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A formative evaluation of the Community-Based Family Support Programme

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Glossary

CBFSP	Community Based Family Support Programme
CDP	Community Development Project
FSPW	Family Support Project Worker
HSE	Health Service Executive
HSLO	Home School Liaison Officer
PHN	Public Health Nurse
PO	Programme Office

Chapter One
Introduction, Context, and Methodology

1.1   Introduction

The Community Based Family Support Programme (CBFSP) was established by the Health Service Executive (HSE)[1] Child Care Departments in Mayo and Galway in 2004. For the HSE Child Care Department, the provision of accessible community-based support for families is a means of protecting children and preventing their entry to state care. This programme was established to offer a family strengths building programme, through individual support and community building, in conjunction with local Community Development Projects (CDPs) and one independent family centre[2]. The benefits expected to accrue from the programme include enhanced self-esteem and family empowerment, evidenced in the families being able to positively influence life events and becoming more resilient in the face of stress. In turn, this was intended to reduce the numbers of children using child protection services and entering state care.

As this is a new and innovative family support project, involving a partnership between the HSE, local CDPs, and Foróige, the HSE asked the Child and Family Research Centre (CFRC) to undertake an evaluation of the project. The aims of this research are to assess the outcomes of the project for the children and families involved and to explore the dynamics of the partnership model and the experience of running family support services in rural areas. This chapter begins with a consideration of family support in a community development context and of the place of community-based family support in the range of services at present. We then move on to look at the rationale for the development of this Programme and to outline the model underpinning it.

1.2   Family Support and the role of the HSE in its provision

Family support programmes focus on early intervention with the aim of promoting and protecting the health, well-being, and rights of children and families. It can be seen as both a style of work and a set of activities that strengthen the child and family's coping, with a particular emphasis on the family's own supportive resources and how these can be used positively (Dolan, Pinkerton, & Canavan, 2006). Family support is considered most effective when locally based and accessible (Gilligan, 2000; McKeown, 2001). A wide range of organisations, (including schools, voluntary organisations and community groups) can have a role in providing family support.

Gilligan (1993) suggests that the role of the HSE in relation to family support should be seen as comprising activities that strengthen a family's functioning in relation to child rearing, supporting them to withstand stresses which affect their ability to care for and nurture children. Specifically, he believes that the role of HSE family support services should be:

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[1] The project was originally established by the Western Health Board which was incorporated into the HSE West in January 2005.

[2] For convenience, the four CDPs and the family centre are collectively referred to as CDPs in the report.

- to strengthen the coping and parenting capacity of a parent or parents
- to maximise the resilience of children in the face of stress, by securing their integration into key supportive institutions such as the school. (Gilligan, 1993, p.2)

Within the HSE Child Care services, there are three distinct but inter-connected service domains as detailed in the Western Health Board's *Strategy for Child and Family Care Services* (2002): child protection; alternative care; and family support. They have as their legal bases the Child Care Act 1991 and the Children Act 2001. The HSE views family support as one domain of work as well as an integrating orientation towards all work with children and their families. Family support as a distinct service area encompasses the Neighbourhood Youth Projects, Springboard projects, other youth and adolescent projects, and Early Years supports. Among the family support services developed following the Children Act 2001 are Family Welfare Conferences and Youth Advocate Programmes.

One of the key roles of HSE family support services is to prevent children and young people from entering care or the child protection system. In particular, one area of particular concern is neglect of children, which represents the biggest reason for referral to the child care system. Families where there are concerns of chronic neglect are often those experiencing great disadvantage with poor employment, health and education needs. It is for this reason that the programme model was developed to combine a focus on addressing disadvantage with targeted family support provision.

1.3   Community Development and the Community Development Programme

Community development is concerned both with building resilience in communities and with empowering non-professionals to lead their own communities (McGrath, 2003, 2004). The national Community Development Programme was established in 1990 in recognition of the role of community development and a community development approach in tackling, poverty, exclusion and disadvantage. The aim of the Programme is to develop a network of community development resource centres and other projects in communities affected by high unemployment, poverty and disadvantage. Projects all have an anti-poverty, anti-exclusion focus and work using community development principles and methods. Projects are concerned with the needs of women and children, those with disabilities, the homeless, lone parent families, the elderly, the unemployed, young people at risk, Travellers, and other disadvantaged groups.

Community development projects encourage the participation of people and groups in society by building their capacity to identify and realize solutions for themselves and their communities. The work of projects is people centred, aiming to enhance the skill and self-confidence of people to allow them to work collectively and influence issues of importance to their communities.

Under the Community Development Programme, the Department of Community, Rural and Gaeltacht Affairs provides financial assistance towards the staffing and equipping of projects. At the end of 2006, 182 projects were participating in the Programme (DCRGA, 2007). Projects are located throughout the country. Each

local Community Development Project is assigned a Support Agency to provide advice and guidance and set standards for their work (Department of Community, Gaeltacht and Rural Affairs, 2007).

There are 9 CDP's in County Mayo and 10 in County Galway. In addition, there are 5 family resource centres in Galway and 7 in Mayo (2 of which are in development stage).   West Training & Development has been contracted by the Department of Community, Rural and Gaeltacht Affairs to provide support to the community development projects and family resource centres.   The support provided includes promoting good practice; working with projects in drawing up work-plans and evaluating their progress and facilitating regional networking between CDPs.

1.4 Community development and family support– common ground

There is some obvious convergence between the activities of family support and community development.   Many community development groups are now engaged in delivering services in marginalized communities such as child development and education interventions (crèches, nurseries, play groups, pre-schools, homework clubs) and parent education programmes. From the perspective of family support, community development addresses the contextual factors which impinge on, and often exacerbate, the problems of vulnerable families.

McGrath (2003, 2004) explored the relationships between community development and family support as work styles as well as the relationships between CDP's and HSE family support services in the West of Ireland and reports a consensus among CDP co-ordinators that family support is an explicit and important element of their work. There is considerable common ground, both in theory and in practice, based on the idea that families and family support services cannot be removed from the community context in which they exist (McGrath, 2004). While the collective focus of community development and the individual focus of family support interventions may appear disparate, they can also be considered mutually-influencing ends of a continuum (McGrath, 2004); community work has a potential effect on all individuals in that community and work with an individual puts that person in a better position to take full part in community activities. Goldsworthy (2002) highlights that it can be difficult to effectively mobilise collective action without some form of personal support that enhances people's sense of self-worth and efficacy. For Goldsworthy, one-to-one casework type interventions offer the means for individuals to channel their energies into confronting structural and institutional injustices, through highlighting their own experiences in policy discussions, lodging letters of complaint, raising an issue with an elected politician, contributing to newsletters and so on. As Goldsworthy is keen to stress, "in this way, casework can be seen as a gateway to other action and activities" (*ibid,* p.330).

1.5   Origins and development of the Community-Based Family Support Project

The HSE West has operated family support projects such as Springboard since the late 1990s in large urban areas but there was some concern that the rural areas, villages and bigger towns which account for a large portion of the region were not served by locally accessible family support services. In 2001, initial meetings took place between representatives of West Training (the regional support agency for the Community Development Programmes of the Department of Social and Family Affairs), the HSE, and the CDPs in Mayo with a view to addressing this by placing family support project workers in rural CDPs. Planning for the Community-Based Family Support Project (CBFSP) commenced when a steering group was formed. The group was composed of the Childcare Manager for Mayo, the Regional Co-ordinator for Family Support from the HSE, two representatives of CDPs, and later representation from the participating projects. A partnership approach with local organisations focusing on disadvantage was considered a viable means through which the needs of families could be addressed. Their objective was to develop a programme, then known as Clainne Cumhact (Family Power) that would combine a local community development approach with the family support programme content of Springboard in a model appropriate to rural and small town demographics. Critically, the programme would have the objective of supporting children at risk and their families, and preventing children coming into care or to the attention of child protection services.

The first round of recruitment was for Community Child Care workers who would be employed by the HSE and placed in local CDPs. Funding was available for 3 projects initially and community childcare worker posts were advertised. Due to the limited number of applicants meeting the criteria, it was decided that the posts would be re-advertised as project workers to allow for a greater variety of prospective applicants with both childcare and community development experience. However, the timescale was delayed due to funding issues regarding the project. By that time, there was a HSE recruitment embargo so it was proposed that the CDPs would employ the family support project workers. Interested CDPs were invited to make a submission regarding their interest in the programme and these were reviewed by the steering group against agreed programme criteria. The outcome of this process was that four projects in County Mayo - Moygownagh, Kiltimagh, Louisburgh, and Parkside– and one in County Galway – Forum were selected.   An issue arose regarding recruitment that could not be resolved between the HSE and the Moygownagh project, with the result that Curam, Claremorris was selected to replace Moygownagh. Each of the five projects proceeded to recruit a Family Support Project Worker (FSPW).

As the CDPs would not have the expertise to provide casework supervision to the FSPWs and the HSE could not employ a project leader, an external organisation was asked to create what would become known as the Programme Officer (PO) post. Foroige, the national youth organisation, which is very active in Mayo, was asked to take on this role. For Foroige the decision regarding taking on this role was not straightforward as it would involve working with children who are younger than their target population, which is young people aged 10-18 years.   It was agreed that the Foroige Programme Officer would

have a role in relation to the four Mayo projects and that the Forum project in Galway would receive casework supervision from the Galway based HSE family support department.

To give a sense of the contexts in which the CBFSP takes place, a profile of the participating CDPs is now provided.

1.6   Profile of the Participating CDPs

	Established	*Catchment*	**Key areas of work**
Curam Family Centre	1989	Town of Claremorris and surrounding rural areas	Counselling Adult education / literacy Space for groups and services
Forum CDP	1989	North West Connemara	Community groups Women, elderly, youth Under and unemployed people
Kiltimagh CDP	1996	Town of Kiltimagh and surrounding rural area	Adult and community education Arts
Louisburgh Community Project	1996	Town of Louisburgh and surrounding rural area	Sonas Children's Arts festival Human rights Women's groups
Parkside CDP	1994	High density community on the outskirts of Ballina town	Childcare facilities Youth work Travellers After school programme

Table: Overview of Projects involved in the CBFSP

The following projects are those within which the community based family support project operates.

Cúram Family Centre Claremorris was founded in 1989 and serves 13 DED's within an approximate 10 mile radius. The centre aims to provide a caring environment where individuals, families and groups can empower themselves through education, training, participation and information. Cúram provides practical services such as a community laundry facility and aims to influence social policy and support locally based voluntary groups. The Centre promotes social inclusion, integration and equality in its work within the community. Services and supports available in Cúram are counselling (individual, family and bereavement), adult education/literacy, community playgroup, parent & toddler group, women's and men's groups, children's art & drama activities, St. Vincent de Paul Society and the Rainbows programme for children. Offices from

the Local Employment Service and Citizen's Information centre operate from the centre and outreach clinics are held by MABS, Mayo Women's Support Service, Mayo County Council and HSE Chiropody Service. Cúram is also used by many community, voluntary and statutory groups as a venue for training, meetings and seminars.

Cúram is not core-funded by any Government Department and relies on small grants, fundraising, donations and rents to cover running costs. It is managed on a voluntary basis by a Board of Directors and, in addition to the Family Support Project Worker, employs two full time staff; a Project Co-ordinator, Counsellor, and three staff members who are participants on a community employment scheme.

Forum CDP began as a Poverty Three Programme for North West Connemara, from 1989 to 1994, and continued as a community development project under the Department of Social, Community, and Family Affairs until 2002 and now under the Department of Rural, Community, and Gaeltacht Affairs. The population served by FORUM is 8,895 and North West Connemara has one of the lowest population densities in Europe (nine persons per square kilometre; the Irish average is 51 and the EU average 143). The foremost targets of Forum's work are community groups, women, the elderly, people with disabilities, the underemployed and unemployed, and the youth of the area. Forum's broad aims are: to tackle the problem of rural decline and peripherality; to develop locally-based initiatives; to improve the lives of people; and to target the disadvantaged and socially marginalised. This is to be achieved through developing existing and piloting new partnership arrangements between statutory, voluntary, and community bodies and through the empowerment of local people through capacity building, the development of sustainable action programmes, and the integration of experience gained into mainstream public policy and practice.

The **Kiltimagh Community Development Project** was set up in 1996 to serve the town and surrounding area. The vision of the Kiltimagh Community Development Project is to continue to develop a dynamic community facility for use by groups experiencing social exclusion. Its main areas of work are in: promoting, supporting, and facilitating community development through the participation and involvement of local people; responding to key issues and identifying needs in relation to marginalised groups and those experiencing poverty and isolation; providing administrative resources, support, and information to individuals on a wide range of social and community issues; and organising adult and community education in partnership with Mayo VEC and St. Louis Community School. The Project is managed on a voluntary basis by members of the local community and representatives from local voluntary groups. They represent Lone Parents, Women, Men, the Unemployed, the Elderly, Youth and People with Disabilities.

Louisburgh Community Development Project was set up in September 1996 in response to needs identified by local people and is part of CDP network (Access West, 2007). It serves the communities of Louisburgh, Killeen, and Lecanvey. The aims of Louisburgh CDP are to

support community activity as a means of social change; to develop new initiatives in meeting gaps between existing provisions and the needs of the community; to co-operate with agencies locally and regionally to become involved in the area; and to encourage and enable people in the community to become more involved in the project and community development according the their needs and interests. Among the services provided are administration including fax, internet, and photocopying; individual and group information and advice on welfare rights, entitlements, funding opportunities, and so on; support in establishing local groups; training and other workshops. Louisburgh CDP seeks to campaign and lobby on social issues, to organise human rights events, and to use the arts as a medium for social change. For example, the annual Sonas Louisburgh Children's Art Festival is organised through the CDP.

Parkside Community Development Project was established in 1994 following a Western Health Board report. It is based in an area of high-density housing on the outskirts of Ballina comprised of some local authority and some private dwellings. The majority of residents are between 20 and 45 years of age, many with young children, and some elderly residents. There are a large number of one parent families. The main issues in the community have to do with housing and infrastructure, employment, education, and drug and alcohol abuse. The target groups are pre-school children, school-age children, one parent families, families with low income, socially excluded families including members of the travelling community, and the elderly. The broad aim of Parkside is to work in a spirit of cooperation with voluntary, statutory, and community groups through the principles and methods of community development to combat the issues of poverty, social exclusion, and disadvantage. Parkside CDP has set up a crèche, an after-school programme, full-time Youth and Traveller Workers, and links with other statutory and voluntary bodies.

Figure 1: Map of Galway and Mayo, indicating the location of the five projects involved in the CBFSP.

1.7 Evaluation methodology

The primary aim of the research was to explore the outcomes for children and families of their participation in the Community Based Family Support Project. In addition, because the project was a new model of providing family support in rural areas, the following process questions were also of interest:

- How has the HSE / CDP/ Foroige partnership been established and worked to date in the context of this project?
- How have the family support / casework and community development approaches complemented each other and / or impacted on each other's project development?
- What has been learned or experienced in terms of the provision of family support in rural areas? (e.g. presenting issues, challenges, suitability of this approach)

The evaluation methodology could be described as 'mixed-methods' in that a combination of quantitative and qualitative methods were employed. The key elements of the evaluation methodology are now described.

Evaluation Steering Group:
An Evaluation Steering Group was formed to provide advice and feedback to the research team in relation to the evaluation. It consisted of two representatives of CDP co-ordinators, two representatives of the FSPWs, the Programme Officer (PO), the Children's Act Service Manager, and the CFRC researchers. The steering group met approximately four times over the course of the evaluation.

Informed Consent from family members:
Families were asked to give informed consent to their participation in the evaluation. They were approached by the FSPW who explained the evaluation and gave them a written information sheet. The consent sought related to:

- permission to look at details about family needs, how the project worked with each family, how things have changed for the family, etc.
- permission to talk to families to see what they think of the project
- permission to talk to other people, for example, FSPWs and referrers.

The information and consent form used is provided in the Appendix. Apart from overall caseload figures, the data outlined in Chapter Three relates only to those families who consented to take part in the study.

Monitoring and Assessment Data:
At the time the CBFSP was developed, an initiative was underway to standardise the use of monitoring procedures and assessment tools across HSE family support services in the West. The intention was that the Community Based Family Support Project would use computer based forms to record information relating to assessment, care plans, reviews and other case information. In addition, staff members were expected to make use of three assessment tools such as the Strengths and Difficulties Questionnaire or Parent Child Relationship Inventory to formally assess the needs of clients and to indicate any change resulting from the intervention. The initial evaluation proposal outlined that the evaluation would make use of data collected by FSPWs through use of assessment tools and monitoring forms, thereby drawing on their routine data collection methods to provide evidence regarding interventions.

A number of issues arose in relation to the use of assessment tools. Some workers were not comfortable about using the assessment tools with some families in some contexts, due to culture, language, inappropriate timing and other reasons. Some FSPWs felt it would be preferable to select the right tool in the right situation rather than being mandated regarding their use. Furthermore, some FSPWs were not experienced in the use of assessment tools and were experiencing technical problems (in relation to formatting and other problems). Following a review of these issues with all FSPWs, the HSE asked that projects would use at least one assessment tool with each family, chosen, based on their professional judgement. It was also accepted that the FSPWs may feel that use of an assessment tool was unsuitable in some cases, but they were asked that this would be only in exceptional cases. Furthermore, the HSE training on tools was re-designed, a new manual was developed and technical problems were addressed.

As mentioned above, because it was intended to use this data as part of the evaluation, the issues raised by FSPWs had implications for the evaluation design. Once these issues were resolved, a system was established to allow for the supply of data to the research team. Names were removed from the data and a code was assigned for each case. A research information form was devised to collect demographic and referral

data in relation to each family.   This form was completed for each family who consented to take part in the research and was forwarded to the research team. Copies of the care plan, review summaries and results of assessment tools used were also provided to give a full picture of the intervention. Consenting service users completed either the Adolescent Well-being Scale (Birleson, 1980), the Adult Well-being Scale (Snaith,Constantopoulos, Jardine, & McGuffin, 1978), the Self-Completion Questionnaire on Parents' Attitudes and Feelings (Gerard, 1994), the Strengths and Difficulties Questionnaire (Goodman, 1997), or any combination. Change over time was determined by testing in the initial stages of the case and towards the end of the intervention. In addition, the researcher asked the family support project worker to provide a narrative summary of each case when they met every six months. Further details in relation to this process in provided in Chapter Four.

Interviews and Questionnaires to assess stakeholders perspectives:
Stakeholders were asked to reflect on the outcomes and processes of the project using a combination of interviews, focus groups and questionnaires. Interviews were undertaken with representatives of all stakeholders including family members, FSPWs, Programme Officers, CDP Co-ordinators, HSE Management and Foroige management. Focus groups were held with CDP Committee members in each project. The family support projects co-exist with a range of services for people in communities and the interaction between family support projects and these other services is important. A questionnaire was sent to all services referring clients to the family support services and to services linked to the family support service in any way.

Timeframe
The evaluation study commenced in January 2005. FSPWs were asked to supply data for all consenting families new to their caseload between January 2005 and May 2006.   The cut-off point of May was agreed in order to allow time for the intervention to take place, with follow up assessments complete by the end of 2006.   An Interim Report was provided in January 2006. A draft final report was circulated in July 2007 and feedback from stakeholders was incorporated into the final report.

1.8 Report outline
This chapter described the background to the Community-Based Family Support Programme and the aims and methodology of the formative evaluation. The next chapter tracks the development of the programme model from its initial conception through the issues that emerged in the course of the project to a revised version. Chapter Three gives an overview of the families who came to the project and of the interventions that were offered, both on an individual basis and through CDP-based groups. Chapter Four describes the outcomes for these families as shown in standardised assessments and interviews as well as from the perspectives of the FSPWs. Chapter Five is a broader assessment of the project and includes the inputs of all stakeholders. Finally, Chapter Six offers some conclusions on the project up to this point and recommendations for its future.

Chapter Two
Programme model

2.1 Introduction
As mentioned in Chapter One, this Programme was developed by the HSE to offer a family strengths building programme, through individual support and community building, in conjunction with local Community Development Projects (CDPs). The model used was developed in the context of local structures and the constraints of legislation and policy. As mentioned in the Introduction, the original intention was that the FSPWs would be based in local CDPs but employed directly by the HSE but the introduction of the recruitment embargo ruled out this possibility. It also prevented the direct HSE recruitment of a Programme Officer, with the result that the post was situated in a voluntary organisation. As a consequence of adapting to these realities, the project model is slightly more complex than would have otherwise been the case. As is inevitable in a project in an early stage of development, work has been ongoing to re-define and fine-tune the work model to ensure that it meets the needs of children and families.

In this Chapter, the programme model is outlined, including the aims and objectives of the programme, management structures, service agreements, targets and referral processes. A number of issues with elements of this model emerged in the course of the project and are briefly mentioned here.

2.2   Aims and objectives of the Programme
The HSE Mission Statement states that the organisation will 'develop, provide, and support a comprehensive and integrated range of high quality child-centred, family-focused child and family services. The HSE, in partnership with others, promotes the welfare and protection of children and families in its area in accordance with legislation and the Health Strategy'. This Statement is underpinned by the following child- and family-centred principles:
- Regard the welfare of the child as the first and paramount consideration;
- Have regard to the rights and duties of parents;
- Give due consideration to the child's wishes; and
- Have regard to the principle that it is generally better for children to be brought up in their own families.

The CBFS Programme was developed as a community-based family support project with a focus on secondary prevention. The core work of family support project workers is to engage in direct work with families and children identified as needing specific supportive interventions. In the original documents in relation to the project developed by the HSE, the specific target objectives were defined as:
- To develop and sustain a family support project in CDPs;
- To make each service accessible to children and families in its catchment area;
- To have an immediate and positive impact and benefit to children and their families;

- To target specific populations who are in need of family support;
- To strengthen family's social capacity and empower individual family members;
- To promote inter-culturalism and combat racism; and
- To develop early intervention services.

The target groups identified were:
- Lone parents;
- Children involved in divorce and marital breakdown;
- Families living in rural isolation;
- Families suffering sudden and traumatic life events;
- New-comer families;
- Parents of adolescents.

In order to achieve the aims and objectives of the Programme, a strengths-based, family support work model was developed to guide interventions. In the original service agreements, some specific examples of the types of interventions that could be developed through the initiative were provided. The examples included:
- Targeted programmes for lone parent families and families living in rural isolation without access to formal support.
- The Big Brothers Big Sisters (BBBS) programme, a community-based friendship scheme between children with specific needs and trustworthy caring adults.
- Support programmes for children experiencing the loss of a parent through divorce, marital breakdown, or bereavement.
- Targeted support for newcomer families with a view to reducing isolation, providing a vehicle for informal networking and undertaking programmes of support for children and adolescents.
- Support for families at times of sudden and traumatic life events.
- Community Mothers programme involving the recruitment of local experienced mothers to provide support, friendship, and practical help to families of young children in their own homes.

In terms of understanding how the CBFSP was positioned, it is useful to consider the project in terms of a framework of prevention. Services to children and families are generally located on a continuum from primary to tertiary services. Primary prevention services such as health care, education and basic income are provided on a universal basis, thus meeting basic needs and, if they function as intended, preventing families from becoming 'at risk'. The next point on the continuum is family support services, which are provided to help families address difficulties and prevent a situation arising where a child has to be removed from home. These are generally referred to as secondary prevention, and indicate that intervention occurs after the family is deemed to be 'at risk'. If a child must be removed from home, tertiary or protective services such as residential and foster care are required (Colton et al, 2001). According to the HSE Child Care Manager, the project was designed to focus on secondary prevention, in that it would be targeted at children and families deemed to be at risk and aim to prevent further difficulties arising for the family.

2.3   Management Structures

The core of the CBFSP model is that the HSE provided funding to the each of the five CDPs to directly employ a family support project worker. The management structures of the project are different in Mayo and Galway. In Galway, just one project, Forum is involved. The Family Support Project Worker is directly supervised by the Forum Co-ordinator and casework supervision is provided by the HSE Family Support Manager for Galway.

In Mayo, a Programme Officer (PO) is employed to provide supervision to the family support project workers.   The Programme Officer is an employee of Foroige and is managed by the Foroige Project Leader for Mayo. The service agreement between Foróige and the HSE describes the Programme Officer's role as providing consultancy, casework supervision and programme direction to FSPWs in Mayo. In addition, under the original model that developed, the Children's Act Services Manager, provided casework supervision to the Programme Officer.   The intention was to ensure co-ordination with the work of the HSE. The PO also acts as the HSE's agent in ensuring that the programme objectives are met, ensuring consistency between the four Mayo projects and ensuring that the service agreement is adhered to. The role includes the following tasks:

- Supervision at least on a fortnightly basis to include joint work or home visits;
- Quarterly and annual reports to the HSE;
- Development of programmes in partnership with FSPWs;
- Training of FSPWS;
- Acting as the main channel of communication between the HSE and the CDPs; and
- Ensuring adherence to best practice techniques.

Since the FSPWs are employed directly by CDPs, they report to the CDP co-ordinator on day-to-day issues such as timekeeping, attendance, and sick leave. Administration is dealt with on a project-by-project basis depending on the resources available to the CDP. These relationships are depicted in Figure 2.1.
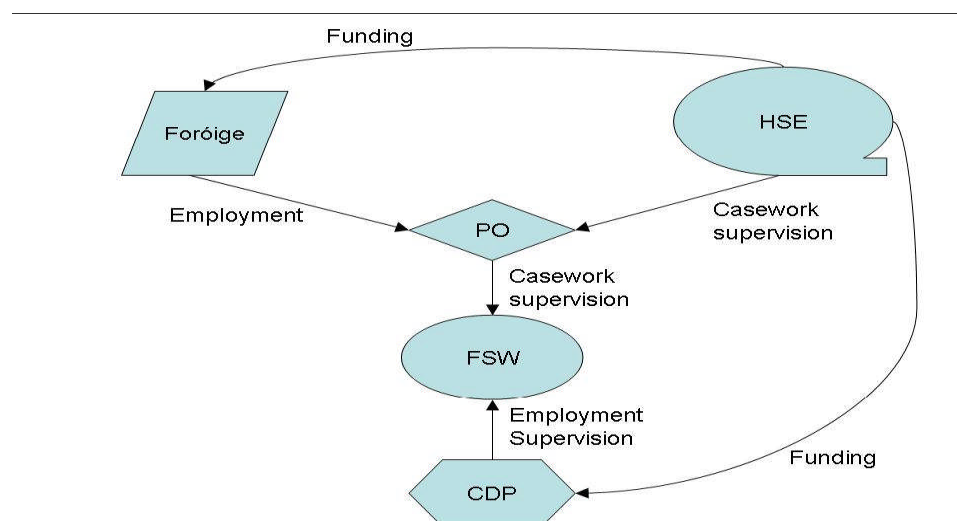
Figure 2.1: CBFSP model

2.4   Service agreements

HSE service agreements set out the terms under which voluntary and other agencies provide ancillary services which are funded by the HSE. Each CDP entered into a three-year service agreement with the HSE. These were identical for each project but allowed for slight changes in the work programme depending on local circumstances. The service agreements for the family support projects include much of the information presented in this chapter as well as complaints procedures, policies and procedures, data collection systems, and insurance.

Annual reports are provided to the HSE by the Programme Officer (who has responsibility for the Section 8 report) and by individual CDPs. An annual work plan is also submitted by each project. The PO meets with the CDP co-ordinators at least every two months to review and amend the work plan, while the Children Act Services Manager meets with them twice a year. Communication among the partners in the projects is facilitated by the PO, which involves reporting to the HSE and communicating any issues or concerns to the FSPWs and to the CDPs. Projects must have child protection policies in place.

In December 2005, a review of the service agreement took place between the HSE and the Mayo community projects. A document was drawn up by Co-ordinators and FSPWs to outline issues they had with the original service agreement. They sought clarity in relation to reporting arrangements, the monitoring and review process, funding and casework supervision. It was clarified by the HSE Child Care Manager that the local CDPs have legal responsibility for case work. Some projects were concerned at this as they do not have responsibility for casework supervision. The issue was not resolved but it was agreed that if project structures were tightened it could help to provide an 'early warning' system if an issue was to cause difficulty. A sub-committee was formed to look at the relationship between the CDP Co-ordinators, family support project workers and the programme officer in terms of accountability and implementation of the early warning system. Other sub-groups were formed to look at the format of reviews, mentoring and the development of new service agreements.

2.5   Targets

It was the intention of the HSE that each project worker would have nine to fifteen pieces of work active at any time, to include three to six group or community activities and six to nine family or individual cases. Annually, each project was expected to deal with eight to ten groups and thirteen to eighteen family cases.

2.6   Referral

Referrals to the family support services can be made by a wide range of individuals and organisations, including social work, psychology, PHN, community groups, family members and self-referrals. Given the positioning of the service as secondary prevention, referrals from the HSE Social Work services are prioritised.

2.7   Committees and Sub-groups

The Co-ordinators of all four Mayo projects meet bi-monthly to discuss common areas of work. The family support project workers meet monthly for peer support, information sharing and planning.

In each project, there was initially an *Advisory Committee* is in place to formally update the CDP regarding the work of the family support project and vice versa. The role of this committee was to feed back to the overall management committee regarding the work of the family support project. In January 2006, it was proposed that this committee be replaced by a *Planning and Review* Committee. The role of this group would be to meet three times per annum to gather information required for reporting and to plan for the coming year.

The original service agreement stated that a *referral committee* would form part of each project, comprising the PO, FSPW, and one local HSE agent.   It was agreed at the Service Agreement review meeting in December 2005 that referral committees could be abolished on the basis that projects found that the referral meetings to be an unnecessary duplication of other meetings. The need to have another HSE agent was felt unnecessary on the basis that the Programme Officer is a HSE agent. Each project was given scope to agree their own method of dealing with referrals.

At the review of service agreement in December 2005, a number of sub-committees were formed to progress action on particular areas of work, including mentoring, format of reviews and relationships between partners. The *mentoring sub-committee* met and identified a number of models that could be used within the projects. It was agreed that family support project workers would, where viable, run two options from this list; namely a parents forum and new mothers programme. The other sub-committees met a minimum of once early in 2006, after which committee and sub-committee meetings were not continued due to emerging difficulties with the role of the Programme Officer.

2.8   Challenges and adaptations to the structures

With four project workers in Mayo the project represented a significant portion of Mayo Child Care resources. The initiative also represented a significant risk for the local child care services who were very conscious of the potential of the service to influence the numbers of children in care and on the child protection record. As a consequence of this it was necessary to ensure that there was casework support for the project workers and consistency of work between the projects. The role of the programme officer was crucial in this regard. The Programme Officer was the link between the projects and the service agreements with the HSE. They had regular meetings with the HSE children's act service manager, the project workers and their managers. Two further layers were evident - firstly the children act services manager visited each site on an annual basis and there was a county wide meeting of CDP managers, workers programme officer and HSE staff.

At the first of these county meetings to review the service agreement in December 2005, it was agreed that the programme officer would dedicate approximately one day per week to each project worker, leaving a day for administration. Such levels of supervision support are generous by HSE child care service standards but were included to allow for the development of positive working relationships between the HSE, CDP managers, family support project workers and their families.

Despite the allocation of supervisory support to family support project officers, the issue of the quality of supervision was consistently raised by FSPWs in the course of this evaluation. In their view, this led to their feeling isolated and unsupported in their work. The HSE became aware of these concerns when the Children Act Services Manager visited each project site in Mayo in June 2006. Some of these concerns were subsequently confirmed and addressed by Foroige. The programme officer was of the view that the structure of the initiative was too complex and prone to misunderstanding and confusion.

In an attempt to resolve these issues, the management model for the Mayo projects was revised at the end of 2006. It was decided that the PO would receive both employment and casework supervision from the Foróige Project Leader and not from the HSE Children's Act Services Manager (CASM) as had been the case. Lines of communication have also been strengthened between all the stakeholders. In addition, the programme officer moved to a new post and a replacement was appointed.

When the new Programme Officer took up post in late 2006, a process of planning and definition was undertaken in relation to the project. A mission statement, strategic aims, project model, objectives and critical success factors were delineated. The document refers to a conceptual basis for both community development and family support and sees the role of the family support project as linking 'self-efficacy with collective efficacy, which is a key characteristic of community development'. In addition, work is ongoing in relation to the compilation of a generic policy document for the community based family support programme.
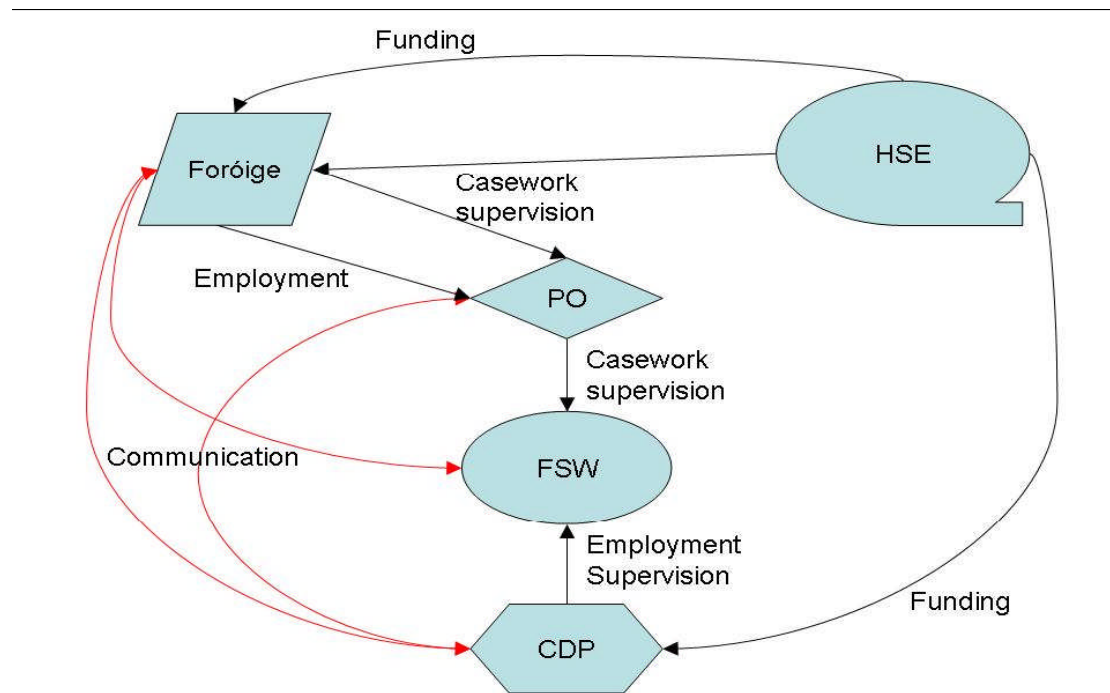
Figure 2.2: Revised Mayo CBFSP model

2.9 Summary

While it borrowed elements from previous work like Springboard, there were many innovations in the model, structure, and work practices. The CBFSP structures have developed differently in Mayo and Galway. In Galway, the Forum project as the only project is managed directly by the Forum CDP. In Mayo a Programme Officer was employed to co-ordinate the service between the four projects and to provide casework supervision. Considerable attention was paid in the first few years to defining the role of CDPs in relation to the project, with regard to legal responsibility for casework, reporting requirements and other matters. Some issues and challenges arose which led to changes being made to the overall programme model. In addition, the work model underpinning the programme was implicit rather than articulated for the first three years of the service; however a comprehensive work model has recently been developed for the Mayo projects.

The children and families engaged with the projects and the interventions used to meet their needs are profiled in the following Chapter. An outline is also provided of how the programme operated in each local project area. Chapter Four then presents the outcomes identified for those children and families.

Chapter Three
Overview of the Programme Model in Practice

3.1 Introduction
The work model of the programme involves a combination of one to one work, home visits, drop-in and group-centred initiatives. This model of working is consistent across the five projects, but the work of each project has developed differently depending on local needs and circumstances. This chapter explores the nature of the CBFSP work in greater detail. Firstly, the elements that make up the CBFSP model are described: one to one work (including home visits), drop-in and group-centred activities. In describing the one-to-one work, a profile of the numbers of children and young people engaged in casework across the programme is provided. In the second part of the chapter, a qualitative account is provided of how the project was received and developed in each of the five sites. We will see that, while the programme model is the same, variations across projects in terms of needs among communities and catchment areas has led to differences in the profile and numbers of referrals as well as shaping the nature of group interventions.

3.2   One to One Work with Children and Families
The model of work used by FSPWs for one to one work involves a series of steps, including referral, assessment, care planning, review and closure. Following referral, an assessment is undertaken with the family, often using assessment tools. Based on the outcomes of the assessment, a care plan is devised between the family support project worker and the family. Objectives are set regarding outcomes from the plan and an initial timescale is agreed. The care plan is reviewed periodically and a formal review takes place with the programme officer and the FSPW every six months. This section provides an overview of the numbers of families engaged in one to one work across the programme since its inception and provides some statistics in relation to the profile of families engaged with. The individual work undertaken with adults and with children are described separately.

Caseload numbers for one to one work:
The numbers of active cases in each year of the project are presented in Table 3.1. It should be noted that projects commenced between September and November 2004 so data are not available for all projects for 2004.

More detailed information for 2006 also shows the numbers of parents and children with whom direct work was carried out. In total, 55 cases were active in 2006 across the five projects involving 63 parents and 68 children. As we saw in the previous Chapter, according to the service agreements, projects were expected to deal with 13 to 18 family cases per annum. As Table 3.1 shows, two projects fell below this target in 2005 and three fell below it in 2006. The reasons given for this relate to the intensity and long-term nature of cases in Parkside and the degree of demand for the service. For example, Curam persistently has a full case load of seven to eight families of varying intensity and a waiting list has been in existence since the inception of the project. By contrast

Louisburgh has had to work very hard to stimulate referrals and has had long periods during which the family support project workers' caseload was below capacity.

Table 3.1: Numbers of active cases in each project area for 2004, 2005, and 2006

Project	2004[1] Total	2005 Total	2006 Total	
			Parents	Children
Cúram	NA[2]	12	13	
			16	13
Forum	NA	13	11	
			15	19
Kiltimagh	6	10	13	
			14	13
Louisburgh	6	8	8	
			8	7
Parkside	8	7	10	
			10	16

[1] Projects commenced September and November 2004
[2] Not available

Profile of families engaged in one to one work:
More detailed information on the families engaged across the five sites in 2006 is presented in Tables 3.2 and 3.3. Family support project workers worked directly with 68 children, 33 boys and 35 girls. The average age of the children worked with was 10.6 years (*sd* = 4.1); girls had a slightly but not significantly higher average age.

Table 3.2: Composition of families in 2006

Number of children in family home	Number of families	%
None	0	0
One	16	29.1
Two	14	25.5
Three	16	29.1
Four	4	7.3
Five	5	9
Total	55	

Table 3.3: Ethnicities of families in 2006

Ethnicity	Number of families	%
Irish	41	74.5
Irish traveller	1	1.8
Irish-English	3	5.5
Irish-Spanish	1	1.8
English	4	7.3
Lithuanian	1	1.8
Nigerian	2	3.6
Romanian	1	1.8
Scottish	1	1.8
Total	55	

In 22 of the families (40%), both parents were at home. In 32 cases (58.2%) mothers were parenting alone and in one case (1.8%) a father was parenting alone. The numbers of children living in these families is set out in Table 3.2. This includes nieces and nephews but not older children no longer living in the family home. The majority of families were Irish and the ethnicities of families are presented in Table 3.3.

Sources and Reasons for Referral:
Almost one in three referrals across the projects in 2006 were self-referrals. In addition, a further 9 per cent of referrals were made by family members. This is a high number and can be considered a consequence of the locally based nature of the service and the value of local and word of mouth publicity. It could be argued that, as the services become well known and trusted in the communities, the rate of self-referral is likely to increase. It is also significant that social work made one in five referrals to the service, while other HSE personnel such as PHNs and psychologists also feature. School and HSLOs account for almost 15 per cent of referrals between them. Overall, the profile of referral shows a good mix between statutory services working with vulnerable families, universal service providers such as schools and families themselves.

Behavioural problems were the reason for one third of referrals, followed by emotional and family difficulties, as outlined in Table 3.5. In nine cases, more than one reason for referral was given.

Table 3.4: Sources of referral

Source of referral	2006	%
Self	17	30.9
Social work	12	21.8
Family	5	9.1
School	5	9.1
Public Health Nurse	4	7.3
Home School Liaison Officer	3	5.5
Child and adolescent mental health services	2	3.6
General adult services	2	3.6
General child service	2	3.6
GP	1	1.8
Other family support projects	1	1.8
Playschool	1	1.8
Total	55	100

Table 3.5: Reason for referral

Reason for referral	2006	%
Behavioural	18	32.7
Emotional	13	23.6
Family difficulties	23	41.8
Other	11	20
Total	65*	

* Nine cases report more than one reason for referral

Profile of Individual work with adults
One to one sessions with adult family members is a key component of the work of the FSPWs. The aim is that, by working with parents to address issues, the outcomes for children will be improved. This work takes a number of forms which are determined by the client and the family support project worker together. These include:
- Parenting
- Emotional support
- Personal development
- Mental health
- Information
- Advocacy; and
- Referral.

Before going on to discuss each of these categories in detail, there is a number of process details worth noting. Firstly, these categories are not mutually exclusive and there may have been some overlap. Secondly, clients and family support project workers met weekly or fortnightly, once again with the flexibility of drop-in meetings, phone calls, and more intensive support as required. Drop-in is described in more detail later. Thirdly, these sessions continued for as long as was deemed necessary by both parties and there was great variation in timeframes. It might be misleading, therefore to suggest an average duration of interventions.

Finally, though it does not constitute a separate category, it is worth noting that family support project workers also facilitated family meetings.

A.   Parenting

Individual support with parenting usually involved determining the exact nature of the problems and possible solutions. Among the most common problems was behaviour management which could be dealt with by deciding and enforcing limits and boundaries. Parents were also encouraged to develop routines with children, reinforced using star charts and rewards, for example.

B.   Emotional support

The need for emotional support arose in circumstance of domestic violence, family breakdown, parenting problems, child sexual abuse, low self-esteem, and unemployment. Though not necessarily trained as counsellors, family support project workers were able to offer this kind of support insofar as they could listen and discuss options with the client regarding how to progress. Where there emerged significant emotional or mental health problems, family support project workers had access a range of medical, paramedical, and social services to which the client could be referred. Emotional support was most often necessary during family separation and at times of sudden and traumatic life events.

C.   Personal development

A pervading issue for many of the clients was self-reported low self-esteem. This was addressed by family support project workers in a number of ways which can broadly be considered personal development. Among the techniques used were training in assertiveness, communication, trust-building, conflict management and stress management. The content of this kind of training is similar to that of group sessions run on the same themes, which are detailed later.

D.   Mental health

The most common mental health issue among the clients of family support projects
was depression. As mentioned earlier, family support project workers could refer clients to counsellors, psychiatrists, and psychiatric nurses where appropriate. In some cases the symptoms of depression were associated with particular problems such as domestic violence, and may have decreased when the underlying problem was resolved. Among the other mental health problems presenting were eating disorders and anxiety.

E.   Information

Family support project workers provided information on rights and entitlements, state benefits, and sources of legal advice. In some cases, the information provided linked to other CDP programmes or state bodies such as community childcare facilities, FÁS and other training agencies, and the Money Advice and Budgeting Service. A more detailed list of services linked to the family support project workers is later in this chapter. These kinds of services were particularly useful to newcomer

families and can be seen as part of the expansion of family support to that group.

F.   Advocacy
Family support project workers functioned as advocates for clients where their professional relationships and status might yield a more positive response than an approach from the client alone. Advocacy and practical support in accessing other services ranged from contacting local councils for housing maintenance to safety planning in the form of contacting a women's refuge. Clients whose first language is not English were often in need of support when dealing with state representatives. Some projects also offered translation and interpretation services to clients. Family support project workers might also use their position and contacts to have a case prioritised with another professional, a child psychologist, for example.

G.   Referral
Referral here is the formal process of directing a client to another service, most often social work, psychology, and psychiatry. It is separate from the less formal information and advocacy functions but they can overlap in some cases, as indicated above. Family support project workers were kept informed of progress with other services primarily by clients themselves and, subject to normal confidentiality procedures, by colleagues and professional contacts.

Profile of Individual work with children
For children, sessions were devised by the client and the FSPW together, sometimes with the input of the parents. In some cases, parents attended these sessions but most often the child and family support project worker worked together. The interventions used with children can be categorised as follows:
- School support;
- Emotional support;
- Personal development;
- Mental health.

As with individual adult interventions, sessions continued as long as was deemed
necessary and children were referred to other professionals as appropriate.

A.   School support
Among the reasons why children were referred to the service were school refusal, bullying, and mental health problems associated with poor school performance such as attention deficit hyperactivity disorder (ADHD). Preventive group interventions aimed at bullying in schools were also used and these are described among the group interventions later. Other underlying reasons for not attending school, such as bereavement and mental health issues, were also dealt with by family support project workers. One intense case involved a young person who was out of school for some time and the family support project worker engaged in one to one support with the young person in relation to their literacy, advocated on his behalf with relevant agencies and worked with the family to

address associated issues. The outcome was that the child returned to school. This FSPW took on a role that she considered should be taken by the Education and Welfare Board but which was not, due to lack of personnel in Co. Mayo.

B.   Emotional support
In the cases of children, loss as a result of bereavement or separation was a common source of the need for emotional support. With some children, family support project workers used creative methods, such as art, to facilitate the support process. These methods allowed the clients to express themselves through art and sometimes provided the setting in which the clients engaged in conversation. As with adult clients, children and young people were referred for specialist help where deemed necessary.

C.   Personal development
Personal development was more often an intervention for older children, that is, adolescents, than for younger children. Areas such as self-esteem, communication, and peer and social relations were addressed. In some cases, health and nutrition advice were offered by the family support project worker, once again with some overlap into the content of group interventions.

D.   Mental health
For younger children, the most common mental health issue was ADHD, which has already been mentioned. For adolescents, depression, suicidal ideation, and eating disorders were the most serious concerns. As with the adult clients, these problems may stem from loss and relationship difficulties but also from issues at school. Also as mentioned earlier, family support project workers could refer clients for psychological and psychiatric services.

3.3 Group interventions
As part of the integration of CDP and family support service, groups were run in the CDPs facilitated by family support project workers for some of their clients but not exclusively so. Some groups were taken by other CDP staff or jointly run by the family support project worker and CDP staff. The content of a group was sometimes drawn from the family support project worker's observations of patterns across cases; for example, a group for young mothers might be run in an area where a number of young mothers were referred for family support. These clients would be invited as well as an open invitation to other members of the community. In this way, other potential clients who might benefit from family support could also be identified. Some groups were for adults, some for children, and some for families. Once again, for ease of discussion the broad range of groups can be categorised as follows:
    Parents and parenting
    Personal development
    Children
    Summer projects.

A. Parents and parenting

Groups for parents served two functions. The first was to provide mutual social support for parents from others in similar circumstances. The second was to improve parenting skills through training, information, and advice. Some groups used formal programmes such as Parents Plus (Sharry, Hampson, & Fanning, 2003) or themes like drugs' awareness. Among the range of different parent and parenting programmes were groups for lone parents, young mothers, parents and toddlers, and parents of teenagers. In the Parkside project, it was possible to offer crèche facilities to participating parents but such facilities were not available in the other projects, which was likely to have been a barrier to participation. Groups running over longer periods often invited guest speakers from organisations such as MABS, Community Welfare, FÁS, Local Employment Service, and Adult Education Guidance. In other cases, activities such as flower arranging, car maintenance, basic computer courses, and swimming sessions were arranged.

B. Personal development

Like the parenting groups, activities that can broadly be termed personal development were initiated based on needs arising in casework. Courses on family communication, assertiveness, self-esteem, stress management, and health and well-being were in response to needs in clients. A more general programme for women was offered through a number of projects. At the more practical end of the spectrum were cookery, home management, and home electrics courses. Here there was some overlap with the activities of some parenting groups. Some projects ran job clubs at which applications, curriculum vitae preparation, and interviews were discussed. Though not obviously or explicitly aimed at personal development, other courses that can be included here are art and drama workshops. These were particularly important elements of the intervention in a number of cases where clients with particular skills and experience in art were asked to facilitate workshops themselves with all the positive potential arising from the acknowledgement of their ability and the responsibility they took on.

C. Children and young people's groups

Groups for children can be considered school-based, activity-based, or issue-based. School-based groups focused on the transition from primary to secondary school and on staying in education. As mentioned in the section on individual school support, there have been some school-based anti-bullying campaigns and workshops. In this way, particular problems can be addressed by a universal intervention without drawing attention to individuals. Activity clubs broadly include art groups, homework and other after school clubs, groups for children with disabilities and their friends, and task-focused activities like the driver theory test. Some projects also hosted children's parties. Finally, issue-based programmes were focused on separation and loss, drugs awareness, suicide awareness, health and well-being, and social skills and self-esteem.

D. Family activities

Some family support project workers recognised the value of families spending time together away from their normal daily lives. Day trips were

arranged for groups of families. Some trips for individual families were also arranged, depending on the circumstances and resources of the projects. Other projects arranged a designated family week including family-based activities and outings.

E.   Summer projects
Summer holidays were identified as a time at which families need support in arranging activities for children. To meet this need, a range of projects for families, for younger children, and for teenagers were run by family support project workers through the CDPs. There are some similarities to the children's groups and to the more recreational elements of the adult groups like arts and crafts. Projects ran for a number of days or weeks, depending on the needs of the community.

Other agencies involved in group interventions
As mentioned earlier, these group interventions were jointly arranged and facilitated by the FSPW and the CDP. For some groups, outside expertise was available from non-statutory organisations, professionals, and through schools to address particular issues. Among the organisations took part in some of the groups are Citizens' Information, FÁS, MABS, Youthreach, MOVE (Men Overcoming Violence), National Women's Council of Ireland, Foróige, St Vincent de Paul, ISPCC, Refugee Information Services, and traveller support groups. Other professionals including psychologists, social workers, public health nurses, community welfare officers, speech and language therapists, and occupational therapists also had an input to some activities. Local primary and secondary schools, the Vocational Education Committees (VEC), home-school liaison officers, the Big Brothers Big Sisters programme, and Neighbourhood Youth Projects were involved in programmes for young people.

3.4 Drop-in
Each of the projects was able to offer an informal drop-in service. This service was used by clients making a first inquiry about the family support service, by current clients at times of particular need, and from time to time after cases had closed. As far as possible, the family support project worker saw people who dropped in this way immediately. Most drop-in's required follow up in the form of phone calls, administration, contact with other services, advocacy on behalf of the family, referral and, in some cases, brief intervention. Many of the clients who are identified as self-referrals made their first contact with the service by dropping in. From this perspective, it is a valuable aspect of the work in that it makes the service accessible to children and families.   The numbers of self-referrals were not available for all projects, but appear to range between 11 and 26 per annum.

3.5   Overview of the Programme in each area
This section provides an overview of how the family support programme operated in each of the five community projects in which it was based. The information provided is derived from interviews with FSPWs, CDP Co-ordinators, CDP Management committee members and written documentation such as annual reports.

Curam Family Support Project

As mentioned in Chapter One, the Curam project, Claremorris, is very well-established and has a strong tradition of providing support services (including counselling, pre-school service, men's and women's groups, bereavement support) to the community, mostly on a voluntary basis. Stakeholders consider the Curam project to be a non-stigmatising place for families to come.

Feedback from stakeholders indicates that the family support project has fitted extremely well with the overall project as it complements the range of family services provided through the centre. The Family Support Project Worker is very well supported by staff in the centre and the integration with the work of Curam appears to have been seamless. Curam services are an important source of referrals as well as being a resource to which families engaged in the CBFSP can be referred. Demand for the service is strong and there is a waiting list. A high proportion of referrals have been related to young people with behavioural problems and liaison with the school in relation to problems presenting has been central to the work. The project has excellent working relationships with relevant services, including social work.

Because a wide range of general community and personal services are available in Curam, the FSPW could avail of these and use her resources to develop initiatives tailored to the needs of her clients. As highlighted in the box below, targeted initiatives were developed by the FSPW to meet the needs of children and young people identified as having personal or family difficulties. These initiatives included groups relating to self-esteem and communication, art workshops, summer programmes and support with transition to secondary school. In addition, the FSPW included her clients in summer programmes and other activities run through the centre. Targeted initiatives for parents to support them with parenting and family communication were also developed, informed by the issues arising in the casework. The FSPW linked clients into services run in the Curam centre, such as counselling, information, training and recreational activities. The FSPW attempted to re-start a lone parents group that had been run through the centre. However, despite intense efforts and a varied programme on offer, the demand for the group was not strong and it was decided to end it.

The key challenges experienced by the Curam Family Support Project are resource related. Demand for the services of the Family Support Project is very high and the service operates a waiting list. The office space is very limited. The project is not core-funded as a CDP or Family Resource Centre and thus is without paid administrative support and is sensitive to any funding difficulties.

Curam Family Support Project

Profile of child care needs arising in casework

School refusal, bullying, emotional difficulties, separation and loss, anger management, depression.

Examples of Group initiatives developed / led by FSPW

- Teenage summer programme for 12 teenagers, in partnership with Teenage Health Initiative (THI)

- Jointly facilitated 2 X 2 week summer camps for children aged 4-12 years in Kiltimagh and Claremorris

- Six week programme on family communication and self-esteem

- '*OK lets Go*' transition from National to Secondary School Programme – 3 x 1.5 hour sessions in local boys and girls national schools

- A 5 week art workshop for 14 children aged 8-12 years based on the theme "Celebrating Me"

- Six week parenting programme for 14 parents

- Workshops for First Year Secondary School students on theme of communication.

- Mentoring/network for new parents

Examples of joint initiatives by FSPW and CDP

- Re-started the New Beginnings Lone parent group which had been running in the centre

- Linked families into the work of Curam, including counselling, Home Management Healthy eating course, parent and toddler group, LES and CIC.

- Referred adolescents to two THI groups run in Curam

- Awareness raising in relation to domestic violence

- Generally linking in with community, voluntary and statutory initiatives in support of children and families

Forum Family Support Project

The need for a family support element to its work was identified by Forum through its broader community development work and in particular, its adolescent support project. The target group for the family support project was identified as children Under 10 and Parents and Carers of children under 10 living in NW Connemara because the Forum Adolescent Support Project is already engaged in family support work with children and families aged 11 and upwards. The project also works with lone parents, young mothers, single fathers and others. Some of the key areas of group work include Junior Clubs in national schools to facilitate children under 10 through play and crafts.

The Forum family support project was slow to gain momentum at the start due to staff changes. The current family support project worker was appointed at the end of 2005.

The Forum management committee is very happy with how the project has developed, believing that it has complemented the work of the adolescent support project very well. There has been a strong demand for the service. Service provision for families in NW Connemara is limited and can be difficult due to the large geographical area and dispersed population. From this point of view, they consider it critical that the family support project was linked in with the wider community development project. Structures and relationships were in place, which facilitated the family project to move quickly. For Forum, the emphasis on early intervention was very important as it links to their community ethos; they are not interested in providing a crisis support service but demands on the service sometimes means that they are drawn into responding to crisis situations. They have found that families are willing to come forward to seek support, but like to have a context for that support in terms of a source they are familiar with and trust. They believe that a project such as this can encourage families in difficulty to look outwards and see the importance of the social dimension in their lives. Forum did not have a difficulty in adjusting to the casework model as they had had such practices in place in their adolescent support project.

Forum Family Support Project
Profile of child care needs arising in casework
Children – behaviour, coping, bereavement *Parents* - establishing routines in the home, accessing other supports - financial, vocational etc and general listening and support.
Examples of Group initiatives developed / led by FSPW
Junior activity clubs for 43 children in national schools - focuses on specific difficulties each group of children are facing Time Out For Parents Programme – involving 15 lone parents in a 10 week programme

Cookery lessons for 'at risk' teenagers

Set up Connemara ARCH Club – recreation and play for children with disabilities run by their parents and the FSPW

Facilitated set-up of Rainbows project (bereavement and loss) in Connemara and referred children to the group

Supports parent and toddler group in Clifden and Leenane

Ran the Parents Plus Course, The Early Years Programme, with crèche facilities in two locations, attended by 26 parents.

Parents course provided for 15 parents developed into a peer support group for 4 parents

Examples of joint initiatives by FSPW and CDP

Supported the work of the adolescent support project where necessary

Refers children to the Rainbows project

Co-facilitates youth summer camps

Generally linking in with community, voluntary and statutory initiatives in support of children and families

Kiltimagh Family Support Project
In Kiltimagh CDP, the family support project has been very well received by families and there is a strong demand for its services. The project has a very high profile location in the CDP on the Main Street of the town. In addition to demand from the general community, the 90 strong refugee community living in the Railway Hotel hostel in the town showed a high need for drop-in, one-to one and group interventions during the first year or more of the project. Domestic violence, mental health problems, relationship difficulties and social isolation have been prevalent in the profile of referrals to the project.

One of the key challenges faced by the family support project in its early stages was that the CDP was going through a transition period and there were periods where no Co-ordinator in place. As a result, the work of the CDP was reduced greatly at a time when community needs were pressing, particularly in relation to refugees and asylum seekers in the hostel. Balancing demands for the provision of a community and group infrastructure with the need to respond to individual work was challenging for the Family Support Project Worker. Given the finite resources of the family support project however, a considerable amount was achieved as seen in a wide range of group work undertaken, funding secured, relationships developed with key agencies as well as intensive individual casework and drop-in support. A new Co-ordinator was employed early in

2006 which has led to greater stability in the work of the CDP and a good working relationship with the FSPW has been developed.

Committee members of the Kiltimagh CDP feel that the FS project has given the CDP a better link with families and children in the area. They see the benefits of being able to link family support clients in with CDP activities, such as stress management and adult education and find it useful to take ideas and direction from the case work regarding groups and services that are needed in the area. They believe that more of the initiatives run by the project are now targeted at families and children. In the early stages, the family support project was quite separate to the main CDP, but over the past year or more the two have become much more integrated. They see evidence in the form of more people coming in to use the project, particularly mothers, children and young people.

From the committees point of view, understanding how the family support project would link with the CDP and addressing roles and responsibilities in relation to supervision and health and safety issues have been challenging. A key challenge faced by the family support project is lack of local services and facilities (e.g. youth, women's groups) to which it can refer service users. Transport issues also make it difficult to refer children and families to services outside the area.

Kiltimagh Family Support Project
Profile of child care needs arising in casework *Parents* - domestic violence, marital difficulties, mental health problems, parenting, stress *children and young people* - bullying, anger management, stress
Examples of Group initiatives developed / led by FSPW Parent network Stress management course Parenting course Young mothers group Anti-bullying workshops Art workshops for children and adults Children's parties Summer scheme – 2 weeks Family day trips Drugs awareness for parents

Examples of joint initiatives by FSPW and CDP
Link clients in with CDP education programmes Sits on steering group of local homework club, involved in inter-agency group for local asylum seekers hostel, community liaison group for local secondary school.

Louisburgh Family Support Project

The family support project was very well received by the Louisburgh CDP committee and general community and excellent relationships have been developed with services such as the HSLO, CWO, PHNs and local schools. The family support service was presented to the community very much as a community service that would deal with a range of issues from basic queries to more serious problems. By the end of 2006, the project noted that there had been a significant progress in work with the local school and pre-school playgroup regarding possibilities for joint working between them and the family support project.

As mentioned in earlier, Louisburgh CDP serves a very rural catchment area and this has had implications for the family support service, primarily in terms of attracting sufficient referrals to the service. Referrals were strong initially but reduced significantly throughout 2005 and early 2006, before increasing again. The CDP attribute this to the local culture which discourages help-seeking, an issue that other services in the area have also encountered. In addition to a low rate of self-referral, the service found it challenging to attract referrals from services, for example, there were no referrals to the service from social work in 2005 or 2006. The project made one referral to social work in 2005 and one in 2006. The Family Support Project Worker has endeavoured to stimulate referrals by increasing the proportion of group work and encouraging referrals from social work and other services. A feature of referrals initially was that few families originally from Louisburgh used the service, with most referrals relating to families who had moved into the area. In the latter part of 2006, increasing numbers of families originally from the area began to use the service. Given the difficulty in attracting casework referrals, it appears logical that the catchment area for the service should be widened, considering that the nearby town of Westport does not have a family support project of this nature.

As well as attracting referrals to the service, encouraging participation at group activities was also challenging for the project. For example, a group on 'parenting teenagers' and a group dealing with bereavement / loss were both cancelled due to low uptake by the community. An information evening regarding possible youth activities for the area and a 'summer family day' were also poorly attended despite widespread promotion. The service also paid attention to encouraging the participation of parents in the development of initiatives in the CDP.

At the outset, the committee felt it was important to give adequate consideration to family support and how it could be 'married' with community development. They were very excited about the potential offered by the project and felt that the trust they had built up with the local community would be a major asset in terms of the family support project becoming accepted. They felt the family support focus would help them to engage people they had not managed to engage previously. One challenge experienced initially was in relation to physical space, wherein a private office space had to be created for the family support project, involving a sub-division of a community room. Policies and procedures regarding confidentiality also took some time to develop at the outset. The FSPW used role play as a means of developing a shared understanding of how the family support project would operate in the context of the project. The family support project has engaged in a range of joint initiatives with staff of the CDP, which was deemed to be mutually beneficial.

The CDP staff and committee members feel that the family support project brings something unique, 'an expertise they wouldn't otherwise have'. They see the project as integral to their work, but yet with its own identity and boundaries. They feel that the project has become a more family friendly place, for example, with more toys and a welcoming atmosphere. They also feel that families in the area are better supported as a result of the project.

Louisburgh Family Support Project
Profile of child care needs arising in casework
Depression, parenting, stress management, behavioural problems
Examples of Group initiatives developed / led by FSPW[3]

- Delivered week-long summer programmes for children aged 13-15 years in partnership with Teenage Health Initiative programme (2004). In 2005, the summer programme was targeted at children making the transition to secondary school

- Hosted THI programme for teenagers from the area

- Women's health course

- Six week parenting programme for 9 parents

- School programme for young people at risk of leaving school early – for 2 groups of 7 participants for 6 weeks each

- Social skills groups for 11-13 year olds - ran for 6 weeks, involving 10 participants

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[3] It should be noted that, due to reduced maternity leave cover, no group work took place by the family support project between September 2004 and March 2005.

- Six weeks assertiveness course

- 'Parents helping parents' mentoring programme - planned for 2007

- Coffee mornings and project launch to raise awareness of the family support project

Examples of joint initiatives by FSPW and CDP

- Time out for women group – 6 week programme to address stress, relaxation and reduce social isolation. Held annually and co-facilitated by FSPW and CDP Co-ordinator

- 'Think Positive, Be Positive' – one day event for sixth year students focusing on suicide prevention and mental health. Information evening for parents and members of the community on suicide awareness and prevention. A total of 150 people took part.

- Community recycling arts project for transition year students

- Family support service clients referred to final year trainee counsellor working with the CDP.

- Christmas festive morning – aim to build social networks and reduce isolation. 15 people attended.

Parkside Family Support Project

Parkside CDP in Ballina is an established community project, with good childcare, youth and community services. The CDP is located in the heart of the community and is well-accepted by the locals, which according to feedback, has proven to be an advantage in that families do not have a problem coming to the family support project. Distrust of statutory agencies is strong in the area but there appears to be a good acceptance of the CDP and family support project. Word of mouth publicity has led to self- and family referrals. As with Curam, the wide range of services run through the project has facilitated internal referrals to and from the family support project where appropriate. For example, through their childcare project, they are able to offer respite to clients of the family support service by providing childcare places. Children have been integrated into youth clubs, summer projects and after-school activities. A family festival week is held by the project and supported by all the staff of the CDP.

The level of family need in the area is perceived to be very high by stakeholders and individual work has been long-term and intense. Referrals have been characterised by multiple problems, including domestic violence, mental health problems, housing problems, parenting and school related difficulties. In addition to casework, the skills of the family support project worker are drawn upon in a variety of ways for the benefit of the wider project. For example, working with staff to improve

quality, targeting and 'goodness of fit' of project services with the needs of participants and designing tailor made initiatives to meet the needs of clients. Clients of the family support casework service have taken part in a wide range of group initiatives run through the Parkside project (see box below).

The philosophy of the Parkside CDP is that the family support base in the area involves paying particular attention to the wider community supports and infrastructure and creating positive and sustainable links with other agencies. Staff and CDP management believe that the pre-existing community development structure has acted as a catalyst in accessing and acquiring the necessary infrastructure, financial and capacity building resources for family support initiatives. They feel that there has been a valuable fusion of family support principles with those of community development and social justice. The committee feels that the family support project has evolved with the project and has helped people in greatest need in the area to be in a position to avail of the services and groups of the wider project and community. Committee members believe that the project has provided them with a crucial link to schools and families which has made the work they do more responsive to need. Because the FSPW is involved in a range of project activities, they don't believe there is any stigma for families in meeting with her.

Parkside staff believe that the family support project has illustrated the need for a local casework service. It is not a 'quick-fix' solution as a complex set of issues often underpins the presenting issue. Cases can be long and intense. From an organisational or philosophical point of view, the adoption of a caseload model has not been a difficulty for the project. Some of the management committee use casework models in their own jobs so it was not new to them, while they are accustomed to the development of policies and procedures through the Parkside Childcare project. A challenge is that the high visibility of the project can make it difficult to operate a 'caseload' in the sense of being able to open and close cases as families continue to drop in when they need to.

Community facilities in Parkside will soon be greatly improved as there are major infrastructure projects underway. This will mean that additional space is available for the family support project, which to date has been challenged by a scarcity of private spaces in which to work with children and families.

Parkside Family Support Project
Profile of child care needs arising in casework Behavioural difficulties, School non-attendance, Effects of domestic violence, Bereavement, Anger management, Parenting , Personal difficulties
Examples of Group initiatives developed / led by FSPW • Teen times – personal and social development discussion group for 6 teenage girls • Teen addiction awareness group – multi-media interactive programme used to explore issues of addiction and enhance resilience and coping – 6 participants • Workshops on domestic violence for Traveller women • Family day out – 133 people • Parkside family week – week of organised activities and events involving 200 plus • Coffee mornings for parents 'Parkside Parents' • Support with preparation for driver theory test for 10 people • 'Mind Links' – 2 day intensive behavioural lifestyle management programme for 30 people and one day refresher programme attended by 25. • Family violence programme – 8 week programme for to assist the recovery and well-being of women and children who have lived with violence in the home • Drugs awareness workshops for parents
Examples of joint initiatives by FSPW and CDP • Drop-in service for local people, offering help with queries, applications and letter-writing to enable members of the community to avail of appropriate information and services. • Parkside summer scheme – month long programme of activities for 80 children • International women's day celebrations, involving 100 women • Lily ceremony and coffee morning to commemorate women who have died by domestic violence • 'Our community, our home' survey to identify the needs of adults and children and inter-agency forum set up to tackle needs arising. • FSPW helps out with initiatives run by the community development and youth workers and vice versa

3.6 Summary

This section has described how the various parts of the CBFSP model have been implemented in practice. The majority of the service resources go to one to one work with children and parents. Approximately 50-55 families have been engaged in the service across the five sites in each year of its operation. In some projects, caseload numbers are higher, reflecting variation in the demand for the service and the intensity of cases.

As has been detailed in this chapter, FSPWs and CDPs have worked together in successfully developing and managing a range of group-based activities and programmes which have the twin consequences of developing communities and supporting families. As highlighted in Chapter Two, the original service agreements gave some specific examples of the types of interventions that could be developed through the programme. We saw from the individual profiles above that targeted programmes for lone parent families and families living in rural isolation without access to formal support were provided in Curam and Forum in particular. Mentoring and parent support programmes were or are currently being developed in Kiltimagh, Louisburgh and Curam. Support programmes for children experiencing the loss of a parent through divorce, marital breakdown, or bereavement were developed in Forum. In Kiltimagh, targeted support was provided for newcomer families with a view to reducing isolation and improving supports. In Louisburgh, in-school support was offered to children to deal with sudden life events, while personal development, anti-bullying and school transition programmes were run in schools by Curam and Kiltimagh. In addition, targeted programmes were developed address teen addiction and to support victims of domestic violence in Parkside. The Big Brothers Big Sisters (BBBS) programme was not provided directly by the projects, as had been planned initially, due to issues related to insurance liability and workload issues. However, the FSPWs made referrals to the programme and promoted the service where appropriate. In general, the FSPWs choice of programmes responded to the presenting situations of their clients.

The evidence suggests that the CDPs have become more focused on the needs of vulnerable children, young people and families as a result of the work of the family support project worker. Likewise, the CDP groups have helped the families who are clients of the family support project workers to access groups and services in their communities that they may not have done otherwise. In most projects, the links with the CDP have been seamless and very beneficial. This is particularly the case where the CDP has a focus on supporting children, young people and families, with Parkside, Forum and Curam particularly notable in this regard. In these projects, there were established groups, services and relationships with which the service could immediately begin to add value by offering one to one work and tailored group initiatives. Referrals could be made for clients to in-house activities and groups as well as those in the wider community. For example, in Forum, the Adolescent Support Project has a very high profile in the community and is linked in closely with schools and relevant agencies. The family support project worker could tap into this network and adapted the ASP model of work with teenagers to meet

the needs of children aged 10 and under. The ASP workers could support the work of the family support project and vice versa. In Parkside, the project has a strong focus on children and young people through its childcare and youth services. It also has a high profile among local people, schools and agencies, which facilitated the family support project worker to link in and respond to needs that were not being addressed by broader community interventions. In Kiltimagh and Louisburgh, the community infrastructure for children and families was less well developed and so the FSPWs had to engage in more groundwork. Chapter Four moves on to address the question regarding the outcomes of these interventions for children and families.

Chapter Four
Outcomes for children and families

4.1 Introduction
Each of the families working with the family support project workers was asked to take part in a formal assessment. Twenty-five families from across the five projects took part. This chapter provides a profile of the participating families, and the reason for their referral to the family support service. The evaluation itself comprised pre- and post-intervention assessment using standardised assessment tools, case files, and qualitative interviews with parents. The interviews with parents included questions on their experience of the project, any changes for them and their families as a result of the project, and their evaluation of the strengths and weaknesses of the project. The views of the FSPWs on the outcomes for families they worked with are also included. This chapter will focus specifically on the changes and outcomes for families; wider programme implementation and overall evaluation issues are dealt with in Chapter Five.

Before dealing with outcomes in detail, Table 4.3 presents some examples of how intervention packages were applied to particular problems, which assessments were used, and the resulting outcomes. There was a broad range of presenting problems so there could be no one-size-fits-all intervention; rather, FSPWs had a range of options, both individual and group-based, for each case. Similarly, there was no one assessment tool suitable to identify changes resulting from every intervention, so a manual of standardised measures was available to FSPWs. Finally, there were numerous changes in the lives of clients resulting from interventions and in many cases these were reflected in the standardised assessments. Where changes took place which were not picked up by the assessment tools, they were raised by the clients or by the FSPWs in their interviews.

4.2 Method for standardised assessment research
This section describes the part of the research which used standardised assessment tools. The participant families are first described, then the assessment tools and the procedure employed for data collection and analysis, and finally the results of this analysis.

Profile of participant families
Of the twenty-five families, six were from Cúram, four from Forum, six from Kiltimagh, six from Louisburgh, and three from Parkside. The majority of the families were rural (88%). Most of families consisted of birth parents and children (52%) while 40% were lone mothers. There was one lone father and one foster family.

Twenty-one families were Irish and three British. There was one French-speaking Congolese family. Of the families who expressed a preference, twelve were Roman Catholic and one Presbyterian. Two children were on the child protection record, one of whom had previously been in care and was the subject of a court order. Twenty-two of these were new referrals to the family support service and three had previously had contact with

the service. The sources of referral are set out in Table 4.1 and the subject of the referral in Table 4.2.

Table 4.1: Source of referral

Source	Number of families	Percentage
Family member	1	4
Home-School Liaison Officer	3	12
HSE Psychology	1	4
HSE Social work	4	16
ISPCC	1	4
Mayo Women's Support Services	1	4
School principal	1	4
Self-referral	10	40
Playschool	1	4
Public Health Nurse	1	1
Teacher	1	4

Table 4.2: Subject of referral

Subject	Number of families	Percentage
Child	7	28
Mother	6	24
Mother and child/children	8	32
Mother and father	1	4
Entire family	3	12

As part of the evaluation process, information regarding each of the twenty-five families was made available to the researchers; namely referral information, care plans, results of assessment tools and review information. At least one member of each family completed the standardised assessment tools. Representatives from fifteen families, fourteen mothers and one father, took part in qualitative interviews about their experience of the project.

Assessment tools
A range of assessment tools was available to family support project workers to use with client families. The decision was made as to the tool or tools most suited to the needs of the families rather than have every family complete each questionnaire. The assessment tools used were:
   The Adolescent Well-being Scale (AdWS; Birleson, 1980);
   The Adult Well-being Scale (AWS; Snaith, Constantopoulos, Jardine, & McGuffin, 1978);
   The Self-Completion Questionnaire on Parents' Attitudes and Feelings (PCRI; Gerard, 1994); and
   The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997).
These assessment tools are taken from the HSE *Assessment Tools Training Manual* which is available to all HSE family support staff.

Table 4.3: Examples of reasons for referral, interventions, assessment tools, and outcomes

Reason for referral	Interventions	AT[1]	Outcome
School refusal	School support BBBS Parenting Advocacy: local authority housing Referral to counselling	SDQ AdWS AWS	Return to school Improvement in parent's coping skills
Domestic violence	Personal development: finances Emotional support One meeting to determine daughter's coping	AWS	Supported through separation
Single parent	Parenting Personal development: finances Family day trip Personal development for children: behaviour	PCRI SDQ	Social support Practical supports Improved family relations Improved confidence
Relationship difficulties	Personal development: communication	AWS	Referral to couples' counselling
Emotional problems	Mental health: depression Parenting Information, advocacy: training and employment Personal development for child: anger management	AWS –	Improved family relations Accessed employment Completed Driver Theory Test Improved behaviour

[1] Assessment Tool; see section 4.2.2 for descriptions

The Adolescent Well-being Scale (AdWS; Birleson, 1980) was originally devised as the 37-item Self-rating Scale for Depression in Young People. The AWS itself is an eighteen-item screening tool for depression among 7- to 16-year-olds scored on a three-point scale: *most of the time*, *sometimes*, and *never*. It has been shown to differentiate between groups of young people with depression and without depression (Firth & Chaplin, 1987). Further investigation by Birleson and colleagues suggested that scores above 13 were indicative of a problem. The Adult Well-being Scale (AWS; Snaith et al., 1978) is also known as the Irritability, Depression, and Anxiety Scale (IDA) and has subscales for depression, anxiety, outward-directed irritability, and inward-directed irritability. There are 18 items scored on a four-point scale. The labels of those points vary from item to item. On the depression subscale, scores of 4, 5, or 6 are considered borderline and higher scores indicate a problem; for anxiety,

the borderline scores are 5 to 7; for outward directed irritability, 5 to 7; and for inward-directed irritability, 4 to 6. The items of the AWS can be a catalyst for discussion as well as a useful assessment.

The Self-Completion Questionnaire on Parents' Attitudes and Feelings is adapted from the Parent-Child Relationship Inventory (PCRI; Gerrard, 1994). This version of the PCRI was used for the Springboard evaluation (McKeown, 2001) and is in the HSE *Manual*. Four of the original six scales are used: support, satisfaction, involvement, and communication. The social desirability check is also retained. There are 47 items on a four point scale from *Strongly agree* to *Strongly disagree*. Levels of need for each subscale are as set out in Table 4.4 (adapted from the HSE *Assessment Tools Training Manual*).

Table 4.4: Levels of need on the PCRI scales

Level of need	Support	Satisfaction	Involvement	Communication
Low	26-31	36-40	48-54	30-35
Some	20-15	30-35	41-47	25-29
High	14-19	21-29	34-40	20-24

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a 25-item questionnaire for completion by children themselves, by parent, and by teachers. There are subscales for conduct problems, emotional problems, hyperactivity, peer problems, and pro-social behaviour. Like other scales, there are ranges for *high*, *some*, and *low* need. The ranges vary depending on whether the child, a parent, or a teacher completes the questionnaire.

Procedure

The Community-Based Family Support Project was designed with in-built evaluation procedures. Much of the data for the research was collected by the project workers in the course of their work with families. Families were referred to the project workers in the ways described earlier. At their first meeting, or subsequently, depending on the circumstances of the families, the project worker explained the evaluation research and asked the family for their consent to participate. Families were not obliged to take part and were free to withdraw at any time. The level of service provided by the family support project worker was not affected in any way by their consent or otherwise. Participation involved completion of standardised assessment tools on two occasions, optional interview towards the end of the evaluation research, and making anonymous data available to the researchers. At all times, research was guided by the ethical principles of the Sociological Society of Ireland and the Psychological Society of Ireland, particularly by commitments to informed consent and to doing no harm to participants.

Families completed the assessment tools on two occasions. The first occasion was in the initial period after referral, most often in the first meeting with the family support project worker. It was not always feasible to proceed in this way owing to the circumstances of families.

Based on the first meeting, the project workers decided which of the above tools best matched the needs of the family. At least one tool was used and others as the project worker saw fit. Having collated the scores, the project workers gave feedback on the areas emerging from the assessments as issues for the families. The second occasion was either at the end of a family's involvement with a project worker, that is, when the case was closed, or after a particular intensive piece of work, a behaviour management programme for children, for example. Once again, the family support project worker could give feedback based on these assessments and on comparison with the first assessment. Results are reported below only for those participants who completed an assessment tool on two occasions. Towards the end of the evaluation research, families were asked to take part in a short interview with one of the research team. The times and places were co-ordinated by the project worker so the anonymity of the participants was preserved. Interviewees were asked about their broad experience of the family support project and whether things had changed for them and for their families as a result of their contact with the project workers. Information sheets, consent forms and interview schedules for family members are all provided in the appendices.

Data management and analyses

When families made first contact with the family support project, their case file was given a unique code to identify it. Original data were retained by the project workers. Anonymous copies of care plans, completed assessment tools, and case reviews were sent to the researchers. Interviews were recorded on audio tape. All anonymous data, including audio recordings, were kept securely at the Child and Family Research Centre. Electronic data were retained on a password-protected computer. Data from standardised assessment tools were entered and analysed using Statistical Package for the Social Sciences (SPSS; SPSS Inc., 2005). Totals for scales and subscales for each participant were calculated prior to data analysis. Tests of difference were conducted to discover change over time, that is, from the beginning of the intervention to the end. There were complete pairs of scores on the Adolescent Well-being Scale ($n = 2$), Adult Well-being Scale ($n = 8$), Parent-Child Relationship Inventory ($n = 8$), and the Strengths and Difficulties Questionnaire (Child-rated $n = 15$; Mother- $n = 7$; Father- $n = 2$).

Content analysis was carried out on interviews using a procedure developed by Heary and Guerin (2006). Initial analysis of the interviews identified important themes which were used to develop a coding frame. This coding frame was then applied to all interviews and the number of interviews in which a given theme was mentioned was recorded. There were ten themes in the coding frame category on outcomes.

4.3 Results
Adolescent Well-being scale

Participants completed the Adolescent Well-being Scale on the required two occasions to determine whether there was a change in their feelings of depression as a result of the intervention. A paired samples t test found

no significant differences in the scores ($t = 0.33$; $df = 1$; $p > 0.05$) as shown in Table 4.5.

Table 4.5: *t* tests on AdWS

AdWS	Time	N	Mean	SD	*T*
Total	1	2	16	2.82	0.33
	2	2	15.5	0.71	

Adult Well-being Scale (AWS)

The Adult Well-being Scale has subscales for depression, anxiety, outward-directed irritability, and inward-directed irritability. Eight participants completed the AWS on two occasions to investigate any change in these constructs following the intervention. A series of paired samples *t* tests were conducted. There were significant differences on three subscales: depression ($t = 5.95$; $df = 7$; $p < 0.05$), anxiety ($t = 7.34$; $df = 7$; $p < 0.05$), and outward-directed irritability ($t = 2.5$; $df = 7$; $p < 0.05$). There was no significant difference in scores on inward-directed irritability ($t = 1.42$; $df = 7$; $p > 0.05$). Inspection of means (Table 4.6) suggests that scores were reduced on all subscales, suggested decreased levels of depression, anxiety, and irritability for these participants.

Table 4.6: *t* tests on AWS subscales

AWS	Time	N	Mean	Need	SD	*t*
Depression	1	8	7.5	Borderline	2.78	5.95*
	2	8	2.88	Low	1.46	
Anxiety	1	8	10.88	Problem	1.55	7.34*
	2	8	5.88	Borderline	1.96	
Outward-directed irritability	1	8	5.5	Borderline	3.34	2.5*
	2	8	3	Low	1.51	
Inward-directed irritability	1	8	2.63	Low	4.1	1.42
	2	8	0.5	Low	1.01	

* Significant at the 0.05 level

The AWS gives score ranges for *problem* and *borderline* cases. Inspection of individual scores with respect to these ranges show that for depression 50% of participants moved from *problem* to *low* scores and 25% from *borderline* to *low*. For anxiety, 68% moved from *problem* to *low*, and 13% from *borderline* to *low*. For outward-directed irritability, only two cases were in the *problem* range to begin with and both moved to the *low* range. Two more moved from *borderline* to *low*. For inward-directed irritability, only one participant was in the *problem* range and two were *borderline* at the first time of testing and all moved to the *low* range.

Parent-Child Relationship Inventory (PRCI)

As mentioned above, four subscales of the PCRI were used. These were: support, satisfaction, involvement, and communication. The social desirability check was also included. Nine participants had the required two sets of scores for this analysis, though not the same participants as the AWS. Only on one test occasion did a score with a suspicion of socially desirable responding occur. A series of paired samples *t* tests was

conducted and there were significant differences on one of the subscales, communication (t = -4.55; df = 7; p < 0.05). None of the other subscales showed significant differences: support (t = -0.97; df = 7; p > 0.05); satisfaction (t = -0.89; df =7; p > 0.05); involvement (t = 0.0; df = 7; p > 0.05). Inspection of the means shows that support and communication increased while satisfaction was almost the same and involvement was unchanged (Table 4.7; the higher the score the lower the level of need).

Table 4.7: t tests on PCRI subscales

PCRI	Time	N	Mean	Need	SD	t
Support	1	8	18.89	High	4.78	-1.67
	2	8	20.22	Some	4.38	
Satisfaction	1	8	33.89	Some	2.89	-0.42
	2	8	35.22	Some	5.14	
Communication	1	8	25.11	Some	2.14	-4.19*
	2	8	29.22	Some	3.07	
Involvement	1	8	46.56	Low	5.34	0.46
	2	8	46.56	Low	3.43	
Social desirability	1	8	15.33	Not suspect	2.59	1.01
	2	8	14.44	Not suspect	2.78	

* Significant at the 0.05 level

Also like the AWS, the PCRI has ranges of scores indicating *low*, *some*, and *high* levels of need. What is important in individual cases is that they move from *high* to *some* or *low* need or from *some* to *low* need and this happened in eight of the nine cases on at least one dimension. It should be noted that in four cases participants continued to have *high* levels of need for support after the intervention.

Strengths and Difficulties Questionnaire (SDQ)
The Strengths and Difficulties Questionnaire (SDQ) had subscales for conduct problems, emotional symptoms, hyperactivity, peer problems, and pro-social behaviour. A total score is calculated based on the scores for all but the pro-social behaviour subscale. The SDQ can be completed by children, parents, and teacher and in this case there were fifteen children, eight mothers, and three fathers with complete data. A series of paired samples t tests was conducted and there were significant differences on some of the subscales. There was a significant decrease in self-reported hyperactivity among children as set out in Table 4.8 (t = 2.17; df = 14; p< 0.05). Mothers also reported significant decreases in conduct problems (t = 3.06; df 7; p < 0.05), emotional symptoms (t = 5.95; df = 7; p < 0.05), and overall scores (t = .28; df = 7; p < 0.05) as can be seen in Table 4.9. While there were no significant differences in father-rated results, these are set out in Table 4.10.

Table 4.8: *t* tests on SDQ and subscales for children

SDQ	Time	N	Mean	Need	SD	*t*
Conduct	1	15	3.67	Some	2.58	0.71
	2	15	3.2	Some	2.24	
Emotional	1	15	3.8	Low	2.33	-0.2
	2	15	4	Low	3.12	
Hyperactivity	1	15	4.27	Low	3.15	2.17*
	2	15	2.33	Low	1.54	
Peer problems	1	15	3.33	Some	2.79	0.67
	2	15	2.93	Some	2.31	
Pro-social	1	15	7.75	Low	2.21	0.19
	2	15	7.63	Low	2.33	
Total	1	15	15.07	Some	7.72	1.01
	2	15	12.87	Low	6.85	

* Significant at the 0.05 level

Table 4.9: *t* tests on SDQ and subscales for mothers

SDQ	Time	N	Mean	Need	SD	*T*
Conduct	1	8	5.25	High	2.55	3.06*
	2	8	3.25	Some	1.75	
Emotional	1	8	5.88	High	2.7	5.95*
	2	8	1.75	Low	1.7	
Hyperactivity	1	8	7.13	High	2.48	1.28
	2	8	5.5	Some	2.93	
Peer problems	1	8	3.5	Some	3.3	0.86
	2	8	2.88	Low	2.53	
Pro-social	1	8	7.13	Low	2.17	1.41
	2	8	8.13	Low	1.36	
Total	1	8	22	High	7.41	3.28*
	2	8	13.38	Some	6.97	

- Significant at the 0.05 level

Table 4.10: *t* tests on SDQ and subscales for fathers

SDQ	Time	N	Mean	Need	SD	*t*
Conduct	1	3	1.33	Low	2.31	0
	2	3	1.33	Low	1.52	
Emotional	1	3	1.67	Low	1.15	-
	2	3	0.67	Low	1.15	
Hyperactivity	1	3	2.67	Low	3.78	0.38
	2	3	2.33	Low	2.31	
Peer problems	1	3	0.33	Low	0.58	-2
	2	3	1	Low	0	
Pro-social	1	3	7	Low	2	-1.51
	2	3	8.33	Low	0.58	
Total	1	3	6	Low	6.93	0.56
	2	3	5.33	Low	4.93	

* Significant at the 0.05 level

As with other scales, the SDQ gives ranges of need, in this case parallel to population percentiles. The ranges vary from subscale to subscale and from respondent to respondent so they will not be detailed here. It is worth noting, however, that on many of the subscales, participants were at the lower end to start with so the few significant differences are more understandable. It should also be noted that the parents who completed the SDQ are not necessarily those of the children who completed it. Whether the child, one or both parents, and teachers completed the questionnaire varied from case to case. This may explain the apparent differences in scores on subscales.

Summary of results from assessment tools
In beginning to draw out the implications of these results, three things are immediately obvious. Firstly, where the parent was the target of the intervention and the AWS was used, there were significant improvements in the parent's well-being; most significantly, anxiety and depression. Secondly, where the family processes were of interest, the PCRI showed improvements in communication. It may be that changes in the other domains were not significant because involvement and satisfaction are two-way processes and most work was undertaken with only parents. Thirdly, where the child was the target of intervention and the SDQ was used, there were reductions in hyperactivity (child-reported) and on conduct problems, emotional problems, and total scores (mother-reported). Since different assessments were used in individual cases according to the needs identified, these results cannot be directly connected. It must also be stated that the numbers of cases in these analyses are small so the results should not be over-interpreted. These points of caution notwithstanding, the positive trend in the results is clear.

4.4 Outcomes as described in qualitative interviews
The content analysis of participant interviews produced the following themes in the outcomes category:

- Confidence;
- Assertiveness;
- Parenting;
- Communication with children;
- Children's lives;
- Communication with partner;
- No longer lonely; and
- Don't know where we would be.

Four of the fifteen participants (26.7%) mentioned their increased **confidence** or self-confidence as a direct outcome of their work with the family support project worker. Three of the parents (20%) cited their **assertiveness**, often associated with improved confidence, specifically with regard to **parenting**, mentioned by almost half of those interviewed (46.7%). The help and support with parenting that family support project workers provided was in turn associated with improved **communication with** their **children** and with general improvements in **children's lives** (as mentioned by seven of the parents).

> *"Everybody's on an even keel and if something does crop up again… I know how to deal with it now"*.

A number of those interviewed spoke of improved **communication with** their **partners** (three; 20%).

> *"Communication between me and the other half has improved"*.

In some cases, this was with their present partner and in others the communication was over separation proceedings, visitation rights, and related matters. Similarly, three parents stated that they were **no longer lonely** since they worked with the family support project worker. Where interviewees were unable to point to specific changes, they were aware that theirs and their families' lives had changed considerably:

> *"When I look back, we have come miles down the road"*.

> *"It's like looking at somebody else's life, looking back at that, and I do […] credit that to [project worker] for getting involved… It's all down to her"*.

It is worth pointing out that some of the themes discussed in these interviews parallel the findings from the standardised assessment tools: communication on the PRCI; improvements in child behaviour on the mothers' SDQ; and decreases in depression, anxiety, and outward directed irritability which may be linked to improved confidence and assertiveness. That changes were expressed in positive rather than negative terms may indicate the effect of the strengths-based approach employed by the family support project workers. Feedback in relation to the approach of the FSPWs and their overall perception of the programme are discussed in Chapter Five.

4.5   Outcomes as described by FSPWs

There were three main themes in FSPWs' comments on outcomes: the time required before outcomes are apparent; the knock-on outcomes of intervention with one family member; and the preventative value of family support.

The family support service works to an open time-frame, an acknowledgement that helping people make changes in their lives does not happen quickly and is an on-going process. Cases are closed when all parties agree to do so and even then there are no guarantees that positive changes had taken place. Making changes often does not happen quickly; rather people have to be ready for change and willing to try new things, according to one FSPW. Even when cases are closed, there is on-going support available through drop-in services as described in Chapter Three. Families can return to the family support service if their circumstances change again. There were a number of cases which were opened, employed an initial intervention with some success, and were closed. At a later stage, the same clients returned to the service in need of a greater degree of support and, because of the initial contact, could quickly begin to address the new issues when they arose. From the perspective of the

FSPW's, this flexible form of intervention is crucial to the success of the programme.

FSPWs mentioned that supports like listening, offering options, and advocacy were important to clients. The reassurance that parents were not doing a bad job were not the only ones ever to have experienced difficulties, and that there were solutions to their problems was perceived to be valuable. Reassurance and its consequences for well-being and self-confidence, like all the positive outcomes mentioned in this chapter, affected the recipient of the intervention most of all but also had an influence on the children. Where one parent was the dominant person in a household their mood could affect all the other members of the household. In many cases, if things were bad for that person, they were bad for everyone. Conversely, if the dominant person's outlook was changed for the better, everyone was better off. These positive outcomes could not always be picked up by the standardised assessments.

An unquantifiable outcome of family support is prevention. While there is no way of telling, a number of FSPWs suggested that families' problems could have progressed to a point where child protection issues required state intervention or adolescents may have dropped out of school. The value of prevention is both for the clients themselves and for service providers who do not have to deal with crisis cases.

4.6 Conclusions
The outcomes for 25 families were formally assessed and they represent a considerable proportion of all children and families availing of family support services as well as representing a range of the needs in those children and families. The most striking conclusion is that there were positive outcomes according to the standardised assessments, to the clients themselves, and to the FSPWs. Importantly, the more objective standardised measures were consistent with the more subjective viewpoints of the clients and FSPWs. As far as possible, presenting needs where matched with a package of interventions and the outcomes were generally positive.

Chapter Five
Assessment of the Programme Model

5.1 Introduction
Earlier chapters have described in detail the background, processes, and outcomes of the Community-Based Family Support Project. The indications are that the project addressed real needs, and, for the families involved, those needs decreased. While this was the main focus of the study, a number of issues were also of interest. Firstly, the programme represents an attempt to develop a model of family support suitable for rural areas. Aspects of the model and the impact of the rural context are discussed. Secondly, the model marries family support with community development and the implications arising from this deserve some reflection. Thirdly, in order to achieve the above, a complex management model was developed, which gave rise to some difficulties. The key issues arising and options for future development of the model are discussed.

5.2 Respondents and analysis
The overall assessment of the project combines the perspectives of all the stakeholders in the Community-Based Family Support Project. Interviews were conducted with the following parties:

- Parents from fifteen families who have availed of the services of the family support project
- Family Support Project Workers
- CDP Co-ordinators
- Members of the Boards of Management of the CDPs
- The Foróige Area Manager, Project Leader, and the first and second Programme Officers
- The HSE Child Care Manager and Children Act Services Manager, Mayo

Sample interview schedules are presented in the appendices.

Service providers who refer people to the family support projects and who were otherwise linked to the family support projects completed postal questionnaires. Of the thirty-three referring agencies contacted, twelve (36%) responded. Eighteen of forty (45%) linked services returned questionnaires. With reference to cases they had worked with, service providers were asked to evaluate the model of community based family support, and their own and their clients' experiences of the service.

The data from these respondents were in the forms of interview transcripts, interview notes, and questionnaires with open and closed questions. Using principles of content analysis as described in Chapter Four, a number of important themes were identified from these data. Themes which were raised by different stakeholders were considered more noteworthy than those only mentioned by one. In describing stakeholders' responses categorised in these themes, care is taken to represent all sides. Where useful, quotes are included to illustrate important points. It should also be borne in mind that over the three-year time-frame of the programme, there were numerous challenges and obstacles and not all of those can be considered here.

5.3 What has been learned in terms of the provision of family support in rural areas?

Family support programmes, such as Springboard, have been provided exclusively in urban areas in Ireland to date. This programme sought to address this issue in the creation of a model of family support applicable to rural areas and towns. The model adheres to established approaches in family support (as outlined in Chapter Two) but provides them in a structure and setting that represents a new departure for this country. In analysing the model, much of the feedback relates to the fact that such service provision is now available in local communities where it was not previously. The programme is underpinned by approaches that are considered good practice in family support – including a flexible, needs-led model, strengths perspective and linkages with other agencies. Feedback suggest that these were considered valuable by stakeholders. The professional and friendly approach of the FSPWs was considered critical to the success of the model.

A.   Locally based family support
There was consensus among stakeholders that the location of the family support project worker in the CDP is the core strength of the model (*"Location, location, location!"* as one linked service provider (15) put it) and enhances the approachability and accessibility of the service.   A number of clients mentioned that the most important thing is that the service is local. The benefits of the CDP base are discussed further in the next section.
"People were making comments that they were just so happy that there was something like this for them, even that they were so rural and would never know where to turn for support in the town and wouldn't be familiar enough with [major town] to even begin to negotiate looking for supports so far away" (FSPW 3).

However, while location is important, simply locating a service in a local area does not guarantee that it will work. The features of the model combined with its local base to achieve the outcomes described in Chapter Five. There is a strong sense that the flexible, needs-led model of work underpinning the project is effective. There was a sense that the programme enables a local needs-led service to emerge while working to a common model. As one Foroige manager commented:
'I couldn't get over the differences in projects. Each one was so different, such different issues going on and it was obvious that the FSWs were tailoring it to the needs there in their own community... They're just responding to what issues are there at that time and delivering the service to meet that need. It's brilliant.'

Likewise, the Programme Officer highlighted how, by being based in the local community and adopting a family friendly model of work, the service occupies a space between the statutory services and the family. *'I think it breaks down the barrier of ... statutory bodies. It makes it a bit friendlier, easier to access.   There seems to be more of an equality in the partnership, that its not just the professional coming in per se, even*

though it is a professional service, but that barrier isn't there' (PO2). The voluntary ethos of the project is attractive to families. As one parent said: *"It's not pushed on you. You can take it or leave it"* (Client 6). While the service is voluntary, it can only work if the client is ready for change and willing to try new things. The project model values individual responsibility - the client must decide whether it is in their and the family's interests to implement a behaviour rewards system or attend a parenting course, for example. Referral to other agencies is also on a voluntary basis and always in consultation with the client. FSPWs do not pass on details to other services without consultation. A number of parents referred to negative experiences of social work services and highlighted how they perceived family support to be different. The voluntary nature of family support is likely to be a key factor in this comparison.

The parents interviewed as part of the research recognised the value of the flexible time-frame for family support, both in individual meetings and from the beginning of the case. One parent compared her experience of seeing a psychologist within a constrained time slot to meeting with the family support project worker:
"Trying to give [psychologist] a run down on the entire week and what happened during the week in the space of about five minutes because then she'd see [daughter] and we'd be running out of time…" (Client 4).
Compared to:
"[FSPW] would come to the house, meet you, talk to you at whatever time suited you. She would actually stay until, like, she could stay ten minutes if that's all or she could stay an hour if it came to it. If the conversation went on for an hour, she'd stay an hour" (Client 4),
Within reason, clients can 'drop-in' to or phone the FSPW outside appointed times. Furthermore, even after a case is closed, clients can still avail of the drop-in service for as long as they feel it is necessary. If clients take part in CDP groups they are likely to come into contact with the FSPW in that setting too, which holds the possibility of offering on-going support. The value of a service with no waiting time was expressed by a mother who, after an incident with her son in school was able to speak to a FSPW, with the outcome that *"I could go home that first night and sleep"* (Client 2). Among the other benefits are that people do not have to travel. Asked what the added value of the service is, one FSPW gave the following answer: *'it's the way we work, the way you meet the family at whatever stage they are …we're involved in their problems. We're also there in the aftermath until the family are able to cope and are managing, then we withdraw. That's unique. If there are problems they're more likely to come back to you before they get worse again'. (FSPW1)*

B.   The nature of help-seeking and rural family support
Rural isolation, both for clients and for family support project workers, had a number of consequences which impacted on the project. The isolation of the clients was at the root of some of the needs presented, primarily the lack of natural family support for people with small social networks in the area. This was raised explicitly by five clients (33%). The town in which

one of the CDPs is based was described as *"like an island"* (CDP 4) in its lack of infrastructure, resources, and connection to other towns.

There were also elements of the culture of rural populations which raised issues for CDPs and FSPWs. Some interviewees suggested that there was an acceptance of domestic violence, of poverty, and of anti-social behaviour in some areas. There was also a pattern of *"secrecy"* (CDP BoM 4) in some areas, not wanting others to know one's business according a CDP co-ordinator. This made it even harder for the CDPs and FSPWs to identify people at risk in the community. A CDP Board of Management member suggested that a religious acceptance of circumstances prevented people from seeking help, as well as contributed to accepting domestic violence in particular. As one client put it:
"I was very much brought up not to ask for help. If you couldn't do it yourself, for God's sake, what are you like?" (Client 8)

Given the issues of rural isolation and reluctance to seek help, it would be reasonable to expect that people might not immediately rush to a new family support service; a number of FSPWs expressed concern that the service would be stigmatised and slow to take off. A Programme Officer noted that the fact that the programme is not run directly by the HSE helps people to overcome their fear and reluctance of engaging with statutory social services.
'I think it's a historical fear here that's associated with social work, children being taken into care…. And its very deep rooted, especially out in rural areas' (PO2)

On the contrary, family support came to be seen as *"positive"* (FSPW 5), *"non-threatening"* (FSPW 2), and very valuable. The individual and group work carried out by FSPWs are seen as complementary means of change which mirror *"natural family support"* (Linked services 8). The PO believes that the voluntary, non-threatening nature of the service means that children are better protected. *'There would be children at risk out there and it wouldn't get referred to social work because of this fear so it would be missed, whereas I think FSPWs are picking things up at an earlier stage before it becomes a major crisis'* (PO2) In addition, the PO sees the high rate of self-referral as indicative of the success of the project on the ground, highlighting that people trust the service and are willing to come forward to seek help. Because the FSPWs are involved in group work in schools and in the community, there is an awareness of their role. One FSPW made the following comment in relation to working in schools:
'Young people know what I'm about. They don't view me as a threat … Everyone is quite aware of it. Its just healthy that there's no stigma. If they need to come to me, its no big deal' (FSPW1)

C.   *Approach of the Family Support Project Workers*
All parents interviewed referred to the approach of the family support project workers as important. They pointed out that FSPWs were not critical, did not look for problems, and emphasised good things in what they did and potential for what they could do next.

"[FSPW] will look for your abilities and bring them out as opposed to just pointing out things that are wrong… she really inspires you to do your best" (Client 8).

"I spent 19 years in the house without looking for a job and if I hadn't got advice from someone I'd still be sitting there" (Client 15).

More than half the clients interviewed (53%) valued talking and being listened to by the FSPWs. One or two clients mentioned being little *"wary"* (Clients 14 and 15) at first but later finding it easy to open up. This is consistent with FSPWs having the time to listen, as mentioned above. FSPWs were also described as *"friendly"* (Clients 6 and 13), *"supportive"* and *"understanding"* (Client 2), and *"compassionate"* (Client 13). FSPWs were credited with *"insight"* (Client 8) by a number of clients. Similarly, clients valued that FSPWs could help them to clarify what it was that they needed. When asked about what she initially wanted to gain from the family support service, one mother replied:

"No… That means you're coming in and you're organised. You're not organised, you're stressed… If you're coming in to use this service you do not have a plan you're just beside yourself with worry and stress" (Client 7).

There was also a sense from clients that there was nothing the FSPWs couldn't do; this includes knowing who else to ask for help, which may be just as valuable in a time of need: *"She just helps you not matter what your problem is. She's never turned around and said 'There's nothing I can do about that'. No matter what it is, she's in there 100%. She's fantastic"* (Client 8).

Likewise, CDP Co-ordinators and Management Committee members spoke very highly of the skills and professionalism of the FSPWs, a factor they considered central to the success of the intervention. All nine of those who responded among the agencies that made referrals to the family support service found the staff easy to contact and courteous, and would continue to refer clients or recommend to others to make referrals.

D.   Inter-agency Linkages:
For two thirds of those interviewed, an important aspect of their use of the family support service was referral to other services. A strength of the model identified by parents is that the FSPW can act as a *"conduit"* (FSPW 3) to state and voluntary sectors. Some of the parents mentioned that if a person has never had any dealings with support services before, they cannot know where to start looking for help, or what they are entitled to: *"Those agencies are out there but they're 'out there' as far as you're concerned if you've never had to turn to them before"* (Client 7).

As we saw in Chapter Four, each of the projects have developed strong working relationships with a wide range of statutory and voluntary bodies. The service providers were asked whether they considered the CBFSP to be a valuable service. All nine referrers who responded and fourteen of the linked services (78%) said family support was either valuable or very

valuable as a resource in their day-to-day work. One service provider welcomed the project as *"I feel it moves away from the medical model which has been dominant in the past"* (Linked services 10). A number of other service providers foresaw possibilities for collaboration with FSPWs: *"I feel the potential of the service is huge and I am keen to explore what the service offers in more detail and as this maximises the benefits of psychology and the Family Support service working in partnership"* (Linked services 16) One service provider was particularly adamant about the benefits of the model, saying *"This model works. Please do not change it"* (Linked services 15)

Some linked services appear to have less clarity of understanding regarding what family support services do. Among the responses on the role of the family support service from linked services were *"to coach life skills"* (Linked services 3), *"to assist families [to] stay together"* (Linked services 3), *"child protection"* (Linked services 13), *parenting and especially education, "direct interventions"* (Linked services 5), *"to provide services, set up projects"* (Linked services 14), *"providing education and awareness and training"* (Linked services 10). While these may all be elements of the work of family support, there are no principles by which these other services seem to understand family support. Some social work departments employ family support workers as part of the social work team, which also led to some confusion at the outset of the project. A criticism raised by one of the linked service providers was about the flexibility of the community-based family support model: *"Workers appear to create their own brief depending on individual areas of expertise so I find it hard at times to know exactly what level of intervention they are using"* (Linked services 12). These responses reflect a lack of clarity in the views of other service providers as to what family support is and highlight the need for further work in terms of defining the role of family support. It is noteworthy that a model and theoretical basis has recently been developed for the Mayo projects (see Chapter one). This should help FSPWs and the POs in communicating with greater clarity regarding the principles and models underpinning their work.

With regard to referrals, relationships with social work services were very strong in some areas but they were weak in other areas. Given the positioning of the service as secondary prevention, it is important that good linkages and relationships with social work are in place across all the projects. Feedback indicates that numerous efforts were made to stimulate referrals, but with little results. This aspect of the model could be addressed at management level within the HSE to encourage greater flow of referrals to the project. The FSPWs and the PO would also like to see more referrals coming from public health nurses, who are a primary source of contact with families at local level.

5.4   How have the family support / casework and community development approaches complemented each other and impacted on each others project development?

McGrath (2004) identifies a number of policy issues relevant to the integration of family support and community development; namely: achieving a workable balance between casework and community development interventions; issues in combining casework and community development approaches and education and awareness for community development practitioners and volunteers regarding 'family support'. These issues were all pertinent in this project as we will see below.   In order for the model to be a success, it is important that both the HSE and the CDPs see the combination of community development and casework as beneficial from their perspectives.   The benefits to both parties are described below, followed by a discussion of some of the tensions and challenges that arose in combining casework and community development approaches.

A.   Benefits to the HSE:
The initiative to develop this project came from the HSE, stemming from a recognition that effective preventative work for children and young people in need is best provided in community based settings, involving voluntary participation of families and provision of a holistic needs-led service. From their perspective of HSE management, the link between casework and community work is very important, but they see the role of the family support project workers as becoming involved in community work in a way that targets the needs of children and families at risk and that increases the access of vulnerable families to community services.   The HSE was anxious to ensure that the casework would be provided to a high quality and that the community work would be the secondary rather than primary role of FSPWs.   Thus, the model had to incorporate structures to facilitate support and supervision of casework, while allowing the local projects to have ownership of the project and to shape it according to local needs.   This endeavour to balance agency and control reflects the need for both partners to have their agendas served by the programme. As we will see later in this chapter, some difficulties arose as a result. However, in general terms, it appears that the both elements of the project have worked together very well.

There were numerous benefits to the HSE of locating the project in CDPs rather than on a 'green field site' in local areas.   Having the CDP as a base for their work meant that the family support projects benefited from its established reputation and could draw upon its inter-agency networks. One FSPW attributed the success of the project to the fact that it is based in the CDP: *"I think because of where I'm based, I think the groundwork was there already and I just came in as another extension of the services already here"* (FSPW 1). Furthermore, families have the reassurance that, as they could be going to the CDP for any of a range of reasons, there is no stigma associated with visiting the FSPW.

Evidence suggests that, although FSPWs found it challenging to balance casework with group activities, the majority of their time was devoted to

casework. The aim of involving casework clients in community activities appears to have been met - of the fifteen clients interviewed as part of the research, thirteen (87%) had attended some CDP based group activity. As outlined in Chapter Four, there were a number of ways in which FSPW became involved in group and community activities:

- Organising group activities themselves that were tailored to the needs of their clients or more generalised community interventions targeted at 'at risk' groups from which potential clients could self-refer
- Helping out with CDP-led activities as a means of getting to know families and raise awareness of their role
- Jointly organising initiatives with the CDP
- Offering 'quality control' to CDP initiatives and practices to encourage good practice in targeting and meeting the needs of families in need
- Referring family support clients to the CDP activities
- Engaging in inter-agency groups and networks to take action of social issues of relevance to their clients.

From the Child Care Manager's perspective, the project is very much targeted as secondary prevention. This secondary prevention role appeared to work very well in well-established CDPs with a good infrastructure of community services for children, young people and families, such as youth summer schemes, playgroups, parent and toddler groups and youth clubs. In such projects, the family support project worker could maintain a focus on the most at risk groups and refer to wider project activities as needed. It could be argued that FSPWs are more likely to be drawn into primary prevention work where the community infrastructure is lacking. The level of development of the CDP and general community services, therefore, appears to impact on the level of prevention at which the FSPW can function.

B.   Benefits to the CDPs:
From the perspective of the CDPs, the model made sense to them as they had been conscious of the need to engage in one to one work with families. Management committee members from the five CDPs said that the skills brought by the family support project address what had been a *'missing link'* in their work.   They mentioned that the family support element would help them to target people in the community *'we hadn't managed to engage with'*, which would *'open up our project'* (BoM4). Some committee members mentioned the role of family support in enabling participation – *'the individual needs support first to build up their capacity to fully participate'.*   The family support project could offer expertise and time to make this happen which *'was a fabulous resource to use and to the whole community'.*   This committee gave the example of some clients who took part in a group for women as a result of their engagement with the family support project worker. These women would not have come if it were not for the family support project as *'we wouldn't have known how to attract them'* (BoM 4). This person went on to say:

'One of the main aims of the CDP is to engage the most marginalised, excluded people in the community and I think family support is definitely

a great way of doing that because some of the individuals would be way beyond … we wouldn't even begin to know who they are in the community. They're almost hidden and we wouldn't even … so it's a great way of getting in touch with these people and I think even when you get in contact wth one person, then it's a family, it extends outwards again. There's another circle around the project if you like even. It also, I think, engages you more closely with the likes of the PHN, the doctors, the schools … so if other issues emerge you have more of a liaison' (BoM4)

C.   Challenges in combining the approaches
McGrath (2004) highlights the need to allow opportunities for CDPs to increase their understanding of family support. According to the CDP co-ordinators and Boards of Management representatives themselves, it took some time to understand the role of the family support project worker and their place in the CDP: *"In the beginning I suppose I was a bit surprised because I had never heard about it before… Didn't really know the structure of it"* (CDP BoM 4). Some projects spent time at the start working on developing a shared understanding of family support and one project used role play to help in this process. One Co-ordinator referred to the emphasis her project placed on '*really looking at family support and community development and how do we marry the two and make them integral to the work?*' She believed that this aspect of the work was '*as important as the direct family work, to get people to understand boundaries… we are getting there*'. Committee members spoke of how, when they had got used to each other, the FSPW had become integral to the overall work of the CDP and the value of the arrangement: *"Once that's done, I think it's an ideal setting and I think they complement each other very well"* (CDP 4). The Programme Officer referred to the importance of bringing information from the HSE '*back to the local level*' as part of her role. Stakeholders consider it critical that clear communication between the HSE, Foroige and CDPs takes place in order to support effective working and avoid misunderstandings.

There were numerous examples of the adjustments needed and the tensions that can occur in reconciling the two approaches. For example, at the outset, projects found that the type of work space required for family support work (private space, large enough to meet families of 3-4 people, place for children to play, waiting area) had to be created. Policies and procedures around matters such as health and safety, confidentiality and child protection had to be developed if they were not already in place. CDPs were eager to have a say over the workers job description in order to ensure that the focus of the work reflected 'where the project is at' (CDP4).

Issues related to confidentiality were the source of considerable discussion within projects and between projects and the HSE. Four examples illustrate how difficulties arose as a result of projects interpretation of the issue of confidentiality. Firstly, in one CDP, clients of the family support project worker did not sign into the building in an effort to preserve confidentiality. However, this practice raised concerns on the part of the CDP around not knowing exactly who was in the building at a given time. This was resolved by instituting a sign-in code which the family support

clients used. Secondly, a health and safety concern arose when a FSPW felt she had to evacuate the CDP premises but, owing to the confidentiality agreements in place, she could not give any reason for this request. Thirdly, some projects had concerns over the safety of FSPWs when on home visits, partly due to some of the family situations they were working with and partly due to the general risks of working alone. They feared that sharing details of the family they were visiting would compromise confidentiality agreements in place. Fourthly, an issue that emerged was the need to strike a balance between protecting the confidentiality of family support clients but yet keeping the management committee and CDP co-ordinator informed of the progress of work. For some CDPs, this was simply not an issue – they said that they have an implicit trust of the FSPW and didn't feel the need to know what she is doing. For other projects, the fact that they did not know the details the casework was problematic on the basis that they have legal responsibility for it. Allied to this point, one FSPW made the point that, because she can't tell her management committee exactly what she does or the outcomes she sees resulting from her work, they *"never got to hear the good side"* (FSPW 1). As the following quote from a management committee member indicates, the CDP largely takes it on trust that the family support project is delivering what they hope it will. *"I know a lot of the work FSPW is doing is confidential and all that…I'm not sure that we know whether that need has been met. We don't know the [details of the work] so we have to assume what she's doing is fulfilling the needs set out but I don't know how you could measure that"* (CDP BoM 4).

For statutory service providers accustomed to case work models, these issues are routinely considered and addressed, but for some community development projects they represent a new departure and caused some anxiety. As a consequence, a considerable amount of time was spent in meetings between the Programme Officer and CDP representatives to resolve them. At a meeting in Mayo in December 2005 to review the service agreement, there was much discussion about the issue of confidentiality. It was the view of the Child Care Manager that standard ways of working on the issue were not applied and that some interpretations of confidentiality were inaccurate and unnecessarily rigid. In his opinion, had these interpretations been negotiated in a 'reasonable and balanced way', they would not have caused such difficulty.

To summarise, therefore, it appears that the agendas of both CDPs and the HSEs were met and that the model enabled both parties to derive benefits from the synergies associated with the combination of casework and community development. It appears that the model's key benefits were in enabling the HSE to embed its family casework in the established networks and reputation of the CDP; in facilitating the CDPs to identify and respond to previously unmet needs and in realising a community development approach to meeting the needs of vulnerable families.

5.5 How has the HSE / CDP / Foroige partnership been established and worked to date in Mayo?

The partnership model in Mayo is very complex. A broad range of partners are involved – including four CDP's, Foroige and the HSE. The reasons for the complex structure were outlined in Chapter One and relate to the need of the HSE to adapt to recruitment restraints in operation at the time the initiative was developed. The high number of stakeholders made it almost inevitable that issues would arise. There was consensus from stakeholders that the programme model was burdensome, but that it operated very well in spite of this. In addition to issues such as confidentiality discussed above, other matters identified during the evaluation related to support and supervision, resources and facilities and options for future development.

A. Supports and Structures

Two key issues were raised by stakeholders throughout the evaluation; namely the quality of supervision and the complexity of programme structures. In relation to the former, FSPWs consistently identified isolation and casework supervision as critical issues. As described in Chapter Two, they and other stakeholders stated that supervision was not satisfactory, which in turn affected the programme. This highlights the significance to the programme of the role of the Programme Officer and the range of associated responsibilities.

In addition to the difficulties caused by supervision, concerns were also articulated about the complexity of programme structures. The structures were changed in late 2006, as described in Chapter Two. However, the Programme officer still has responsibility just for FSPW casework and not for other issues, which maintains the spilt in the supervision of the FSPWs. Some stakeholders feel that there are too many strands and that the model is too complex, which can give rise to employment issues.

> *'I think partnership is great but partnership with employment issues is certainly not great … There's too many employers. I think it needs to be more clear-cut. I think one employer …and a PL position .. supervision and employment'* (F1)

Were the FSPWs all employed by a single agency, this would not be an issue. However, this would mean that the close relationship between the FSPW and the CDP could be affected.

B. Resources and Facilities

With regard to caseloads, we saw in Chapter Three that caseload targets were met overall but fell slightly short in two projects. One of the projects experienced difficulty in achieving the caseload targets due to a low rate of referrals. It would appear logical that the catchment area of local services is flexible to allow a widening of the geographical base if the service is operating under capacity. Other projects have had some very intense cases, involving a protracted period of involvement. Stakeholders feel that providing a needs-led service means that the service has to be open and adaptable and that caseload targets set for the project must be sensitive to this. Furthermore, there is pressure on FSPWs to carry the

caseload and thus the project is exposed to staff shortages due to sickness, maternity leave, parental leave, etc. As one FSPW commented: '*If I'm out sick, that's the project on hold*'. The HSE Child Care Manager's believes, however, that the programme's case loads, supervision arrangements and programme costs allocations are generous in comparison with those in other arenas of the child care services.

Physical facilities available to the project were not always ideal. Space within some individual projects was cramped and generally restricted possibilities for working creatively or for working with bigger families. In buildings where offices were shared, client confidentiality could not be guaranteed. Projects have done their best to make the space attractive to children and families but this remains an issue. In addition, there is no central office or space for the project workers to meet. FSPWs said that they would find it valuable to have a central space to meet, ideally one where they could develop a resource library. On the positive side, staff have access to the HSE training courses and can organise their own team meetings and training.

An allocation of €3,000 per project is given for programme costs. Applications for additional funds were processed differently in different projects, ranging from solo applications by the FSPW to joint applications with the CDP to solo applications by the CDP. While individual FSPWs have successfully raised additional funds, they feel that the administration time taken to do so has been at the expense of direct work with families. In a climate of public sector retrenchment, it is unlikely that additional funding will be made available. It may be useful to look at making joint applications for programme costs for the overall project via the PO, thus reducing the pressure on individual workers. Were such programme funding available, it could also be used to fund group facilitators to run programmes for clients of the service, thus freeing up the FSPWs to adopt more of a developmental role in relation to group work, rather than direct provision.

C.   Options for future development
For clients, there was no question but that the project should continue. A number of people expressed concern in the course of the interview that the FSPW was going to be *"taken away"* (Client 8). Others suggested that it should be expanded, that there should be *"one in every town"* (Client 13) and that more space should be available. All fifteen of the clients interviewed said they would recommend using the family support service and nine of them (60%) had already done so. Similarly, all nine of the referrers who responded and all seventeen of the other linked services said they would recommend the service and several of the linked services had already done so.

While FSPWs, service providers and CDP co-ordinators agreed that the CBFSP model should be continued and expanded, there were a number of suggestions for the direction of that expansion. On the one hand, there is demand for a second FSPW in some of the existing projects. Some respondents suggested expanding into other counties and to other towns; there were recommendations around feasibility studies in new areas.

Another suggestion was to expand services to certain disadvantaged populations, to have a designated FSPW for the travelling community, for example. The potential for more youth work, more focus on school-based programmes, and links with the probation services were all raised. From the FSPWs there were suggestions as to how to improve their current level of practice. A central office equipped with a library of resources for family support project workers was proposed. Even without this facility, FSPWs recognised a need for more team meetings and for training to ensure best practice standards are maintained. Some ideas around better balancing individual and group work in the CDPs were put forward.

There are a number of options regarding the future development of the model. The first option is the model remains the same, that is, the revised model from Chapter Two. This appears to be working successfully and has been informally welcomed by stakeholders. The process of policy development and joint planning currently underway will help to strengthen and consolidate the model.

The second option is for a Project Leader position to be created in Foroige to supervise the FSPWs, rather than a Programme Officer position. It should be noted that Foróige is proposed as they are the organisation presently involved but a different non-statutory organisation could be involved. The Project Leader level in Foróige has more autonomy and could be better placed to facilitate the relationships between the HSE, CDPs, and Foróige. However, this would not be possible within Foróige if the CDPs continued to employ the FSPWs. The implication is that Foróige could also employ the FSPWs but they would continue to be based in the CDPs premises. However, this may fundamentally alter the nature of the close working relationship between the FSPW and the CDP co-ordinator which has been essential to the success of the present model. It may be that as CBFSPs are set up in other areas Foróige is not available to participate and some other organisation might then be involved, in which cases further revisions of the model may be necessary.

The third option is that the HSE could employ the Project Leader or PO and that Foróige or other voluntary organisation would no longer be involved. Employment of an HSE PL depends on the HSE recruitment policy and whether it is feasible to do so. This option loses the value of Foróige's experience and expertise and limits the future possibility of co-operation between CDPs and Foróige. Given the current HSE recruitment embargo, this option is unlikely to be feasible.

5.6   Summary
In this section, the feedback from all stakeholders was collated to form and overall assessment of the programme model and answer the research questions. Firstly, we saw that the programme was valued as a source of much needed support for children, young people and families in rural areas. Among the positive features identified were its local base, flexible, needs-led model, approach of the FSPWs and linkages with other agencies. Secondly, the combination of family support and community development was seen as beneficial from the perspective of the HSE and CDPs. Each partner had to adjust their way of working somewhat in order

to work effectively together for the needs of children and families. There is evidence that a rounded approach to the needs of families emerged, with the majority of clients interviewed reporting that they took part in community activities as a result of their involvement with the FSPW. Finally, the partnership model worked well overall but problems arose in relation to supervision and structures. Options for the programme structure going forward were discussed.

Chapter Six   Conclusions and recommendations

6.1   Conclusion
The Community-Based Family Support Project extends over three years, five sites and more than sixty cases and one hundred individuals. This report has attempted to do justice to all phases of the Programme's development and to all stakeholders. This report examined the project outcomes, the partnership model; the nature of rural family support; and the interaction between community development and family support approaches.

As outlined in Chapter One, there is considerable overlap in the aims and methods of community development and family support. This was one of the reasons why the community-based model of family support was applied to rural family support services. It was expected that the individual focus of family support work would complement the community-focused group activities run by CDPs. As it transpired, all stakeholders found the mutual influence and co-operation was beneficial to both parties and, most importantly, to families. Project outcomes were assessed in three ways: by standardised assessment tools; by semi-structured interviews with clients; and by consultation with FSPWs through interviews and written reports. Each of these methods identified positive outcomes and these could be clearly linked to interventions and in turn to the presenting problems. It is worth noting that, while the sample sizes for some of the statistical tests were small, results were complemented by the other methods. While not all issues could be resolved and while some statistical results were not significant, there is strong evidence that the Community-Based Family Support Programme had positive outcomes for children and families. Overall, community-based family support is a promising model of intervention.

The five CDPs had distinctive histories, distinctive profiles in their communities, and distinct strengths. It would have been restrictive to insist that FSPWs operate in exactly the same way in each of the five CDPs rather than allow them to adapt their work to meet local needs. This is not to suggest that there was no foundation to the work and a detailed model was described in Chapters Two and Three. The broad strokes of interventions were present in all projects and the finer detail differed. One of the challenges that the Programme expected to face was the rural setting of the CDPs and the consequences for accessing clients; this was the case despite the level of need which prompted the development of the service in the first place. As it transpired, there was a considerable appetite for the service and comparatively less stigmatisation of family support than had been expected. As has been discussed, accessing services in other towns was a difficulty for many people and the locally available family support service made introduction to other services possible. This is also due to the connections made between FSPWs and other agencies. Based on clients' evaluations of the approach of the FSPWs themselves, it appears that the workers were among the models' greatest strengths.

The Community-Based Family Support Project model in Mayo was innovative, ambitious, and not without risk. Considerable co-operation and flexibility on the parts of the main stakeholders, the HSE, the five CDPs, and Foróige was required to agree a common way of working. The collaboration between stakeholders over the past few years has resulted in strong working relationships that have enabled difficulties to be addressed. A key weakness articulated by stakeholders relates to the quality of support and supervision provided; an issue that needs careful attention as the programme evolves. It appears that the model is now working well but that some additional changes could be made, as recommended below.

6.1 Recommendations

- A key recommendation emerging from this research is the need for greater streamlining of the programme model in Mayo. This process has started with the development of a new mission, aims and objectives and practice model and work is currently ongoing regarding the development of a common set of policies and procedures. However, from the FSPWs perspective, it is not ideal that supervision is split between the CDP Co-ordinators and the Programme Officer. There are six partner organisations involved in the programme in Mayo, which has led to a proliferation of committees and sub-committees to clarify relationships and procedures. A number of options regarding the future of the programme were outlined in Chapter Five. Given the demanding and intense nature of the work, there is a need for a support model that enables the FSPWs to work in a way that is safe, supported, effective, and progressive. To achieve this, it would make sense to have the PO and FSPWs employed by a single agency, but to have the FSPWs still based in the CDPs. Processes could be put in place to ensure that the relationship with the CDP remains strong. This option would have the benefit of ensuring that CDPs resources are not tied up with employment related issues, enabling them to focus energies on joint working for the benefit of children and families. In the case of Forum, however, there does not appear to be an issue in this regard and the current model should be maintained. Were additional projects to be developed in Galway, the structures would need to be re-examined and the learning from the experience in Mayo taken on board.

- There appeared to be a lack of clarity on the part of outside agencies as to what family support actually is and what it involves; clarification would serve to improve the profile of community-based family support services among other service providers, among prospective clients, and for funding applications. The development of a clear model of practice should help the programme in communicating with other agencies regarding its role.

- In terms of achieving the aims of preventing children entering the child protection and alternative care systems, it is critical that links between the CBFSP and social work and other core HSE services,

such as public health and psychology are strong. While excellent working relationships have been developed in many areas, referrals from these professions to the programme are weak in some projects. To maximise the potential value of the project in each site, it would be valuable if the issue of the co-ordination of local prevention efforts is addressed at strategic level within the HSE.

- While CDP's work within particular catchment areas, these catchments may be limited in terms of ensuring a flow of casework referrals for a full-time family support worker. On the other hand, the level of presenting need in other CDP catchment areas is such that the demand may be great on one staff member or there may be family support needs in nearby areas that are not being addressed. It is therefore recommended that the programme be flexible regarding catchment areas, with a remit to work beyond the CDP boundaries if deemed necessary.

To conclude, on the evidence presented in this report, the Community-Based Family Support Project has been very successful. The model of placing family support project workers in CDPs has resulted in positive outcomes for the children and families served.

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Appendices

A. Information Leaflet and consent forms for research and interview – Family members
B. Interview schedule for families
C. Research Baseline Information Form
D. Interview schedules for FSPW, CDP co-ordinators and BoM members and Programme Officers
E. Questionnaire for linked services

Information and Consent form for Families

1. This research is about….

… whether the family support project is doing a good job. The main idea behind the research is to find out what families think of the service and if it is of benefit to them.

2. It being done because …

… the (Forum) and the HSE wants to make sure that it is doing its job for children and families as best it can.   This is a new project and we need to get feedback from families to make sure that we are meeting your needs.

There may be small (or big!) things that we could do better but we wont know unless families have an opportunity to tell us.

3. You are being asked to take part because …

… we need to learn from you, the families. Your experience of the project is very important.

4. The research is being done by …

… Bernadine Brady.   She works for NUI, Galway as a researcher and is also attached to the HSE.

5. The research will involve …

- Looking at written information about the project and what it has done. This includes details about family needs, how the project worked with each family, how things have changed for the family, etc.
- Talking to families to see what they think of the project
- Talking to other people, for example, people who refer families to the service.

6. The information used …

… will be analysed to get an overall picture of families' views of the service. The way the information will be presented in the report will be general, for example, phrases like 'overall, families thought…' or 'one parent said that …' will be used. No names will appear in the report so it will not be possible to identify individual families.

7. In terms of confidentiality …

… all information that Bernadine will have will be anonymous. The names and addresses of all families will be removed before Bernadine is given any information.

Later on, she may want to contact you to talk to you about your experience. But, the family support worker will contact you first to check if its okay and you only have to agree to it if you want to. If you do talk to the researcher, only she will know what you say and she won't discuss what you say to her with anybody. Your name or address will not be used in connection with this research.

8. The reason we would like you to take part ….

… it that we think that the best way for us to see what the project is like and if it can be improved is to ask those who use it what they think. This research is an opportunity for you to give your view. In the future, we hope that what we find from the research will make a difference to how other families are treated, not just by this project, but by other services that work with families too.

9. Your involvement in the research is completely voluntary ….

… but we would be delighted if you were willing to take part and would encourage you to do so.

10.   If you are willing to take part …

You don't have to do anything except let us know if its okay to allow us to provide details of your involvement with the project to Bernadine (remember that no names and addresses will be on the information so she will not know who it is).

If you would like further information or if you would like to talk to the Researcher, there is no problem. You can contact Bernadine on 091-493522.

If you are willing to take part, we would like you to sign the form, which confirms that the study has been explained to you and that you agree to take part.

The research project has been explained to me. **I give my consent** to take part.

SIGNED: _____

Date: _____

The research project has been explained to me. **I don't give my consent** *to*

take part.

SIGNED: _____

Date: _____

Consent form for interview

Please read the following statement and, if you agree, please sign your name.

"I agree to participate in this interview, for researchers to use my answers in their research, and for anonymous quotes to be published in a report, book, or article. I understand that I will not be recognised, as my name will not be used and all identifying material will be removed. I understand that all identifying data will be destroyed following completion of the study.

"I understand that I can refuse my consent or withdraw at any time from the interview and this will not affect the service I get from XXXX Family Support Project in any way.

"I have spoken with the researcher and have had the opportunity to ask questions about this study."

Signed:_____

Date:_____

"I also agree to have the interview tape-recorded."

Signed:_____

Appendix B

Interview schedule for families

Introduction

1. "My name is Brian Merriman and I work with the Child and Family Research Centre at NUI, Galway. We're doing some research to see how well the Community-Based Family Support projects work, of which Curam is one. One of the best ways to see how well they work is to ask the people who took part. I have a few general questions about how you came to be involved in the family support project, about how you got on with the family support worker, about the kinds of things you did as part of the project, and about whether things have changed for you and your family as a result. If there's anything you'd rather not discuss that's fine and if you want to stop at any stage that's all right too. We're not really concerned too much about the specific details of your family, more about whether the family support worker was of help to you all. This is nothing to do with the family support workers and only I am working on this part of the project."
2. *Letter of Consent*
   Recording
   Anonymous
   Length of interview
3. Any questions? Are you happy to start?

Process

1. How did you first make contact with the family support project?
2. Had you previously been involved with other services?
   a. If so, was there any connection with the family support worker?
   b. Did the family support worked refer you to other services?
3. When you started, how was the project explained to you?
4. What was your relationship like with the family support worker?
   a. Your family's?
5. Tell me about what happened whenever you met the family support worker.
6. What was good about what the family support did?
7. Was there anything the family support worker wasn't able to help you with?
8. Did you use the questionnaires?
   a. How did you find them?
9. Did you ever consider pulling out of the project, or not turning up to meet the family support worker?

Care plan

10. Did the family support worker draw up a plan about what you were going to do together?
11. What were the things you wanted to get out of the project?
    a. *In general if not in detail.*
12. Did those things happen?

Outcomes, evaluation

13. Are there any other things that changed for you as a result of the family support project?
   a. For your family?
   b. In what ways?
14. Do you think family support offers something that other services don't provide?
   a. *Compare: HSE services*
15. What are the best things about family support?
16. What is not so good?
17. Would you recommend family support to another person in a similar position?

Community Development Project

18. The family support worker is based in Forum Community Development Project, isn't that so? What can you tell me about what Forum does?
19. Were you involved in any of the Forum activities?
   a. If so, as a result of being involved in the family support project or not?

Conclusion

1. Do you have any questions?
2. Is there any thing else that you have not yet asked or discussed?
3. Once again, the information in this interview will be anonymous.
4. Thank you for your help.

Appendix C

Research Baseline Information Form

Service User No.   _____

Age on intake: _____

Urban: _____   Rural: _____

Ethnicity: _____

Language: _____

Religion: _____

Family Composition:
(include parent, sibling or child living outside home and any other person living in family home)

Code (if relevant)	Age	Relationship to Service User

Child/Young Person is/has been on Child Protection Register: _____

Other Children/Young Persons in family is/has been on Child Protection Register: _____

Child/Young Person is/has experience of a care episode, including residential care, foster care, foster with relatives, etc.: _____

Other Children/Young Persons in family is/has experience in a care episode, including residential care, foster care, foster with relatives, etc.: _____

Child/Young Person/Parent is/has been subject of court order: _____

Key Agencies Linked with Family currently:
_____
_____
_____
_____

Key Agencies Linked with Family in past:
_____
_____
_____
_____

Referring Agency:
_____

Did referrer wish to remain anonymous: _____

New Referral: _____   Re-Referral: _____

Date of Referral: _____

Was the person/parent/carer aware of referral: _____

Initial reason for referral:
_____
_____
_____

Type of service requested:
_____
_____
_____

Initial Action Taken:
_____
_____
_____

Summary of Assessment carried out:
(please attach score sheets for assessment tools)
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
Please attach aims and objectives/care plan designed for service user/family.

Appendix D

A.   Interview Questions for Family Support Project Workers

Direct work with families:
Can you give me an overview of what your direct work has involved over the past six months?
Run through the caseload and families you are working with.
Briefly, for each family, give me an overview of what the issues are, what you have done and how you feel it is working.
Can you give me an example of work you have done that you felt worked very well?
Can you give me an example of something that has not worked so well?

Community, group work:
Can you give me an overview of what your community / group work has involved over the past six months?
How do you link in with the work of the CDP?
How were these areas of work decided or agreed?
How has the FS work and the work of the CDP overlapped / complemented / influenced each other?
What do you see as the key differences in your approach and that of the CDP?
Have there been any benefits or difficulties as a result of these differences?
Do you feel that your work brings an 'added value' to the CDP work? If yes, in what ways?

Environmental factors:
What are the key gaps and strengths in services for families in the area?
What external factors in the area work to help or hinder your work? (e.g. rurality, urban issues, transport, lack of services, etc)

Programme management and structure:
What has been your involvement with the wider CBFSP (i.e. training, networking, programme development, supervision)?
Have you received adequate support and supervision?
Does the programme model support the work on the ground? What works well / not so well?
Do you have adequate resources?

Overall:
What has been rewarding / challenging in the past six months?
Do you feel the family support project is making a difference in this area? Please explain.
Are there any recommendations / suggestions you would like to make for how the programme could work better?
Anything else you would like to say?

B. Interviews with CDP Co-ordinators & Management committee members

Overall:
1. What was your understanding of the role / purpose of this project at the outset?
2. What have been the major achievements to date?
3. Has it done what you hoped it would or has it turned out differently to how you expected?
4. Are there local cultural factors that have influenced how the project was worked? (e.g. open / closed, reluctance to seek help, distrust of services)
5. What were the key challenges encountered?

How project addresses family needs:
6. What has been the profile of needs presenting? Were these surprising or as expected?
7. What are the particular strengths of the project in addressing child and family needs?
8. What makes this project different from an existing service provider with additional resources (i.e. what is unique about the approach of this project with families)?
9. What advantages and disadvantages are associated with a local casework service?
10. What would have happened to these families if this project did not exist?
11. How could the casework with families be enhanced or more effective?
12. What kind of a profile does the FS project have in the community?

Impact on the CDP:
13. The FS work involves a casework model – is a community development project an appropriate place to host such a service? Are there differences or conflicts associated with combining the two approaches?
14. Do you feel that the FS work brings an 'added value' to the CDP work? If yes, in what ways?
15. Does the CDP bring an added value to the FS work? If yes, in what ways?
16. Is the CDP targeting different populations than it would have if this project did not exist?
17. How have the needs of casework clients been met through group / community work (be it CDP-led group work or FS group work)?
18. What challenges has the FS project posed to the CDP? How have these been addressed?
19. Is the FS work seen as integral to the CDP or separate? Can you give examples of how it is integrated and separate? Could the FS element be better integrated?
20. Has the CDP engaged in fundraising for the FS project or shared resources?

Programme management and structure:
21. What you think are the strengths, weaknesses, opportunities and threats of the programme model as it currently exists?
22. How have the problems and challenges flagged to date been addressed?
23. If you were designing a programme model from scratch, knowing what you do now, what would you recommend? Are there any other options worth considering? (e.g. FS workers employed by a single agency but based in projects)
24. Have resources been sufficient?
25. How would you characterise working relationships with local statutory and voluntary services?

26. What has been your experience of using the assessment tools? (FS Workers)

Overall:
27. Is this a valuable model? Would you advocate its adoption in other areas? If so, what are the key features that makes it worth replicating?
28. Are there any recommendations / suggestions you would like to make?
29. Anything else you would like to say?

C.   Interview schedule for Programme Officers

Introduction

We're looking for your feedback on the supervision of FSPWs, the partnership model, the referral processes, general strengths and weaknesses, and the future development of CBFS.

What has your role involved since you began?

> **b.** Job specification
> **c.** Identify areas
>> **i.** How is each going?
>> **ii.** Issues for each area
>> **iii.** Issues for direction of programme

Supervision of family support project workers

In general, how do you find the super vision role?

> **d.** What is your relationship like with the family support workers?
> **e.** How do you find the fortnightly supervision meetings?
> **f.** Do you have regular phone contact?

How do you find the group interventions

> **g.** Do you facilitate any group interventions?

To what extent do you have a role in monitoring the standard of work with clients, in quality control?

> **h.** To what extent do you have a role in training?

Partnership model

What is your overall take on the partnership model?

> **i.** Structure
> **j.** What is your relationship like with the CDPs, HSE, Foróige?
> **k.** What are the inter-agency relations like, on an organisational rather than personal level?
> **l.** Do you think the partnership model has been successful?

What are the strengths and weaknesses of the model?

Referrals

In your experience, how receptive have other services been to referring clients to the FSWs?

> **m.** Social work
> **n.** Have you tried to sell the FSW service?

    o. Have the FSWs been able to help clients gain access to other services, psychology and medical for examples, faster than would otherwise be the case?

Do you think the right people are being referred?

Do you think the right interventions are being provided?

    p. Groups jointly run
    q. Either party going beyond service agreement

What do you think is the added value of the CDP link?

Strengths, weaknesses

What is the best thing about community-based family support?

The worst?

    r. What is the impact of the largely rural nature of these projects?
    s. How do you thing CBFS compares to other services?
    t. Are the facilities and resources adequate?

What have been the major achievements to date?

What are the emerging issues?

Future development

Do you see CBFS continuing as it currently operates?

    u. Do you see it expanding?
    v. What are the priorities to maintain?
    w. What would you change?
    x. If you were designing a programme like this from the start, what would you do?

Appendix E

Questionnaire for Referrers and Linked Services (compressed)

1.   What is your job title?

2. Please indicate your level of familiarity with the work of the Community Based Family Support Project by ticking the relevant box below?

Not Familiar   **Familiar**   **Very Familiar**
☐   ☐   ☐

Please Comment

3. What do you understand the role of the Community Based Family Support Project to be?

4. Do you feel there is a need for such a service?

Yes
☐
No
☐

Please Comment

5. The Community Based Family Support Project specifically places family support workers in the context of a community development project. What is your opinion of this model?

6. Are there any current service gaps for which you think the Community Based Family Support Project could play a role?

Yes ☐ No ☐

Please Comment

7. Are there any services which the Community Based Family Support Project currently provides that could be provided by other agencies?

Yes ☐ No ☐

Please Comment

8. Please rate the overall value of the Community Based Family Support Service as a resource to your organisation. A score of **1 = No Value**, a score of **5 = Very Valuable**.

1   **2**   **3**   **4**   **5**

9. Would you recommend the Community Based Family Support Project to a parent or young person / child?

Yes ☐ No ☐

10. Do you have any recommendations for the future direction / operation of the Community Based Family Support Project?   Yes ☐ No ☐
If yes, please specify:

11.   Please use the space provided for any additional comments.

Thank you very much for completing this questionnaire.