in care.   The Amiens Street Childcare Centre highlighted the role of therapy in helping children to recover from traumatic experiences.

- Whitefriar Street Community Education and Development Project has an advisory group of participants to offer feedback and suggestions for the ongoing work of the project. Geraldstown House's work is constantly evolving in response to the needs of a changing community. Muirhevnamor Springboard Project was developed in response to an identified community need and tailors its services to the needs of individual families.

- Interventions aimed at tackling parental isolation, stress and depression are important in terms of promoting family and child well-being. The Post-Natal Distress Group profile highlights how peer support interventions can have a therapeutic effect on mothers, while signposting them to other vital health and community services. Early detection of isolation and depression, with ongoing support, reduces the prolonged effects of undiagnosed depression and family stress. Home-Start, Tullamore has experienced a strong demand for its parental support services, especially its weekly family morning, and has found that isolation and loneliness affect parents from all backgrounds.

- The MWHB Parenting Strategy was developed in the realisation that all parents have support and information needs.   Responding to these needs is both supportive and preventative in that it can improve the well being of families and avoid the escalation of potentially damaging issues or problems.

- The Gleann Alainn service in Cork City, in working with very difficult adolescents, all of whom have marked behavioural problems, see the importance of meeting the needs of its service users as a

corner-stone to good practice. Whilst acknowledging that many see the problems of service users as negative and perhaps almost unworkable, staff in the centre continued to use a strengths based perspective in working with service users and retain a 'needs-led focus' in how they work with young people, despite their behaviours.

Collaborative and Strengthening:

The profiles in this document suggest that services are all endeavouring to work in a collaborative way with children and families, building on their strengths and abilities. While for most services, collaborative work is inbuilt in their overall approach, a number of interventions are specifically designed to engage parents and children as collaborative partners.

- For example, the Marte Meo method of intervention is led by the parents identifying a question or problem and working at their pace to find a solution. It empowers the parent and family to communicate in a way that makes life easier for all the family. Risk to children is reduced by identifying current difficulties being experienced by children and families. The model also helps family support workers, social workers, public heath nurses and other professionals to reflect on their own practice and ensure that they are not working in a way that is disempowering for the family concerned, despite their good intentions. The Back to Basics model is also led by the child and develops the intervention around their needs.

- The Family Welfare Conference model is rooted in a family strengthening perspective. Its experience has been that, if given space and resources, families are capable of producing a plan that draws on their own sources of support, with outside help.

- For parents who are very vulnerable, it takes time for them to realise that they have a right to express their opinions and needs and to feel comfortable doing so. The Family Resource Centre, Tallaght and Granard Action Project highlighted the importance of giving parents the time and space to develop their confidence and relax into the service. Once they have done this, they are then able to assert their wishes and needs and utilise services in a way that better meets their and their families' needs.

- The Western Health Board adopted a systematic approach to improving participation of parents at child protection conferences, which included the provision of better information, clearer procedures and staff training. Evidence of improved participation is currently being examined through research.

Culturally Competent:

- While a number of the profiled services are working with people from various ethnic and cultural backgrounds, not many specific examples of culturally competent work practices were raised in the process of the research. One exception was Sligo Family Support, which adapted the educational materials used in its Lifestart Programme,'The Growing Child', to reflect Traveller culture.

'Whole child' approaches:

- Most interventions for young people at risk and children in care had strategies for working with parents, as well as the young people, underlining the crucial role of parental care giving in the young person's life. For example, the Gorey Youth Needs Group works with the child and young person, as well as his / her parents, school and other service providers. It developed a parenting programme in response to expressed need from the parents of its target group. Likewise, while the aim of the 'Big Deal' contract is to keep the child in school, it recognises that addressing the parents' needs is a key factor in providing a stable context to support the child to survive and thrive in school. Evaluation of the Family Rights Group, a support group for children in care, highlighted that the parents were marginalised, isolated and had unmet needs as individuals as well as parents.

- The Amiens St Childcare Centre adopts a 'whole child' approach to supporting children in care in the context of their families, friends and communities. It facilitates children to maintain their relationships and co-ordinates local services to meet their specific needs. Relationships with families continue even after they have left the centre.

- The Airne Villa assessment and resource unit undertakes a holistic assessment of children's needs. Information is gathered and assessed about the child's relationships and environment and efforts are made to locate supports in the most appropriate way.

Staff Interested and Able:

- A number of profiles drew attention to the relationship between staff members and service users as crucial to the effectiveness of the intervention. For the Geraldstown House Family Resource Centre, the relationship established with users of the service is of crucial importance and is based on respect, understanding and genuineness of care. The Gleann Alainn Unit also sees the relationship between staff and young people as a powerful therapeutic tool, which means that staff have to be highly committed and genuinely interested in the young person. A number of other projects felt that the personal commitment and interests of staff members was a central factor in the success of their work.

End Note

This project set out to provide an insight into the range and depth of work taking place in child and family services in Ireland and to enhance our understanding of good practice. It did this by identifying a set of principles associated with good practice in child and family services, profiling the work of 26 services across 8 categories as described by local practitioners. The document concluded by highlighting some examples of how the good practice principles are currently translated into practice by these services.

The initiatives profiled in Section 3 demonstrate that there is a huge body of knowledge and experience built up in relation to work with child and family services in Ireland. While some of the interventions have a long track record, others have been developed in the past number of years. Staff working at management and intervention levels are eager to share their experiences and to learn from those of other people.

This document indicated a number of areas of particular strength. Many of the services are staffed by highly skilled and committed staff, who show tremendous interest in the users of the service and work in a collaborative and family-strengthening way with children and families. In many cases, services are implementing proven work practice models and reflecting and adapting them to suit local need. There is a commitment to developing partnership working with parents and children and to tailor services to meet their individual needs. This is not to say that the work is not challenging and difficult. Services are facing big challenges, as the level of presenting and unidentified need remains great. The job of meeting children's needs is never 'done'.

While this is not an evaluative study, and the emphasis is on what is being done well as opposed to what is not being done, it is useful to draw attention to a number of areas that were not particularly evident in the material presented:

- Evaluation and reviewing of outcomes: Many of the services have no procedures in place to evaluate their work. While evaluation requires resources, good practice principles suggest that it is something that is essential to ensure that the service is operating effectively.

- Cultural competence: As Ireland becomes an increasingly multi-cultural society, there is a need for training and strategies to ensure that services are culturally competent. Learning from the UK and other international experience is likely to be useful in this regard. Ways of making children's health and welfare services relevant and responsive to the needs of Traveller families must also be a priority.

- People with disabilities: It is notable that just one of the services nominated by Health Boards relates directly to people with disabilities. This is not to suggest that good practice is not taking place with people with disabilities, but that it is something that was not put forward by Health Boards in this case.

Notwithstanding these comments, what is enclosed is a rich resource of policy and practice in child and family care put forward by practitioners willing to share with others what they do. For this alone they are to be commended, for their collective experiences and analysis of their practice can assist all involved in the search for better outcomes in working with children and families in adversity. The profiles should be of

interest to policy-makers and planners in that they demonstrate the immense value of investment in child and family services.

Looking to the future, it could be a valuable exercise to revisit the set of services involved in this report at a later point, in order to gain insight into what changed in relation to practice and what remained robust in terms of good working for children and families. There is also potential for further sharing of experience, in greater depth than the scope of this project permitted. Further projects could include national or regional networking, websites and twinning of projects, be it in relation to issues, models or approaches. The document, therefore, can be considered as a starting point from which a process of sharing and learning in relation to good practice can be developed and should be encouraged.

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PRACTICE WORKBOOK		
My / Our Thoughts on This Report	What Key Messages Can I / We Take From The Report?	What Actions Can I take Based On The Report?

PRACTICE WORKBOOK		
My / Our Thoughts on This Report	What Key Messages Can I / We Take From The Report?	What Actions Can I take Based On The Report?

APPENDIX 1

Practice Workbook

PROJECT	SUBMITTED BY	ORGANISATION TYPE	CONTACT NAME	ADDRESS	TEL.	E-MAIL
Kilkenny Community Early Years Project	South Eastern Health Board	Voluntary / community organisation with HB funding	Joanne Julien *Project Co-ordinator*	Bishop Birch Training Institute Nuncio Rd. Kilkenny	056-70234	kceyp@oceanfree.net
Sligo Family Support Ltd.	North Western Health Board	Voluntary / community organisation with HB funding	Marian F. Quinn *Co-ordinator*	Pearse Road Sligo	071-46034	lifestartsligo@eircom.net
The Marte Meo Project	Northern Area Health Board	Direct Health Board service	Colette O'Donovan *Co-ordinator*	17 Middle Mountjoy Street Dublin 7.	01-8601648	martemeo@eircom.net
Home Start, Tullamore	Midland Health Board	Voluntary / community organisation with HB funding	Patricia McLoughlin, *Co-ordinator*	St. Mary's Youth Centre Tullamore, Co. Offaly	0506-22996	patriciamcloughlin@mhb.ie
Post-Natal Distress Group	South Western Area Health Board	Direct Health Board Service	Anne Kinsella *Counsellor and Group Facilitator*	Briancan Ballymore Eustace Co. Kildare	045-864263	
Parenting Initiative	Mid Western Health Board	Direct Health Board service	Chris Sheridan *Principal Community Worker*	87 O'Connell St. Limerick	061-483392	csheridan@mwhb.ie
Whitefriar St. Community Education and Development Project	South Western Area Health Board	Voluntary / community organisation with HB funding	Brigid Ruane Project *Co-ordinator*	Whitefriar Street Community Centre 56 Aungier St. Dublin 2	01-4754673	ruane@iol.ie

APPENDIX 2
Contact Details for Organisations Profiled

PROJECT	SUBMITTED BY	ORGANISATION TYPE	CONTACT NAME	ADDRESS	TEL.	E-MAIL
Geraldstown House	Northern Area Health Board	Direct Health Board service	Breda Merity & Tom O'Donnell *Project Leaders*	Geraldstown House Ballymun Cross Dublin 9.	01-8422408	
Family Resource Centre	South Western Area Health Board	Direct Health Board service	Monica Hynds *Team Leader*	16 Main Rd. Tallaght Dublin 24	01-4515708	Monica.hynds@erha.ie
Muirhevnamor Springboard Project	North Eastern Health Board	Voluntary / community organisation with HB funding	Alice Malone *Project Manager*	St Joseph's NS Muirhevnamor Dundalk Co. Louth	042-9351680	muirhevnamor@esatclear.ie
The Big Deal Contract	Western Health Board	Direct Health Board service	Eileen O'Toole *Acting Project Leader*	Westside Family Services Resource Centre Seamus Quirke Road, Galway	091-585011	westsidefs@eircom.net
Gorey Youth Needs Group	South Eastern Health Board	Voluntary / community organisation with HB funding	Pat Kelly *Project Co-ordinator*	Woodstock Hall Lower Esmonde Street Gorey Co. Wexford	055-22611	info@goreyyouthneeds group.com
The C.R.I.B Youth Project and Café	North Western Health Board	Voluntary / community organisation with HB funding	Anne Marie Kelly *Project Manager*	Rockwood Parade Sligo	087-9087141	
Granard Action Project	Midland Health Board	Direct Health Board service	Marie Gaffney *Project Leader*	Barrack Street Granard Co. Longford	043-87220	mariegap@eircom.net

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Contact Details for Organisations Profiled

PROJECT	SUBMITTED BY	ORGANISATION TYPE	CONTACT NAME	ADDRESS	TEL.	E-MAIL
Back to Basics	Midland Health Board	Direct Health Board service	Linda Welford, *Senior Occupational Therapist*	C/o Childhood Autism Team 7A Lough Sheever, Casson Ballard Rd., Mullingar Co. Westmeath.	044-84822	
Integrated Model of Self-Regulation	North Western Health Board	Direct Health Board service	Dr Helen Gogarty	District Hospital Donegal Town.	073-21074	Helen.gogarty@nwhb.ie
Gleann Alainn	Southern Health Board	Direct Health Board service	Andy Denton *Acting Unit Manager*	St Stephen's House Glanmire Co. Cork.	021-4822509	dentona@shb.ie
The Family Welfare Conference Service	East Coast Area Health Board	Direct Health Board service	John O'Riordan *Manager*	24 Lr. Baggot Street Dublin 2	01-6760835	
The Family Rights Group	Mid Western Health Board	Voluntary / community organisation with HB funding	Chris Sheridan *Principal Community Worker*	87 O'Connell St. Limerick	061-483392	csheridan@mwhb.ie
Parental Participation at Child Protection Conferences	Western Health Board	Direct Health Board initiative	Paddy Martin *Principal Social Worker*	Killala Health Centre Killala Co Mayo	096-32404	Paddym19@eircom.net
Airne Villa Resource and Assessment Unit	Southern Health Board	Direct Health Board service	Martina Twomey *Unit Manager*	Rock Road Killarney Co. Kerry	064-37739	Twomeym3@shb.ie

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Contact Details for Organisations Profiled

PROJECT	SUBMITTED BY	ORGANISATION TYPE	CONTACT NAME	ADDRESS	TEL.	E-MAIL
Amiens Street Childcare Centre	Northern Area Health Board	Direct Health Board service	Paddy Ormond *Manager*	69 Amiens Street Dublin 1	01-8741791	
Aftercare Programme	Mid-Western Health Board	Direct Health Board service	Sally Scott *Team Leader*	Social Service Centre Henry St. Limerick	061-312739	sscott@mwhb.ie
Children's Services Forum, Carlow	South Eastern Health Board	Direct Health Board initiative	Mary Keogh *Assistant Director of Public Health Nursing*	Community Care Head Quarters, James Green Kilkenny	056-52208	oldens@sehb.ie
Family Support Policy Framework	North Eastern Health Board	Direct Health Board initiative	Rose Cullen *Development Officer*	Regional Child Care Office Aerbridge House Dunshaughin Business Park Dunshaughlin Co. Meath	01-8250907	Rose.cullen@nehb.ie
Quality Management System	Western Health Board	Direct Health Board initiative	Martina McGrath *Principal Social Worker*	Child Care Office Abbey Street Roscommon	0903-26732	

APPENDIX 2

Contact Details for Organisations Profiled

Section 1- Background Details

1.1   Please Indicate the Title of Good Practice Model

1.2   Please State Health Board Area where the Good Practice Model is Located

1.3   Please indicate who Operates the Good Practice Model:

☐   Health Board

☐   Voluntary Organisation with Health Board funding
(please specify organisation(s) involved)

☐   Partnership between Health Board and Voluntary Organisation(s)

☐   Other (Please Specify)

1.4   Please provide the following information for a Contact Person for Good Practice Model

Name and Title

Address

Telephone Number

Email

1.5 Please indicate the month and year when Good Practice Model began operating

_____/_____

1.6 Please indicate the Predominant Service Domain of Good Practice Model:

☐   Family Support

☐   Child Protection

☐   Alternative Care (incl. fostering, residential care, aftercare and adoption)

☐   Cross-Domain

Section 2 - Description of Good Practice Model

2.1   Please outline the background to the Development of the Good Practice Model

2.2   Please Outline the overall Mission / Vision / Aim of the Good Practice Model

2.3   Please List the Specific Objectives of the Good Practice Model

2.4   Please Outline the General Strategy or Approach that the Good Practice Model Adopts

2.5   Please Outline the Key Activities of the Good Practice Model

2.6   Please outline staff numbers, the professional / disciplinary groups involved and the staffing / management structure of the Good Practice Model

2.7.   Please outline the ways in which service-users are involved in the Good Practice Model

2.8   Please outline the main results of the Good Practice Model

2.9   Please provide any additional relevant descriptive information on the Good Practice Model

Section 3 - Good Practice Criteria

3.1   Orientation towards Supporting Children and Families
Please outline how the Good Practice Model is especially orientated towards supporting children and families. (Provide no more than five points)

3.2   Effectiveness
3.2.a. Are there demonstrated results that reflect objectives of the Good Practice Model?
3.2.b. What evidence exists in relation to the achievement of the objectives of the Good Practice Model?
3.2.c. What are the views of service users on the effectiveness of the Good Practice Model?
3.2.d. Has the Good Practice Model been formally evaluated? Yes ☐   No ☐

If yes, was the evaluation carried out :

Externally   ☐
Internally   ☐

What are the main findings and conclusions of the evaluation?

3.3.   Transferability
3.3.a. Is this Good Practice Model applicable to other health board areas?
3.3.b. What would be required in order to adopt this approach in another health board area?

3.4. Value for Money

3.4.a. On what basis do you think that the Good Practice Model represents Value-for-Money?

3.5 Innovation

Please outline if and why you think that the Good Practice Model is innovative. In doing so, please identify whether the model:

(i.)   Has been tried elsewhere in Ireland or abroad (to your knowledge)

(ii.)   Is the first replication of something that has already been tried abroad (to your knowledge)

(iii.)   Is a novel adaptation of an already extant approach.

3.6. Research Literature

3.6.a. To what extent is the Good Practice Model supported in the research literature? Please reference relevant literature.

3.7. Areas of Improvement

3.7.a. Are there any dimensions of the Good Practice Model that could be improved? Please list no more than five such dimensions.

3.8. Overview

3.8.a. In your view, overall, what are the key dimensions that makes the Model an example of Good Practice? Please list no more than five points.

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