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# Current Practice in Meeting Child Health Needs in Family Support Services: Variation by Service Type and Perspectives on Future Developments

Saoirse Nic Gabhainn, Pat Dolan, John Canavan & Siobhan O'Higgins

*The needs of all service users include those related to physical, emotional, sexual and mental health. This article documents where child health needs are recognised and being met within family support services in the west of Ireland, investigates whether there is variation across different types of family support services and presents the views of service providers as to how health needs could be more fully addressed. Four randomly selected service managers were interviewed; followed by a census survey of managers within the region. Thirty-three managers returned questionnaires (80% response) on their formal briefs in relation to health, perceived health needs being met and unmet, approaches to meeting health needs and resources required to adequately meet client health needs. Emotional and mental health needs were most frequently being met within current services, while group work, one-to-one work and referring on were all popular approaches. Systematic differences emerged by service size and client group. Access to expertise and staff training were perceived as the most popular approaches to improving service provision. These data illustrate that there is a need to develop guidelines for practice, foster links between services and provide for specialised staff training in relation to child health issues.*

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## Introduction

Underpinning the Irish National Children's Strategy (Department of Health and Children, 2000), the overarching policy statement for children in Ireland is a commitment to a "whole child" perspective. This perspective

... allows those working with or supporting children to focus on their particular interest and responsibility, while, at the same time, recognising the multidimensional aspect of children's lives. (Department of Health and Children, 2000, p. 24)

The implication of this for policy-makers and service providers is profound in that it challenges them to think more deeply about the needs of children and adolescents and their role in meeting needs in an integrated and complementary way. The commitment of community-based family support services working with children, young people and their parents "where they are at", and in collaboration with others, suggests that the challenge is already being met. However, in spite of growing evidence on the effectiveness of interventions in relation to the psychosocial development of children and young people (Dolan, 2007; McKeown, 2000), little is known about the extent to which the wider health needs of service users are met. Similarly, the extent to which family support services operate a "health promotion" culture or engage directly with the wider physical health needs of service users is unclear. This article aims to address this deficit, and presents data based on interviews and a survey of family support managers from the west of Ireland to illustrate the extent to which health needs are perceived as being met through current practice, the variation in meeting such needs according to service type and the perspectives of managers on the way forward. These data suggest that there are specific challenges ahead in maximising the potential of family support services to meet health needs among children and that a clear strategic direction, with associated support mechanisms, would be valued by service providers.

### *Child Health Issues*

The World Health Organisation (1946, p. 100) definition of health as a "state of complete physical, mental and social well-being not merely the absence of disease or infirmity" informs this research. Health is seen as a resource for everyday living, a positive concept emphasising social and personal resources as well as physical capacities. In children, the concepts of health and development are very much interrelated. Childhood is a period of dependency and development, so health is not as static a phenomenon as adults may experience. It cannot be defined narrowly, it is multidimensional, and has been conceptualised as a continuum or an evolving state (Szilagyí & Schor, 1998).

In recognition of such broad perspectives on health and childhood, and in the context of a desire to meet the needs of children more holistically, recent Irish policy documents have consistently highlighted the importance of connecting physical and mental health and social needs, and to do so within the specific contexts of children's

lives. The National Children's Strategy (Department of Health and Children, 2000) framed this connection for children in an ecological context, identifying the wider health needs of children but also emphasising the contexts in which such need can be met, including actions by the child, his/her family, school and wider community, working separately and in unison. This approach was further advocated in the Irish National Health Strategy (Department of Health and Children, 2001) through its emphasis on the need to develop multidisciplinary locally-based Primary Care Teams. The underpinning rationale is that the most effective way of meeting the full needs of children is through multiple actions ranging from routine universal inoculations to targeted social or physical/mental health interventions in the context of multidisciplinary teamwork. The *Get Connected* report (National Conjoint Health Committee, 2001) emphasises the requirement that staff understand the connection between physical and emotional development. Importantly, the strategy suggests that the needs of children can be met through appropriate services. These themes are echoed in children's policy documents from the United Kingdom, such as *Every Child Matters* (Department for Education and Skills, 2003), and Northern Ireland, *Our Children and Young People: Our Pledge* (Office of the First Minister and Deputy First Minister, 2006)—both of which emphasise outcomes across a range of domains of children's lives and identify the challenge for integrated policy and services for children. Despite the apparently widespread acceptance of such approaches as being desirable, their very complexity means that guidance provided on how to implement such services is frequently abstract or bureaucratic, and that high-quality evaluation is rare.

### *The Importance of Families*

Child mortality has declined remarkably in the past decades; preventable unintentional injuries are now the major cause of death in adolescence (Molcho et al., 2006). Morbidity is more common and involves physical, emotional, psychological, behavioural or developmental problems or clusters of conditions. Differences between children in relation to health status can be seen amongst those with chronic health problems or disabilities, racial and ethnic minorities, children in families with high levels of social stress, and children otherwise disenfranchised, including the homeless and those in care (Molcho, Gavin, Kelly, & Nic Gabhainn, 2008; Szilagyi & Schor, 1998). The set of "Best Health for Children" policy documents strongly advocated interlinking social service interventions with child health in Ireland. These reports all identify the need to bring together social and wider health needs for families. The initial *Best Health for Children* report (National Conjoint Health Committee, 1999, 2002) outlined the need to target services for children within the provision of better universal services for families—an approach similarly advocated within social work policy, particularly in the United Kingdom (see Hardiker, Exton, & Barker, 1991).

Many health issues in children are related to heredity, and a child's health status can affect their development, which may in turn influence their future health.

Aujoulat, Simonelli, and Deccache (2006) argue that in some instances illness can disrupt the process of child development, most especially if it is severe enough to interfere with the ability to learn, and thus can affect the ability to interact with others (e.g. peers and family). The dependency of childhood means that the family is the setting where health-related behaviours and attitude are first shaped (Tinsley, 2002), and the family environment has been shown to be of considerable importance for young people's health (Vaux, 1988).

Families, particularly parents, play a major role in the provision of both social and physical environments for their children; and influence the characteristics and timing of their experiences (Szilagyi & Schor, 1998). It has been well documented that poor relations and conflicts with parents are associated with poorer psychological health among children (Laftman & Ostberg, 2006; Sweeting & West, 1995), although such relationships are likely to be bi-directional. Should a major illness occur in a child, it is not contained within that child but has ramifications for all family members (Banner, Mackie, & Hill, 1996; Bromley, Hare, Davison, & Emerson, 2004), who may then develop health needs of their own requiring care, or be less able to meet the needs of the sick child (Bromley et al., 2004). In terms of general health and well-being, it appears that family structure is probably less important than the ability of the family to meet the child's physical, social and emotional needs (Laftman & Ostberg, 2006). In addition, families often control children's use of health services, and they promote and model health risk behaviours, health-promoting behaviours, emotional health and social functioning (Schor & Menaghan, 1995). Although the influence of peers generally becomes stronger during adolescence, parental support and influence remains important and relevant (Gowers, 2005; Harter, 1999).

### *Improving Children's Health*

There is a relative paucity of literature in relation to successful community interventions in regard to child health. Examples in the literature of successful interventions tend to focus on particular disorders or disabilities amongst children (for example, Bromley et al., 2004; Emerson, 2003). However, the need for interventions (in attempts to target the determinants of children's health) to move beyond health services and to become the concern of politicians, social planners, child and family welfare practitioners, community support agencies, and so on, has been discussed (National Conjoint Health Committee, 1999; Tarren-Sweeney, 2005). A range of environmental factors have been documented to influence the general health and well-being of children and young people (Kuntsche & Kuendig, 2006; Thompson, Iachan, Overpeck, Ross, & Gross, 2006; Vieno, Santinello, Pastore, & Perkins, 2007), and as children mature, an increasing number of settings become influential for health: these include social relations in school, with peers and significant adults and in the neighbourhood or community (Morrow, 1999). Thus the settings approach to health (Tones & Green, 2004) argues that cross-sectoral and interdisciplinary approaches are likely to be most successful in maximising child health.

Nation et al. (2003), in their review of effective prevention programmes, found that the programmes that engage children within and in conjunction with their environmental context are most likely to produce change. In order to justify prevention programmes designed to tackle a host of problems, evidence suggests that “at-risk” children tend to be vulnerable to multiple negative outcomes as a result of dysfunctional families, neighbourhoods, schools and peer relationships (for example, Donovan, Jestor, & Costa, 1988). The child’s initial venture outside the family setting is often into the world of school, where relationships with peers become increasingly significant for health (Laftman & Ostberg, 2006).

In 2003, the Irish Government made Social, Personal and Health Education compulsory in both primary and post-primary schools in an attempt to enhance the health of every child. The rest of a child’s day is spent either within the home or in their community, where they may participate in organised leisure activities. Being a part of a youth group involved in leisure-time pursuits has been associated with the development of initiative and the resilience to cope with the demands and stresses of life (Dworkin, Larsons, & Hansen, 2003; Gilligan, 2001), which are important indicators of health in themselves, as well as relevant predictors of health outcomes. Controlled longitudinal studies confirm that youth activities can provide a rich context for positive development (Dworkin et al., 2003). Youth work can be seen as creating a context for adolescents to become producers of their own development (Larson, 2000). Indeed, the role of youth work in promoting the health of adolescents is clearly set out in the National Youth Health Programme Strategic Plan 2005–2007 (National Youth Health Programme, 2005), which recommends actions that ensure the full set of needs of young people are addressed.

### *The Current Study*

There is evidence to suggest that a settings approach to child health can be effective in promoting positive health or preventing risk behaviour, particularly so for schools, communities and youth work. There is also evidence for the value of community-based interventions for specific disorders. However, the documentation of successful community-based interventions for existing health needs is less common. While a holistic approach to meeting the needs of children is now established in policy, it is as yet unclear how this should be translated into practice in order to meet the wider health needs of children through community-based interventions. Thus, the objectives of the research considered in this case study are:

- (1) to investigate the extent to which child health needs are recognised and met by family support services in the Health Service Executive (HSE) West Region;
- (2) to establish the extent of any variation in the extent to which child health needs are recognised and met by service type; and
- (3) to gather and present the views of service managers as to how child health needs could be more fully addressed.

## Methods

Two sequential data collection methods were employed with family support service managers within the Irish counties of Galway, Mayo and Roscommon. First, a short series of interviews were conducted with a small subsample of managers. These were designed to gather exploratory data on the structure and operation of family support services in the region and to ascertain the extent to which health issues were perceived as relevant to the functions of service managers. The interviews informed, and were followed by, self-completion questionnaires sent to all managers in the region.

### *Sample*

All managers of family support services listed on HSE databases for the western region were included in the sample, comprising 41 in total. Four managers from the full list were randomly for inclusion in the interview component of the study, and all identified managers were included in the survey sample.

### *Measurement and Data Collection*

Questions included in the interview were drawn from an initial literature review. The interviews consisted of 12 key questions, plus prompts. The four managers were contacted by letter and subsequently by telephone, and times and dates were agreed for interview. All interviews were conducted via telephone by a single interviewer and took between 25 and 35 minutes each; they were audio-tape-recorded and subsequently transcribed in full.

The interview data were subject to data-driven thematic analysis. The key issues and questions to be included in the questionnaire component of the study were drawn from these analyses. A 14-item questionnaire was constructed to reflect the issues highlighted by interviewees. Nine of the questions invited open-ended comments or further details from respondents. Individual questionnaires were posted directly to each family support manager with an explanatory letter and a FREEPOST envelope to facilitate return. Questionnaires were re-sent to non-responders after a three-week delay, and follow-up telephone calls were made after six weeks. A total of 33 questionnaires were returned, reflecting a final response rate of 80%.

### *Data Analysis*

All quantitative data were analysed with SPSS (version 12.0). Where appropriate, chi-square or Fisher's exact probability tests were employed to compare responses from different service types—specifically between services with only one full-time staff member and those with a greater number of staff, and between those services that include infants among their client group and those that do not. All qualitative data were analysed using content analysis following the guidelines of Strauss and Corbin (1990).

**Results**

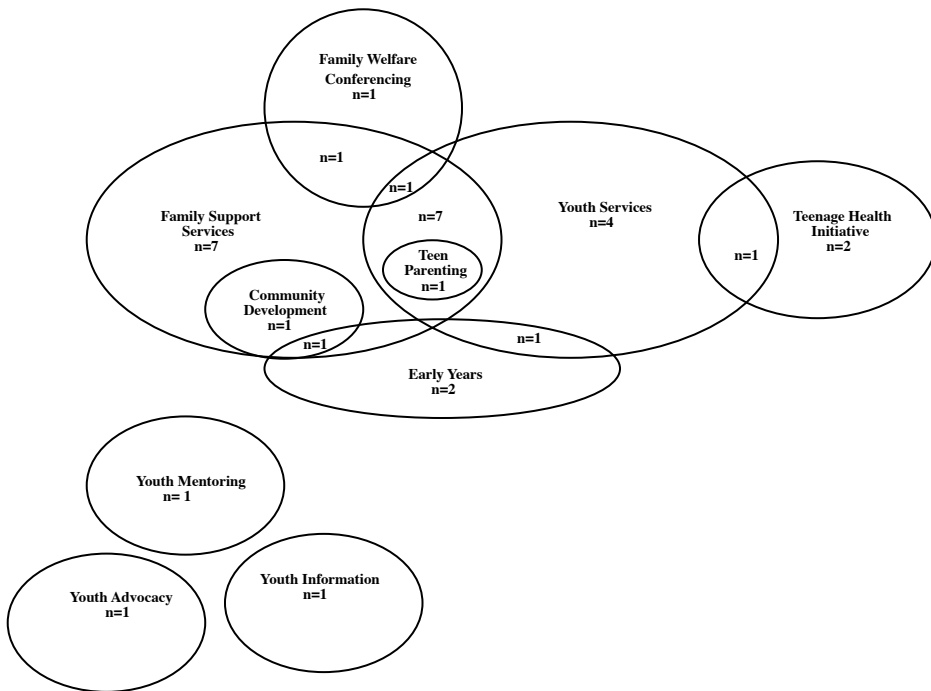
All 33 respondents managed family support services within the HSE western region. They were provided with a list of options to choose from in order to describe their service. Many respondents indicated that their service could be described in more than one way; this is represented in Figure 1.

*Size of Service*

Of the responding services, 40.6% ( $n = 13$ ) had one full-time staff member; and of these, seven had just one full-time employee while the other six also had part-time staff working with them. In total, 59.4% ( $n = 19$ ) services reported more than one full-time staff member, ranging from two full-time staff to 18 full-time and 15 part-time staff.

*Age of Client Group*

Those working with infants represented 36.4% ( $n = 12$ ) of all respondents. Of these, only one limited their service to young children (i.e. zero to six-year-olds) while the other 11 worked with children up to 18 years old. The remaining 64.6% ( $n = 21$ ) of services did not work with infants or young children; six of these reported that they



**Figure 1** Respondents' Self-descriptions of their Services.



worked with 10–18-year-olds, and the remainder worked with a variety of ages ranging between eight and 23 years.

### *Health as a Formal Component of Services*

Respondents were asked whether health needs were a stated part of their brief and whether they had any practice guidelines in relation to health issues. Table 1 presents the percentages reporting that they had such a brief and guidelines, for all services and by service type.

Only four respondents reported that meeting health needs was not at all part of their brief, and two of these were information services. It was most common for emotional and mental health issues to be included in the brief of services, but only 52% reported that they had in place practice guidelines related to health. There were few substantial differences between types of service. Family support services were less likely than youth services to report that their brief included meeting the mental health needs of their clients, while those with a higher complement of staff were more likely to report that meeting emotional, physical and sexual health needs was in their brief. Services that did not include infants among their client groups were more likely to report that their brief included meeting emotional, mental, sexual and other health needs.

### *Meeting Health Needs within Services*

Respondents were asked to report the proportion of staff time concerned with meeting the health needs of children or young people; which health needs, if any, were being met within their service; and what methodologies or approaches they employed to meet health needs. Overall, a mean of 65.4% (standard deviation = 28.0)

**Table 1** Respondents Reporting that their Stated Brief is to Meet Health Needs: Percentages for all Respondents and by Service Type

Health needs and practice guidelines	All	Family support	Youth service	One staff member	More than one staff member	Serves infants	No infants served
Emotional health	81	89	93	67	95*	75	85*
Mental health	72	74	86*	75	74	58	80*
Physical health	66	68	64	58	74*	67	65
Sexual health	66	63	71	58	68*	42	80*
Other health needs	31	26	36	33	32	17	40*
Health practice guidelines in place	52	47	67*	39	58*	17	71*
<i>n</i>	32	19	14	13	19	12	20

\* $p < 0.05$ .

of staff time spent on meeting the health needs of clients was reported, and this did not vary significantly by service type. Tables 2 and 3 present the percentages reporting that their service met specific health needs and the methodologies employed, for all services and by service type.

Overall, it was reported that emotional and mental health needs were most likely to be met by services. Family support services were more likely than youth services to report that they were meeting both the emotional and physical health needs of their clients, while youth services were more likely to report that they were meeting mental health or other health needs. Larger services were more likely to report meeting the emotional and physical health needs of their clients, but less likely to report meeting their mental, sexual and other health needs. Those services that included infants as clients were more likely than those services that did not include infants among their clients to report meeting the emotional and physical health needs of their clients, but less likely to report meeting sexual health needs.

Overall, in order to meet the health needs of clients, referral to health services and one-to-one work with clients were most frequently reported. Family support services were more likely to report employing referral to voluntary groups, while youth services were more likely to report the use of group work approaches. Larger services were more likely than those with fewer staff to report employing all approaches with their clients. Services that included infants among their client groups were less likely to report using one-to-one work or group work to meet the health needs of their clients, but were more likely to report referral to voluntary groups.

In the open-ended comments, most reported adopting a mixture of approaches depending on the health needs that were identified, and linked specific approaches to particular needs, such as meeting emotional health needs through group-work; while others noted approaches taken such as arts, sports and advocacy work. Some reported referring young people on to specific agencies that were perceived to be better equipped to meet particular health needs, and a minority reported that they also provided specific links with such agencies for their clients.

**Table 2** Respondents Reporting that their Service is Meeting Health Needs: Percentages for all Respondents and by Service Type

Health needs being met	All	Family support	Youth service	One staff member	More than one staff member	Serves infants	No infants served
Emotional health	97	100*	93	92	100*	100*	95
Mental health	94	95	100*	100*	95	92	95
Physical health	79	79*	67	69	84*	83*	76
Sexual health	61	53	53	62*	58	50	67*
Other health needs	18	21	27*	31*	10	8	24
<i>n</i>	33	19	15	14	19	12	21

\* $p < 0.05$ .

**Table 3** Respondents Reporting Approaches to the Health Needs of their Clients who are Children/Young People: Percentages for all Respondents and by Service Type

Approaches to meeting health needs	All	Family support	Youth service	One staff member	More than one staff member	Serves infants	No infants served
Referral to health services	91	94	93	85	94*	91	90
One-to-one work	85	94	93	69	100*	82	90*
Group work	72	78	87*	62	67*	64	76*
Referral to voluntary agencies	66	61*	53	54	83*	72*	62
<i>n</i>	32	18	15	14	18	11	21

\* $p < 0.05$ .*Unmet Health Needs*

Respondents were asked whether they believed there were unmet health needs among their client group, and, if so, whether this was a consequence of health not being within their brief or a lack of skill or resource. They were also asked what steps, if any, were taken to help address identified unmet health needs.

Mental, sexual and physical health needs were reported as most frequently unmet by services. These included issues like addiction, grief, relationships, hygiene and dental care. The health needs of specific groups of young clients were noted as being unmet, including homeless young people, ethnic minorities, children with disabilities and asylum seekers. Lack of skill among staff was cited as a key reason why some health needs cannot be met by current services, as was lack of resources.

Table 4 presents the percentages of respondents, overall and by service type, who reported addressing unmet health needs through specific approaches.

**Table 4** Respondents Reporting Steps to Address Unmet Health Needs of their Clients who are Children/Young People: Percentages Overall and by Service Type

Meeting unmet health needs	All	Family support	Youth service	One staff member	More than one staff member	Serves infants	No infants served
Refer on to other services/agencies	97	95	100	100	95	92	100*
Collaborate with other service/agencies	88	90*	80	77	95*	100*	81
Collaborate with families	79	90*	67	77	79	92*	71
Programme development within service	61	79*	53	46	68*	83	48
<i>n</i>	33	19	15	14	19	12	21

\* $p < 0.05$ .

As approaches to addressing unmet health needs, respondents most frequently indicated both the referral of clients on to health services and collaboration with formal and informal supports. Family support services, larger services and those that included infants were all more likely than others to report employing collaboration with other services/agencies as well as programme development within their service to help meet the currently unmet health needs of their young clients. Family support services and those that included infants among their client group were also more likely to report collaborating with families. Those who reported that they served an infant client group were less likely to report that they referred on to other services.

Referring clients to other services was common; referrals to general practitioners, family planning clinics, psychology services, drug treatment services, social work, local counsellors and support groups were all reported. In a minority of cases, respondents reported that they would work collaboratively with another service or agency, such as psychology or social work. Nevertheless, frustrations were expressed with the lack of formal health services available, and especially so in relation to mental health services. Long waiting lists, accessibility of services and the issue of service division into age groups were all singled out as particular difficulties. The importance of ongoing support for and collaboration with families was also highlighted. Only in one case was it reported that services were bought in to help meet the needs of clients.

### *Towards Meeting Unmet Health Needs*

Respondents were asked whether they felt there was anything they could do to address the health needs that were currently not being met, and what would enable staff to work towards meeting these needs. Table 5 presents the percentages of respondents who agreed that specific enablers would help them to meet currently unmet health needs, for all services and by service type.

Overall, the majority of respondents agreed that access to expertise, staff training and increased and dedicated funding would enable their service to meet health needs. Family support services were more likely to report that access to expertise would help them to meet the currently unmet health needs of their clients. On the other hand, youth services were more likely than family support services to report that dedicated funding, dedicated staff, increased time with service users, restructuring or re-configuring service aims would help. Larger services were more likely to report that greater access to expertise, dedicated funding and more physical space would help them to meet currently unmet health needs among their clients. Services with fewer staff were more likely to report that training for staff, increased and stable funding, dedicated staff, increased time with service users and restructuring would help. Those that included infants among their client group were more likely to report that access to expertise, increased time with clients and stable funding would help them to meet unmet health needs among their clients;

**Table 5** Respondents Reporting what would Enable their Service to Meet Unmet Health Needs of their Clients who are Children/Young People: Percentages for all Respondents and by Service Type

Health needs and practice guidelines	All	Family support	Youth service	One staff member	More than one staff member	Serves infants	No infants served
Access to expertise	72	83*	60	69	78*	91*	62
Training for staff	69	72	73	69*	53	64	71*
Increased funding	66	56	50	69*	61	64	67*
Dedicated funding	59	56	53	62	78*	46	67*
Increased time with service users	45	50	73*	50*	44	45*	33
A dedicated staff	44	44	47*	46*	39	36	50*
Stable funding	41	39	67*	46*	39	27*	19
More physical space	38	39	40	31	44*	27	52*
Re-structuring	22	11	20*	31*	17	27	48*
Reconfiguring service aims	15	11	27*	15	16	8	19*
<i>n</i>	33	18	15	14	18	11	21

\* $p < 0.05$ .

while all other approaches were more frequently cited by those services that did not include infants as clients.

Respondents provided ideas for additional services/programmes and approaches that they perceived as necessary. These included more emphasis on planning and practitioner training, improving the coherence, clarity and operation of referral pathways and integration with other agencies, the development of specific and targeted interventions, such as goal-specific youth groups, and borrowing interventions that “work” from others. The need for more staff within their service, and for increased levels of human, physical and financial resources to deal with all the health needs expressed by their clients were also highlighted.

## Discussion

These data illustrate that there is considerable activity within the family support sector that works to identify, support, advocate for and intervene in children’s lives in order to improve their health status. There are many examples of good practice, specifically in relation to policy advances, needs assessment, interventions and programme development as well as engagement with other branches of the health and social services. In addition, there is interest among family support services in furthering their role in child health. Services appear knowledgeable about their strengths and weaknesses and report willingness to respond to the gaps in service delivery that they identify. This suggests that recent policy advances (for example, Department of Health and Children, 2000, 2001) have been taken on board by service providers.

*Gaps in Meeting Child Health Needs*

However, not all aspects of child health are currently being addressed adequately and differences do exist between service types. Participants have identified that, for many services, particularly for those with a single staff member, dealing with physical health issues is considered beyond their remit. Traditionally, members of the medical and nursing professions have addressed physical health problems (National Conjoint Health Committee, 1999), and to some extent the perceptions of family support services suggest that such a demarcation is extant. While doctors and nurses do have specialist clinical training, there remain non-treatment aspects of physical health that could be addressed in community settings by trained personnel, given appropriate education and resources (National Youth Health Programme, 2005).

Concerns are also expressed about the capacity to address the sexual health of children. Respondents identified a general lack of skill, and to some extent knowledge, in this area; although in contrast to physical health, sexual health was more likely to be recognised as being within their remit. An important distinction related to mental health should be noted. Positive mental well-being was perceived as being clearly within the remit of family support services, and indeed was considered by many respondents as a crucial component of the services being offered. On the other hand, there was a palpable reluctance to affirm the role of family support services for children who are exhibiting the signs and signals of psychiatric or mental illness. Consideration of gaps in meeting these specific health needs is particularly relevant in the context of the desire of services to both increase staff skills and have access to specialised support, generally in the form of access to services. Indeed this would be indicated by best practice guidelines (National Conjoint Health Committee, 2001), and was particularly highlighted by family support services and by those who serve infants as clients in this study. A complimentary approach would be to work more closely with families (National Conjoint Health Committee, 1999), and there were particularly wide variations in the use of this approach to help meet currently unmet health needs. This relative reluctance to engage with families among some service types, particularly youth services, requires more detailed attention—particularly given the pivotal role of parents and families for the health careers of children (Laftman & Ostberg, 2006; Schor & Menaghan, 1995).

*Children at Particular Risk*

While there is variation in the extent to which respondents perceived that family support services do or could meet the health needs of children, one issue emerges strongly. Most respondents report that there are specific groups of children whose needs are even less likely to be met by existing services; and argued that specific skills and approaches may need to be developed to meet these gaps. The health needs of children from ethnic minority families, asylum seekers, homeless children and children with disabilities were identified as requiring particular attention, which should include policy and programmatic developments as well as appropriate health

services provision. The particular needs of specific population subgroups have been recognised previously (Molcho et al., 2008; Szilagyi & Schor, 1998), and have been included in relevant policy (Department of Health and Children, 2000, 2001). However there is need for more detailed attention to some of these groups, particularly those relatively new to Ireland, and for whom it may be necessary to borrow approaches from other jurisdictions (Beal, 2004; Victoria et al., 2003). In terms of the development of new programmes or interventions, the involvement of families and children as well as service delivery staff will be critical to ensuring both relevance and applicability (National Conjoint Health Committee, 1999, 2001).

#### *Developing Practice Guidelines and Training*

Irrespective of policy, research or programme developments, these findings indicate a clear need to develop practice guidelines for family support services in how to deal with child health issues among their service users. This gap is particularly relevant for those services who count infants among their clients, where only 17% of those included here report having health practice guidelines in place. Apart from the need for such guidelines to cover “actions required” by staff in respect of basic identification and assessment of health needs, they also should be underpinned by a protocol that states the roles and responsibilities of workers in meeting the health needs of those they work with and for. Once such clarity has been established, an initial and ongoing programme of training will help ensure that service staff have greater capacity and a clear remit to work appropriately with the health needs as well as the social needs of those who attend their service. Guideline development and training should recognise the uniqueness of the various services, particularly around the relative appropriateness of one-to-one or group work with clients. Such developments would more fully recognise the holistic and interconnectedness of health (WHO, 1946) and appear central to meeting the agendas set out in current Irish national policy (Department of Health and Children, 2000, 2001), but are also relevant to the development of family support as a dedicated and recognised profession (Dolan, Canavan, & Pinkerton, 2006).

Such training should differentiate between actions that family workers can take directly—for example, providing self-care and healthy relationship advice—to those that require a more indirect action. In such instances, workers will need to refer on to specialist services, with or without the provision of ongoing support from within the service. This would require staff to have adequate knowledge and to be fully briefed on the types and availability of health services locally, be cognisant of good interagency and multidisciplinary working together, and matters such as referral procedures and children and parents’ entitlement to the wider network of health and social services. However, it is noteworthy that many staff reported a lack of knowledge regarding the wider set of health services that are available for children and families locally, regionally and nationally. The lack of dissemination of adequate information on entitlement, nature and availability of services was clearly frustrating to staff. This mirrors other research on child health services in family support, which documented that parents share the very same frustration (Dolan & Holt, 2002). In that study one

of the key needs expressed by parents who were visited by public health nurses was their need for more information on what services they could access and where to find them. Given this commonality between professionals working in the “frontline” and those who use services, the need for middle and senior healthcare managers to improve information on service provision is clear.

### *Strategic Direction*

More widely, these findings have implications for policy both in terms of the cost-effective use of resources and best fit in term of organising services. In the context of developing services into the future, there is a clear choice. On one hand, it could be argued that community-based family support services should be orientated not as child health services at all, but solely in terms of being a referring agent to other mainstream health “expert” services. Conversely, a better way to proceed may be to advance the skills of staff to enable them to work more directly on healthcare issues, and particularly so through better multidisciplinary working. Realistically, the true choice may well lie somewhere between both positions and be determined by pragmatic matters such as the cost implications of providing training, and/or matters of professionalism where workers’ roles may or may not be open to change. Whatever route is followed, as indicated within the primary healthcare strategy, the key goal of meeting needs of service users in an efficient manner must remain the sole policy focus.

### **Conclusion**

In conclusion, this study has illustrated the extent to which family support services are already engaged in meeting child health needs and where they feel less well equipped. Importantly it provides guidance for future developments. There are policy and practice implications of these data that deserve further attention. It is clear that there is interest and commitment to meeting child health needs among family support services, but that gaps remain in current provision. Thus it will be necessary to provide clearer guidance to service managers on how to translate policy into practice in this area. Such guidance should include how to identify deficits and gaps in practice, and how to access appropriate resources to improve service provision. Such advice should be tailored according to the overarching objectives of the service, existing resources and priorities and the client group being served. The key principles of family support (Dolan et al., 2006) and health promotion (WHO, 1987) are not dissimilar; they overlap and focus on similar issues (e.g. empowerment) and mechanisms (e.g. facilitation). Thus there may be some potential for symbiosis. One way forward could be the development and implementation of health-promoting family support services, along the lines of health-promoting hospitals, schools and workplaces (Clift & Jensen, 2005; Tones & Green, 2004). The adoption of such a settings approach to meeting child health needs within this key community sector should be further explored by statutory and voluntary-sector employees in both service areas.



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