Family Support Agency

Revised Edition
January 2013

Strategic Framework
for Family Support

within the Family and Community
Services Resource Centre Programme

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Preface

This Strategic Framework for Family Support within the Family and Community Services Resource Centre Programme was written for the Family Support Agency by Dr. Kieran McKeown, Social & Economic Research Consultant. Kieran provides technical support and advice to the Family Support Agency.

The Framework was first adopted by the Board of the Family Support Agency in May 2011. This is a revised version of the framework, taking account of the Report of the Task Force on the Child and Family Support Agency, published in July 2012.

The Family Support Agency extends its thanks to Kieran for his work in writing and revising the document and to the Board Sub-Group for the Programme for its support in overseeing the work.

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1. Introduction

The Family Support Agency (FSA) was set up in 2003 to provide support for families. It is a statutory agency under the aegis of the Department of Children and Youth Affairs and funds a programme of 106 Family Resource Centres (FRCs) throughout Ireland. It also funds voluntary organisations to provide counselling services for adults, parents, children and couples. It provides information to the general public, supports research on families, and offers advice on family-related matters to the Minister for Children and Youth Affairs. From 2013, the FSA will be merged with the Child and Family Support Agency and the FRC programme will be part of the new agency's direct or core services[1].

The first FRCs were set up in 1994 by the then Department of Social Welfare[2], as an initiative to mark the International Year of the Family. Ten FRCs were funded on a three-year pilot basis and, following an evaluation[3], it was decided that these and similar FRCs would become part of a mainstream funded programme.

The Commission on the Family (1996-1998) gave its imprimatur to FRCs by declaring that it was 'most impressed by the range of services provided by the centres' and considered that the first 10 FRCs 'represent(ed) extraordinary value for money for state investment'[4]. The Commission on the Family characterised the approach of FRCs as 'empowering of individuals, builds on family strengths, enhances self-esteem and engenders a sense of being able to influence events in one's life'[5]. It endorsed this approach as 'a primary preventative strategy for all families facing the ordinary challenges of day-to-day living, and has a particular relevance in communities that are coping with a stressful environment'[6]. The Commission recommended a ten-fold increase in FRCs from 10 to 100 'over the next 4 to 5 years', and a doubling of the level of financial support to each project. The target of 100 FRCs was reached in 2007 and, at a conference to mark the achievement, the Minister for Social and Family Affairs announced a Government decision to expand the number of FRCs by six per year over the period of the National Development Plan (2007-2013)[7], in order to reach a target of 142 by 2013[8]. In 2012, there were 106 FRCs throughout the country funded by the Family Support Agency[9].

This strategic framework is informed by the vision of the FSA to support families, communities and individuals through FRCs. The strategy is aligned with national policy on families, as articulated by the Commission on the Family[10] and subsequently in the National Children's Strategy[11], the Agenda for Children's Services[12], the HSE's 2012 Service Plan[13],

the strategy statement of the Department of Children and Youth Affairs[14], and the Task Force on the Child and Family Support Agency[15]. It is also aligned with national policy on the importance of delivering services in, with and through communities, particularly the National Health Strategy[16], the Primary Care Strategy[17], the National Health Promotion Strategy[18], and the National Strategy for Service User Involvement[19]. Building on this policy, FRCs have become a ready-made portal for the development and delivery of a range of services and developmental initiatives (e.g. childcare, access visits for parents separated from their children and working with particular groups at risk of exclusion), while also participating in wider fora such as Children's Services Committees, Social Inclusion Measures (SIMs) Groups, Primary Care teams and networks and Regional Advisory Committees for Domestic Violence. Finally, FRCs are aligned with national policy on addressing social exclusion and the particular needs of excluded communities as articulated in the National Action Plan for Social Inclusion[20].

It is recognised that, from a public policy perspective, promoting the well-being of families is a responsibility shared by many Government Departments and agencies. To be effective, this requires collaboration between those who work directly with families, and includes the involvement of families as partners in that collaboration. This is a hallmark of the FRC programme which is informed by awareness that families, especially those living in communities experiencing multiple forms of disadvantage, require a process that is both community-based and community-involved in order to address the different dimensions of need. For that reason, each FRC project has a board of management which includes representatives from the local community to represent different needs for family support in that area. This approach is consistent with national policy on the role of community and voluntary organisations in meeting people's needs[21], and the importance of community development as a way of promoting a society which is more equal and supportive of those at risk of being excluded through lack of resources, opportunity or influence[22]. It is also consistent with the values of the Department of Children and Youth Affairs[23] and the vision of the Task Force on the Child and Family Support Agency[24].

Family support services which are community-based and have involvement by the community are more likely to be accessed by families[25]. There is evidence that this approach is also more effective in producing better outcomes for families. The evaluation of Sure Start, a family support programme in the UK[26], found that services which were organised to promote 'empowerment' had improved outcomes for parents and, indirectly, for children[27]. According to the evaluation: 'The programme characteristics that go with empowerment

include community groups and parents being involved in the planning and delivery of services; parent representation; staff training opportunities; clear exit strategies for users; services to include self-help groups; evidence that staff and users constitute a learning community; and evidence of mutual respect for all parties'[28]. Significantly, the evaluation also indicated that better outcomes were produced when Sure Start was linked to primary health services since this made it easier to identify families in need thereby 'enabling early use of services that lead directly to stimulating experiences for children, or indirectly, via improvements in parenting'[29]. Further evidence on the effectiveness of community involvement in service delivery emerged from a formative evaluation of the Joint Community Participation in Primary Care Initiative (2008-2010)[30] which identified one of its outcomes as 'improved capacity, motivation and commitment from the community to participate in primary care and for PCTs [Primary Care Teams] to understand the value of community participation, particularly with regard to the broader context of the social determinants of health'[31].

FRCs are located within a community-based model of family support and this model is at the heart of the Programme. The centrality of community development in informing the approaches, values and methods underpinning the work of FRCs is a defining feature of their contribution. A further defining characteristic of FRCs is that they are managed by local voluntary management committees, which are critical in facilitating meaningful participation within communities and in ensuring local knowledge and accountability. Voluntary participation is an important aspect of the work of all FRCs and is encouraged at every level within the Family and Community Services Resource Centre Programme. Whilst individuals are not required to participate, the Programme operates within a framework that promotes and supports respect for human and family rights, and engagement and dialogue with participants is central to the family support objectives. The overall objective is to improve the well-being of parents and children by supporting all families through the normal challenges of family life but especially those in disadvantaged communities. This involves a range of actions to bring about significant improvements in nationally agreed outcomes for children and their parents. The choice of actions to achieve these outcomes will be made in collaboration with families, in keeping with the community development ethos of FRCs, and informed by evidence-based knowledge about what influences family well-being and the types of programmes and initiatives that are known to be effective.

The strategy builds on the FRC experience of working with vulnerable families for nearly 20 years and seeing this in light of a clear conceptual understanding of family and well-being,

and the large body of evidence that is now available about family functioning and programme effectiveness. That is why the rationale for the strategy and its implementation are spelt out, since this ensures that it is based on sound reasoning and solid evidence and is therefore more likely to achieve its outcomes. In light of this, each aspect of implementation has been carefully considered including an operational definition of family (Section 2), rationale and objective of strategy (Sections 3,4), family needs (Section 5), strategic focus, actions and outcomes (Sections 6,7,8), preparing a local family support strategy (Section 9), staff competencies, training and supervision (Sections 10,11,12), monitoring and evaluation (Section 13). We now document each of these elements of the strategy.

2. Definition of Family

In Ireland, the Constitution defines family as founded on marriage[32]. However the more conventional understanding recognises a broader concept, usually referred to as '*de facto* families'[33], based on a wider set of intimate relationships between couples, between parents and children, and between extended family members. This wider understanding of family is closer to the definition of family adopted by the United Nations[34], and by the European Convention on Human Rights[35] which Ireland has adopted although, like all international agreements, these are subject to the Irish Constitution.

Family therefore may be defined for the purpose of this strategy as the set of close personal relationships which link people together - sometimes in the same household, sometimes across different households, and almost always involving different generations – especially but not exclusively the relationship between parents and their children[36]. These relationships are created socially and biologically, and may or may not have a formal legal status. De facto families therefore are characterised by the range of relationships between couples (including life partners/cohabitees), between parents/guardians and their children, between siblings, between grandparents and their grandchildren, and between extended family members.

In Ireland it is possible to identify a wide range of de facto families but the majority of children, over 70%, still live in families based on marriage; the remainder are divided almost equally between those whose parents are cohabiting (15%) and parents who are living without a partner (14%)[37]. Consistent with this, about a third of births in Ireland are outside

marriage although many of these are already in relationships and some proceed subsequently to marry[38].

The legal and *de facto* understanding of families in Ireland typically centres on relationships between parents and children. However the recent passing of the Civil Partnership Act 2010[39] adds a new dimension to family law by granting legal recognition to same sex couples, as well as giving certain rights and obligations to cohabiting couples. A key provision of the Act is a redress system for financially dependent cohabiting partners who have lived together in an intimate relationship for five years, or two years where there is a child or children of the relationship. This redress scheme may be activated at the end of a relationship, whether by break-up or death, and allows a financially dependent cohabitant to apply to court for certain remedies, including maintenance, property, pension adjustment orders, or provision from the estate of a deceased cohabitant. The broader significance of this Act lies in giving greater legal status to *de facto* families despite the fact that such families have no standing in the Irish Constitution.

These considerations highlight how the defining feature of family is relationships, especially those relationships which connect parents and children to each other. This starting point is important from a strategic perspective because it clarifies how support for these family relationships – directly as well as indirectly – constitutes the remit of this strategy. It is true that families are influenced by other relationships - such as those which are community-based, work-based, or interest-based - but, for the sake of clarity and consistency, the focus of this strategy is on family relationships, and only on other relationships to the extent that they impact on family relationships. Equally, it is true that families are influenced by a range of factors in the wider socio-economic and policy environment, both inside and outside the household but again, for the sake of clarity and consistency, these are only part of the strategy to the extent that they impact on family relationships.

Recognition of the *de facto* nature of families also highlights why a family and a household are not the same thing, even though the collection of official statistics consistently merges the two. It is of course recognised that there can be more than one family in a household but equally – and the reality is that this is increasingly the case in Ireland as elsewhere – there can be one family in more than one household as when parents are living apart and the father is not living with the children. One of the consequences of merging the concepts of household and family is that 'it makes no allowance for non-resident parents who may have a substantial degree of contact with their children. Even without contact, it is arguable that

non-resident parents still retain a role and significance within that family, much like the missing piece of a jigsaw which is always present by its absence; the vast amount of case study material on children who are placed for adoption or in care, or children who remain attached to a non-resident parent after divorce, testifies to the abiding presence of the absent parent'[40]. This confusion between family and household often creates the misapprehension – in public policy and services as much as in popular culture – that non-resident parents (usually fathers) who do not live in the same household as their children are not part of the family. This consideration needs to be borne in mind in order to ensure that the strategy, as implemented by FRCs, is inclusive of all family members.

3. Rationale for Strategy to Support Families

The rationale for the strategy is that family relationships are universally acknowledged to have deep and enduring effects on the well-being of individuals and society. This was articulated in many of the recommendations by the Commission on the Family in 1996: 'The experience of family living is the single greatest influence on an individual's life and the family unit is a fundamental building block for society. … It is in the family context that a person's basic emotional needs for security, belongingness, support and intimacy are satisfied. These are especially important for children. Individual well-being has a high priority as a measure for family effectiveness and as an objective of family policy. …Continuity and stability in family relationships should be recognised as having a major value for individual well-being and social stability, especially as far as children are concerned. Joint parenting should be encouraged with a view to ensuring as far as possible that children have the opportunity of developing close relationships with both parents, which is in the interests of both children and their parents. The fundamental human activity of care, intimacy and belongingness can take place in a variety of family forms. Policy should recognise the diversity and provide appropriate supports where necessary'[41].

The Commission's view is supported by a substantial body of evidence to show the importance of family for the well-being of individuals and society. This evidence falls into two broad categories: the benefits that stable, healthy family relationships confer on (i) adults and (ii) children. The converse of this is just as important and there is substantial evidence that children and adults can be harmed significantly when family relationships are not stable and healthy.

In the case of adults, much family research has focused on the difference in well-being between adults who are married and those who are single, where marriage is a proxy indicator of how family relationships impact on individual well-being. Remarkably, and almost without exception, the research evidence shows that good marriages – by comparison with those who are not married - are more strongly associated with adult well-being than almost any other variable[42]. It is true that these studies do not establish a causal link between marriage and well-being – and designing such a study would be difficult - so it is a matter of debate whether marriage makes people happier or happier people marry, and the likelihood is that the causation works both ways. According to one review of the evidence, the benign effect of marriage can be explained as follows: "on average, marriage seems to produce substantial benefits for men and women in the form of better health, longer life, more and better sex, greater earnings (at least for men), greater wealth, and better outcomes for children"[43]. Other reviews show that separated and divorced adults have the highest rates of acute and chronic medical conditions and are at increased risk of admission to mental hospitals and committing suicide[44]. Similarly, studies have shown that just as good marriages have benefits for physical and mental health, bad marriages have negative consequences associated with depression in women and poor physical health in men[45]. One recent review of the evidence found that 'troubled marriages are reliably associated with increased distress and unmarried people are happier, on the average, than unhappily married people'[46]. There is limited evidence available on the well-being of cohabiting couples as compared to those who are married. However, evidence suggests that the quality of relationships is the critical factor.

In the case of children, the best scientific evidence, established over many years, is that the quality of interaction between a parent and a child is the best predictor of a child's normal healthy development. This was well-established by researchers in the field of attachment theory in the early part of the last century[47], and has been re-established in this century by studies such as the US NICHD Study of Early Child Care. According to this study: 'one of the most important and consistent predictors of child cognitive and social development was the quality of the mother-child interactions. The more sensitive, responsive, attentive, and cognitively stimulating the mother was during observed interactions, the better the children's outcomes. This result was the same when researchers examined attachment security, language development, pre-academic letter and number skills, and social behaviour'[48]. Although most studies have focused on mother-child interactions - partly reflecting the differentiated roles of mothers and fathers in child-rearing and the convenience, from a research perspective, of focusing exclusively on this relationship – the benefits of parent-

child interactions lie in the qualities rather than the gender of the caring adult, as more recent research on fathers demonstrates[49].

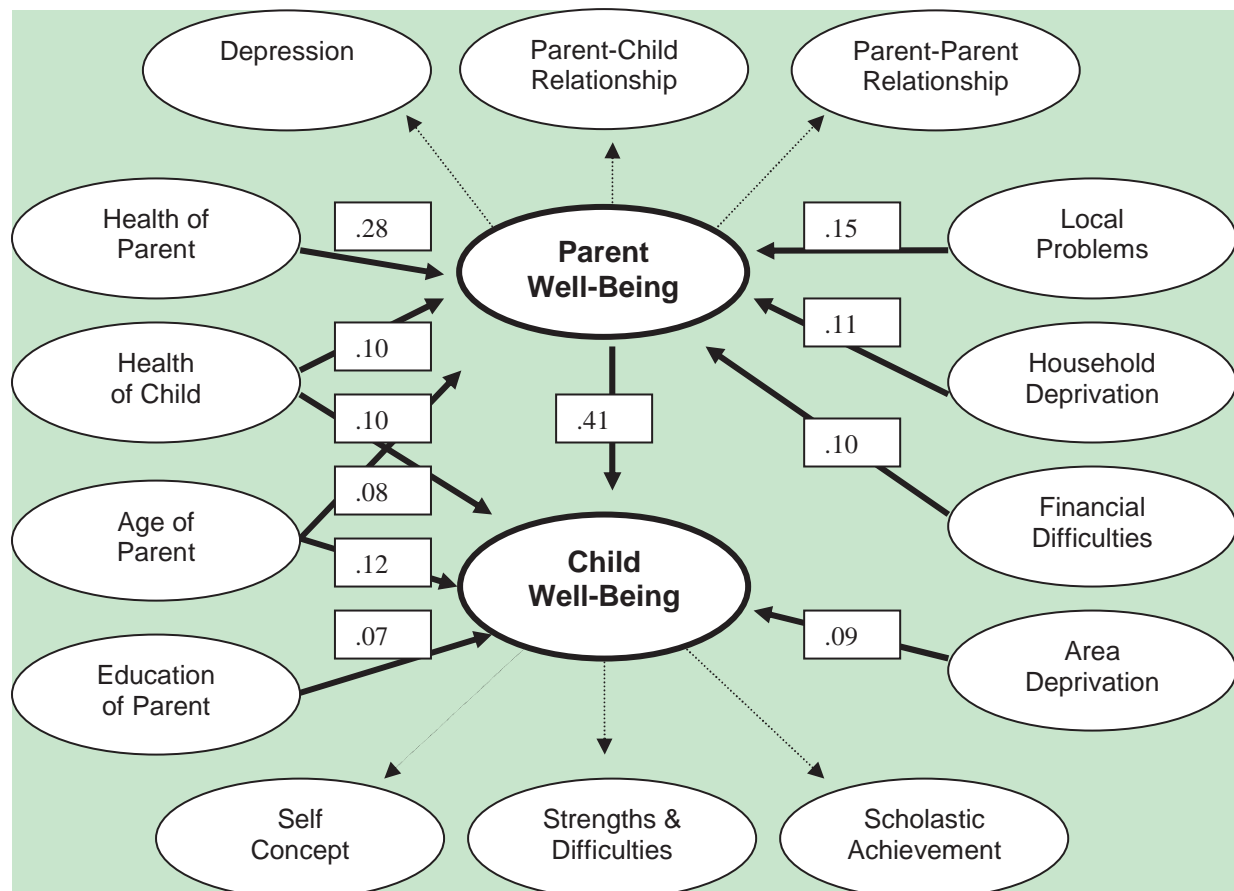# 4. Objective of Strategy to Support Families

The overall objective of the strategy is improving the well-being of parents and children by supporting all families through the normal challenges of family life. In order to achieve this objective, it is necessary to understand the nature of well-being and the factors which influence it.

4.1 Well-Being of Children and Parents

Well-being is about the enjoyment of life. It is a way of describing the quality of life and happiness of individuals, families, communities and society itself. The concept has deep roots in almost every philosophical and religious tradition, and has been revived in recent times as a way of offering a more holistic understanding of what constitutes a full life. In the area of health, for example, it has been used to promote an understanding of health as 'more than the absence of illness'[50], just as mental health is now seen as 'broader than the absence of mental disorders'[51]. Informed by this perspective, a new field of research has been created, called positive psychology, in order to understand what makes people well instead of the more traditional focus of psychology on pathologies[52]. In the field of economics, there has been a parallel realisation that the welfare of societies is not adequately measured by its income and a broader understanding based on the concept of well-being is required[53]. In the area of philosophy, there are equally important questions about the sources of well-being since the answers to these questions have relevance for how one seeks well-being[54].

A number of recent studies in Ireland have focused on the measurement of well-being in families[55], but the most significant source of data on family well-being is Growing Up in Ireland (GUI[56]): National Longitudinal Study of Children. Analysis of GUI, using the 9 year old cohort and based on two-parent families, has quantified the power of the parent-child relationship by first defining the concept of parent well-being (comprising depression, parent-child relationship, and parent-parent relationship) and child well-being (comprising self-concept, strengths and difficulties, and scholastic achievement) and then analysing the key influences on each[57]. A graphic summary of the results of this analysis is presented in Figure 1.

Figure 1 Influences on Well-Being of Parents and Children

Source: Derived from Pratschke, Haase and McKeown, 2011.

Figure 1 shows that a one-unit change in well-being of a parent (usually the mother since the primary caregiver is usually the mother in GUI) is associated with a 41% change in well-being of the child. In other words, when parental well-being improves the child's well-being automatically improves. The converse of this also applies: when parental well-being deteriorates the child's well-being automatically deteriorates. From an intergenerational perspective, and taking a wider body of evidence into account, one could say that the parent-child relationship is the main route by which the well-being of one generation is handed down to the next, whatever the family type.

Figure 1 also shows how being healthy (based on the mother's report of her own health and her child's health) is central to the experience of well-being for both parents and children. In addition, socio-economic factors, particularly household deprivation and financial difficulties, have a direct and adverse effect on parental well-being and, indirectly on child well-being; however children are also directly and adversely affected by the level of deprivation in the

area where they live. Parental education is another route through which socio-economic factors have an influence since lower levels of parental education are associated with lower levels of child well-being. Also, children of younger parents tend to have poorer well-being, partly because children benefit from the greater maturity of older parents and partly because mothers who are younger when they have children also tend to have lower levels of education which is less beneficial for children.

These findings, which are consistent with numerous studies on the factors which influence the well-being of children and their parents[58], are relevant to the design and delivery of services for children and families because they provide a map of how services could align themselves with the processes of well-being in order to strengthen protective factors and mitigate risk factors. The parent-child relationship is crucial to this but so too are the wider contextual influences, since parents effectively act as a buffer between the child and these wider influences. That is why a range of supports for families in adverse socio-economic circumstances is required in order to promote the well-being of children and their parents.

These findings also draw attention to the relative importance of different influences on well-being. The evidence in Figure 1 indicates that improving parental well-being, and its components, is one of the best ways to improve child well-being, though naturally not the only way. In fact there are few services, if any, that produce an impact on children that is equivalent to parents. For example, childcare programmes like High Scope[59], Early Head Start[60], Effective Pre-School and Primary Education Project[61], all have relatively small effects by comparison. The same applies to family support programmes like Sure Start[62] and Springboard[63]. None of this implies that the relatively small effects of programmes and services are not worthwhile[64]; the point is that interventions which are carefully designed and targeted at the processes of well-being are more likely to show a measurable effect.

As research has become more subtle and sophisticated, it is possible to separate the inter-locking strands of child and parent well-being by distinguishing between immediate and direct influences on the child (usually referred to as 'proximal influences') and those which have an indirect and more distant influence (usually referred to as 'distal influences')[65]. Proximal influences typically refer to characteristics such as the personality traits and states of parents[66] as well as the relationship of parents to each other and their children, while distal influences include characteristics such as the socio-economic characteristics of the household as well as the level of disadvantage and service provision in the neighbourhood and wider community[67]. Some variables – such as personality, support networks, socio-

economic status, local community – have been found to exercise a direct as well as an indirect influence on child well-being, suggesting their pervasive influence on the family system[68]. This approach to understanding children and their parents is informed by the 'ecological perspective' which is now the dominant paradigm in this field[69].

The significance of this evidence lies primarily in the fact that interventions are more likely to be effective in producing better outcomes for children when they target direct (or proximal) influences rather than indirect (or distal) ones[70]. To some extent, this evidence is already well known[71] but its implications needs to infuse the wider vision of Family Resource Centres and their services.

4.2 Interventions to Improve Well-Being of Children and Parents

The findings outlined above have a number of important implications for the strategy to support all families through the normal challenges of family life. First, interventions which target *direct* influences on well-being are likely, other things being equal, to have greater impact than those which target *indirect* influences. Indeed, interventions which target indirect influences will impact on well-being only to the extent to which they change the direct influences[72]. This understanding draws attention to the need to think of family support as a continuum of direct and indirect interventions and, for each intervention, to take account of the evidence on how it is expected to increase the well-being of children and their parents. In turn, this type of analysis draws attention to the need to think through the implications of intervening with a parent or child, and to become aware of the pathways that one is trying to influence in order to bring about improvements. This type of analysis is illustrated in subsequent sections of the strategy by using the logic model to link needs, actions and outcomes (Sections 5-9), and by outlining the considerations which will inform the selection of specific programmes (Appendix 2-3).

Second, any intervention to improve the well-being of parents is also likely to improve the well-being of their children. Indeed, the results in Figure 1 suggest that any intervention which improves parental well-being is likely to have more beneficial effects, other things being equal, compared to any intervention directly with children. This, as other research has shown, justifies a multi-dimensional approach to family support[73] while also giving primacy to the role of parents in shaping child outcomes[74], notwithstanding the high drop-out rate usually experienced from parenting programmes especially by more disadvantaged parents[75]. In other words, the findings identify parents as key agents in their own well-being

and the well-being of their children. While this does not exclude direct interventions with children – such as pre-school, after-school, youth and sports activities, etc. - the key lever of change in the family system is parents and the factors which directly influence their well-being and their relationship to the child.

Third, the different influences on parental well-being are mutually reinforcing so that, for example, creating a positive mental attitude - whether through engagement and activation in education, employment, informal networks, or community - may generate a psychological momentum which encourages problem-solving and a sense of well-being. Naturally, being positive does not exclude the negative or pretending that life is better because of adversity. Rather it seeks to achieve a balance where positive thoughts and feelings outweigh the negative[76].

The insights of cognitive psychology[77] and positive psychology[78] are directly relevant in this context by showing how a person's psychological and emotional well-being can be increased by changing the way they think about the past, the present and the future[79]. This is consistent with the 'broaden-and-build theory of positive emotions'[80] which suggests that people with more positive emotions tend to have a greater capacity for building friendships and support networks as well as being more creative at solving the problems and challenges of everyday life[81]. In other words, people with more positive emotions are more likely to see the world in terms of expansionary 'win-win' options rather than contractionary 'win-lose' options. In addition, cultivating positive emotions has been shown to encourage those qualities - such as persistence, flexibility and resourcefulness - which are essential to solving problems[82].

Fourth, the realities of limited resources in terms of income, education and employment – and the associated challenges which sometimes accompany these such as indebtedness, depression, addiction – remain substantial constraints on the well-being of parents and, indirectly, on their children. There are no easy answers to these challenges, at least within the remit of FRCs, but it is necessary to offer sustained support and encouragement to help parents engage in education, training and employment while at the same time seeking to raise the educational expectations and standards of their children. At the same time, it is also clear that child outcomes are unlikely to improve by simply improving the socio-economic status of their parents unless there are corresponding changes in the parent's well-being and in their parenting relationship with the child[83]. This finding is not new but its

policy implications in terms of 'preventing poor children becoming poor adults' are only now being realised[84].

5. Prevalence of Family Support Needs

This strategy is developed to address the needs of families, particularly but not exclusively those living in disadvantaged areas. These needs can be understood at two broad levels: household-level needs and area-level needs. Household-level needs refer to the needs of parents and children in the household relative to households in Ireland. Area-level needs refer to needs of the area in which the FRC is located - its ED (Electoral Division) - relative to other EDs in the county and Ireland.

These two aspects of need facilitate an understanding of how the individual needs of parents and children are shaped by their household characteristics and by the area in which they live. This in turn allows a social analysis of the determinants of need, and is consistent with the broader 'ecological perspective'[85] of how needs and outcomes are shaped by different layers of influence surrounding parents and children. This is also consistent with the community development perspective informing the work of FRCs, based on the understanding that needs and outcomes are shaped by the distribution of society's resources to individuals, households and areas.

5.1 Household-Level Needs

The household-level needs of parents and children can be described under four broad categories, all of which are interrelated: poverty, parental well-being, child well-being, and family type. These categories are simply indicative of the types of need to be considered by family support services based on the data available. However, as the analysis in the previous section indicated, it is the pathway between these different influences and the well-being outcomes of children and parents that are central to deciding on the most appropriate forms of support to be offered to families in each context.

Poverty

Poverty is a core indicator of need because it indicates a lack of income and other resources necessary for living. By extension, it is also an indicator that a person or household does not have the means to access those resources due to unemployment, itself related to lower levels of education, and itself often a consequence of family background and previous experiences of poverty. In this sense, poverty is frequently understood as having a structural and life-cycle quality which can be difficult to break, particularly when it occurs over different generations within the same family.

In Ireland, there are three poverty rates and the most recent data pertains to 2009: at risk poverty rate (14.1%)[86]; deprivation rate (17.3%)[87]; and consistent poverty rate (5.5%)[88]. Whatever rate is used, there are three factors consistently associated with poverty which are relevant to family support. First, children (0-17 years) are more likely than any other age-group to experience poverty. Second, one-parent households are more likely than any other household to experience poverty. Third, households in poverty are more likely to be in arrears compared to other households on items such as utility bills and rent/mortgage arrears. By these indicators therefore, it is clear that family support services need to take particular account of children and parents who live in poverty, especially those in one-parent households.

Parental Well-being

Parental well-being, understood in terms of physical, mental and relationship well-being, is known to vary systematically by socio-economic status and family type. Although the majority of Irish parents are well, there is a marked 'social gradient' in the likelihood of being well because 'the most powerful influences affecting health and the promotion of health are socio-economic factors, in particular poverty. Every major health problem has a significant social gradient, with those at the lowest socio-economic level suffering most ill-health'[89]. Numerous studies in Ireland testify to higher rates of depression among lower socio-economic groups[90]; and an international review of evidence on the prevalence of depression among mothers with young children concluded that 'approximately 1 in 10 women with young children experience depression … with prevalence rates often reaching two times these levels among mothers living in poverty'[91]. Similarly, health behaviour influences physical health and higher risk behaviours - such as smoking[92], smoking during pregnancy[93], the use of sedatives, tranquilisers and anti-depressants[94] - is higher among parents living in

poverty and in areas of disadvantage. Conversely, health-seeking behaviour, such as breastfeeding[95] or immunisation of infants[96], tends to be lower where the mother's education is lower. The same social gradient also applies to the quality of the neighbourhood in which parents live which tends to be poorer for those in the lowest income group[97]. These different dimensions of parental well-being are simply an illustration of how parents living in disadvantaged circumstances tend to have greater needs compared to other parents. By implication, they also help to illustrate the context in which most FRCs operate.

Child Well-being

The majority of children in Ireland are healthy, physically and mentally, but a minority experience difficulties. This minority is more heavily concentrated in families where the parents have lower education and income. For example, the children of unskilled and semi-skilled manual workers are more likely to be over-weight or obese[98]. The prevalence of children with emotional or conduct problems, as assessed by the mother, is more likely among mothers with the lowest levels of education[99] and this pattern is also found in other studies in Ireland[100], the UK[101] and the US[102]. School attendance and academic performance is also associated with the family's level of education[103]. Conversely, the children of mothers with lower levels of education spend more time playing video games and are more likely to have a video/DVD player in the bedroom[104]; while the children of higher income parents are more likely to participate in structured sports clubs and cultural activities[105]. These findings, drawn mainly from the Growing Up in Ireland National Longitudinal Study of Children, are simply designed to indicate some of the areas where there are significant and measurable differences in the well-being of children and, correspondingly, areas where family support services may intervene.

Family Type

Family type is a steady predictor of need, with those living in one-parent households at higher risk of reduced well-being compared to families in general. However, as with other indicators, family type needs to be interpreted with care since it is the cluster of factors associated with it, rather than family type *per se*, which are generally understood to be the active ingredients of risk. To begin with, the concept of a one-parent household comprises different types of families. In Ireland, one-parent households constitute 18% of all households with children[106]. These households are made up of single unmarried parents (57%), separated / divorced parents (35%), and widow(er)s (8%)[107]. We have already seen

that one-parent households are more likely to live in poverty and this is clearly a risk to well-being. Moreover it seems likely, other things being equal, that the marginalised position of one-parent households relative to two-parent households is likely to deteriorate for the foreseeable future as dual earning households - currently constituting about 47% of two-parent households with children in Ireland[108] - becomes the norm.

The concept of family type also masks the pathway by which parents and children end up in their family type. This is illustrated by findings from the Growing Up in Ireland National Longitudinal Study of Children which show how, for children, the pathway to one-parent households is sometimes paved with risk factors: 'As would be expected, in comparison with children from two-parent families, children from single parent families were more likely to have experienced the death of a parent, conflict between parents, the divorce or separation of their parents, or moving home – all events associated with disruption or turmoil in the life of the child. … . Children from single-parent families were more likely to experience four or more stressful life events than children from families with two parents. … . Theory and research suggests that it is the cumulative effects of experiencing multiple stressors that most adversely affect a child's development, as opposed to the presence or absence of specific stressors per se. …. Thus, children who are reported to have experienced several life events are of particular concern to researchers, educators and clinicians'[109].

It is important to emphasise that while there are more risk factors associated with one-parent households compared to two-parent households, other things being equal, most children and their parents have the resilience to overcome these risks and live normal healthy lives. This is underlined by the analysis of Bronfenbrenner on the success factors for children in one-parent households: 'Not all single parent families, however, exhibited these disturbed relationships and their disruptive effects on children's development. Systematic studies of the exceptions have identified what may be described as a general immunizing factor. For example, children of single parents were less likely to experience developmental problems especially in families in which the mother (or father) received strong support from other adults living near home. Also helpful were nearby relatives, friends, neighbours, members of religious groups, and, when available, staff members of family support and child care programs. What mattered most was not only the attention given to the child – important as this was – but also the assistance provided to the single parent or by others serving in the supportive roles previously noted. It would seem that, in the family dance, it takes three to tango'[110]. These considerations highlight why the concept of family type masks a range of

other more proximal processes which affect the well-being of children and parents and it is these which need to be taken into account in family support services.

5.2 Area-Level Needs

Area-level needs in the catchment area served by each FRC are defined by the relative deprivation or affluence of the ED (Electoral Division) in which it is located by comparison with other EDs in the county and Ireland. This is based on data from the CSO Census of Population using the deprivation index[111]. The deprivation index distinguishes three dimensions of deprivation – demographic, social class, labour market - and allows each ED in Ireland (comprising 3,409 EDs in total) to be ranked on each of these dimensions and on its overall deprivation score. This information is publicly accessible on the Pobal website[112] and can be used to construct a profile of area-level needs for each FRC catchment area using the template in Table 1.

Information on the accessibility of an area to services is also an important indicator of need. In the case of children, this could take the form of information on access to services such as pre-school, school, after-school projects, psychological assessments for children with learning difficulties, sports and leisure facilities, etc. For adults, area-level needs may be defined by accessibility to services such as GP, family support, mental health, shops, outlets for leisure, culture and sport, etc.

Table 1 Area-Level Needs in FRC Catchment Area

Socio-economic Dimensions of Need	EDs in FRC Area	County of FRC	Ireland
Demographic Decline			
% population aged <15 or > 64 years			
% change in population over previous 5 years			
Social Class Disadvantage			
% adult population with Primary School education only			
% adult population with a Third Level education			
% persons in households headed by 'Professionals' or 'Managerial and Technical' employees, including farmers with 100 acres or more			
Mean number of persons per room			

Labour Market Disadvantage			
% households with children aged < 15 years and headed by a single parent			
% persons in households headed by 'Semi-skilled Manual' and 'Unskilled Manual' workers, including farmers with less than 30 acres			
Male unemployment rate, based on Census			
Female unemployment rate, based on Census			
Overall Relative Deprivation / Affluence of Area			
Area: Affluent (scores 10+)			
Area: Slightly above national average (0.0 to +9.9)			
Area: Slightly below national average (-9.9 to 0.0)			
Area: Disadvantaged (-19.99 to -10.0)			
Area: Very/Extremely Disadvantaged (-20.0 or less)			

6. Strategy Relative to Different Types of Family Support

It has become conventional to characterise interventions in health and social services into three types[113]: (i) prevention, designed to stop or reduce the risk of a problem occurring in a population; (ii) early intervention, designed for those already at risk of a problem occurring in a population in order to stop or reduce it; (iii) treatment, designed for those already experiencing problems in order to make them better or stop them getting worse. The use of these three types of intervention – also referred to as primary, secondary and tertiary prevention - depends on the type and severity of need and degree of specialty required to address each.

This classification has also been used to distinguish three types of family support services[114]:

(i)   developmental family support, also called primary family support[115], which aims to strengthen the social supports and coping capacities of children and their families. The focus of this type of family support is on strengthening developmental opportunities for the child and family rather than on specific problems. Developmental family support is typically based on a community development perspective, such as used by FRCs, and builds supports through group-based activities such as parenting programmes, personal development groups, recreation groups, youth programmes, parent / adult education relevant to family living, etc.

(ii)   compensatory family support, also called secondary family support[116], which aims to compensate for the debilitating effects of family problems such as poverty, mental health difficulties, relationship problems with partner or children, addiction, disabilities, etc. This type of support takes the form of more specialised programmes

or interventions delivered on a one-to-one basis to address the factors which threaten the well-being of parents and children in order to improve the family's capacity to provide a nurturing environment for all its members.

(iii)   Protective family support, also called tertiary family support[117], aims to protect the child and family from problems that have already developed, particularly where there is child neglect or abuse. This type of family support falls within the remit of the child protection system and is the statutory responsibility of the HSE and the Gardaí. Protective family support is usually highly directive, sometimes based on court order, and supports parents to establish relationships and routines of care for the child that are at least 'good enough'.
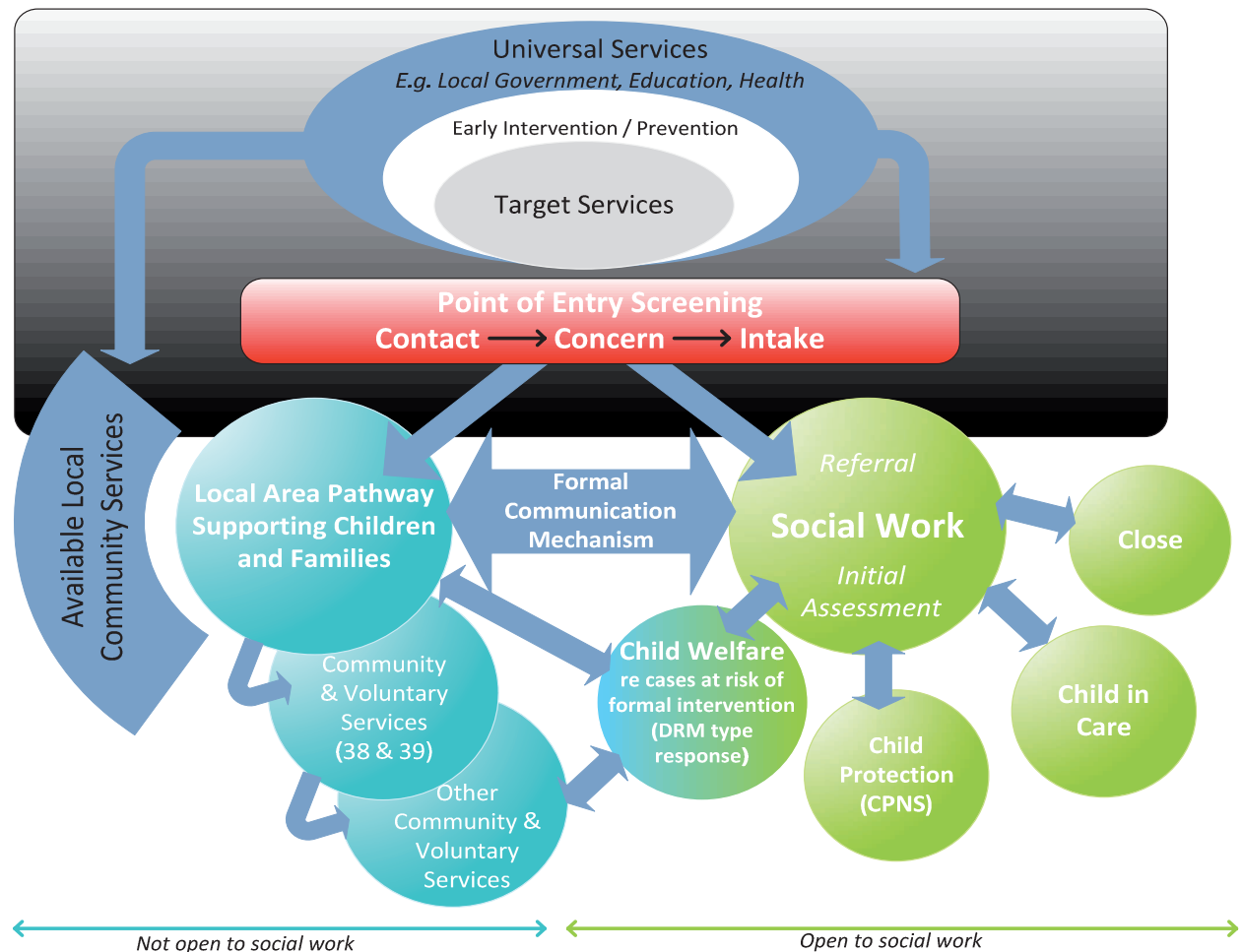
FRCs combine both the 'developmental' model and the 'compensatory' model of family support. As such, they focus on strengthening the family's capacity to provide a nurturing environment for all family members (the developmental model) while also intervening to address problems which have developed and become manifest (the compensatory model). Both in turn are linked to the 'protective' model of family support run by statutory services through the child protection guidelines of each FRC. This means that the family support strategy of each FRC represents a continuum of interventions which are available to families in their catchment area and accessible to each household as required.

The importance of linking these different types of family support to each other in order to provide a holistic model of service is widely recognised. Experience in Ireland, as elsewhere, testifies to the fact that system failures to protect children often arise because there is a lack of developmental and compensatory family supports, or the child protection system operates in isolation from these developmental and compensatory support services[118].This understanding is clearly articulated by the Task Force on the Child and Family Support Agency and is the reason why it recommended bringing all family support services within the one agency: 'Numerous investigation reports have documented how fragmented services have failed to meet the needs of children. It is crucial that certain services for children are now realigned from across a number of agencies into a single comprehensive, integrated and accountable agency for children and families, the Child and Family Support Agency (CFSA). The Task Force's vision for the Child and Family Support Agency is that it will, under the direction of the Department of Children and Youth Affairs, provide leadership to relevant statutory and non-statutory agencies, to ensure that the conditions needed for children's well-being and development are fulfilled. The Task Force's 'vision for a quality Irish

childhood' is relevant to and intended to encompass all organisations, agencies and sectors that provide services to children, young people and their families.' [119].

A graphic illustration of how the integration of services will work in practice in the Child and Family Support Agency is illustrated in Figure 2. FRCs are particularly well-placed to work within this framework.

Figure 2 Integration of Services in Child and Family Support Agency

Source: Jeyes, 2012.

7. Outcomes of Family Support Strategy

The purpose of services is to meet needs. In the case of services for children and families, this could be reframed by saying that services are valuable only if their outcome improves the well-being for children and families. This implies that the value of services, including their value-for-money, is determined by results as expressed in terms of outcomes.

National policy for children is committed to five outcomes[120], as summarised in Table 2, and the achievement of these outcomes has been national policy for over a decade[121]. In abbreviated form, these five outcomes cover the areas of: (i) health (ii) education (iii) safety (iv) income (v) participation. These outcomes are to be achieved by the Child and Family Support Agency of which the FRC programme is an integral part. The strategy therefore is aligned with these outcomes while also extending its focus to include parents and the wider community in which children live. The reason for that, as we have seen above (see Section 4), is because the well-being of children and their parents is highly inter-dependent with the result that achieving better outcomes for parents is also a way of simultaneously achieving better outcomes for their children; to a lesser degree, the well-being of children and parents is also influenced by the well-being of the community in which they live.

Table 2 Outcomes to be Achieved by Family Support Strategy

Outcome Area	Outcomes for Children and Their Parents
1. Health	Healthy physically, mentally and emotionally
2. Education	Supported in active learning
3. Safety	Safe from accidental and intentional harm; Secure in the immediate and wider physical environment
4. Income	Economically secure
5. Participation	Part of positive networks of family, friends, neighbours and the community; Included and participating in society

These outcomes are designed to ensure that the strategy is aligned with national policy while also keeping it outcome-focused[122]. In other words, the strategy is designed to make sure that the actions of FRCs – defined in the next section – are aligned to achieving these outcomes for children and their parents.

8. Actions to Achieve Outcomes in Family Support Strategy

The strategy comprises two broad categories of action: developmental activities and programmed activities. Developmental activities have the quality of being responsive and flexible to needs as they arise and are part of the way in which an FRC may support people to identify and respond to expressed needs in the context of family, neighbourhood and community. Programmed activities are also responsive to need but the response is in the form of a programme of work which is known to be effective in addressing a particular set of needs. The balance of activities in any FRC depends on the needs in each community, the skill-set of staff, and the network of services available in that area.

8.1 Developmental Activities

Developmental activities have the quality of being practical and responsive to the requirements of each local situation. At an individual level, examples might include support in seeking training and employment, personal development courses, listening and befriending, giving information about a service that someone may wish to use, putting people in contact with each other, acknowledging family rituals such as birthdays or key transition points such as the first day at primary or secondary school, celebrating achievements, offering sympathy and support at times of adversity, loss or bereavement, etc. At a community level, developmental activities might include organising self-help activities such as women's groups, men's groups, residents associations, after-school activities, networking with service providers and policy makers, advocating for improved services, encouraging participation in community activities, etc. These activities support positive community involvement that help parents and their children to feel more attached to the place they call 'home' and promote a sense of belonging and security that are part of being well.

Naturally, this list of developmental activities is not, and cannot be, exhaustive since life continually generates circumstances where new forms of support are evoked. In this sense, such activities have a spontaneous quality that responds to circumstances as they arise and change. Thus, while these activities will try to engender a family-friendly atmosphere in the localities where FRCs work, there is likely to be significant variation due to the different circumstances in each area and the different qualities that staff and volunteers will bring to this aspect of the strategy.

8.2 Programmed Activities

Programmed activities are typically based on a programme of activity that is believed, or known, to be helpful to those who participate. These programmed activities are usually evidence-based, targeted at parents, children or both, and may be individual-based or group-based. Individual-based programmes might include counselling or assessment of needs. Group-based activities typically take the form of manualised programmes such as those listed in Table 3, which have been shown to be effective in other settings. These programmes are different from the more responsive and flexible group-based programmes for parents such as courses on personal development, health, recreation, gardening, cookery, etc; or similar informal programmes for children such as after-school, sports clubs, youth clubs, etc.

Table 3 List of Formal Programmes for Parents and Children in Ireland*

Programme(Listed by Age of Child)	Age of Child	Mode of Delivery
Community Mothers	0-2 years	Individual Parent
Lifestart	0-5 years	Individual Parent
High/Scope*	0-5 years	Group of Children
Parents Plus	(i) 1-6 yrs (ii) 6-11 yrs (iii) 11-16 yrs	Group of Parents + Video
Triple P - Positive Parenting Programme** / ***	0-18 yrs	Group of Parents
Incredible Years*	(i) 2-7 yrs (ii) 5-12 yrs	Group of Parents + Video
Strengthening Families	12-15 years	Group of Parents and Children
Functional Family Therapy*	11-18 years	Parent, Child or Family

See Appendix Two for more details on each programme.
*Listed as a 'Level 1' evidence-based programme in UK report on early intervention where 'Level 1' refers to meeting the best criterion on evaluation quality or impact[123].
**Listed as a 'Level 3' evidence-based programme in UK report on early intervention where 'Level 3' refers to meeting 'good enough' criteria on evaluation quality or impact[124].
*** Listed as 'Near Top Tier' in US review of programme effectiveness[125].

An illustration of how the strategy is designed to align actions to outcomes is presented in Tables 4a and 4b. Naturally, the strategy will vary from one FRC to another but the underlying 'logic model' will endeavour to show the 'logic' between the action and the expected outcome. We discuss this in more detail in the next section as part of a framework for preparing a local family support strategy.

Table 4a Illustration of Alignment between Developmental Activities and Outcomes

Outcomes	Main Focus of Developmental Activities		
	Community	Adults & Parents	Children
1. Healthy physically, mentally and emotionally	- Health promotion initiatives - Researching local health needs / participation in primary care - Advocating on physical health / mental health issues - Healthy food initiatives/youth cafes - Community gardens/allotments	- Health related support groups, eg mental health, cancer support - Exercise classes e.g. aerobics / yoga - Counselling services - Carers Support Groups - Family fun days	- Participation in youth clubs - Sport and recreation - Fitness classes - Breakfast clubs - Summer activity camps - Family fun days

2. Supported in active learning	- Information on/delivery of adult education/training - Community Arts Initiatives - Literacy initiatives	- Family learning initiatives/reading club - Homework Support Group (for parents) - Personal development - Arts and Crafts activities	- After-school Clubs - Homework Clubs/ study groups - Early School Leavers initiatives - Arts and Crafts activities
3. Safe from accidental and intentional harm / Secure in the immediate and wider physical environment	- Campaigns on Domestic violence / elder abuse - Community Safety Initiatives - Community mediation service - Garda Information Service - Campaigning / fundraising for community facilities eg playgrounds, ramps - Crime prevention initiatives - Tenant participation / regeneration initiatives	- Domestic Violence Initiatives - Self-defence courses - First Aid training for families - Counselling - Regional advisory groups on domestic violence - Drugs awareness training - Neighbourhood watch initiatives - Narcotics Anon / Alcoholics Anon Groups	- Information on how to stay safe - Psychological support and counselling
4. Economically secure	- Community Savings Banks - Hosting MABS/ other service providers - Enterprise initiatives eg Local Markets - Jobs Clubs - Seminars for Unemployed People	- Information on income supports - Supporting entry to labour market and enterprise supports - Community Employment Schemes - Promoting local business initiatives	- Practical measures to overcome economic barriers to participating in learning, sport, recreation, etc.

| 5. Part of positive networks of family, friends, neighbours and the community / included and participating in society | - Support/social groups for particular groups eg disabled people, Travellers, LGBT, Older People, Migrants
- Women's, men's, lone parent initiatives
- Self-advocacy groups
- Leadership programmes
- Involvement in FRC eg Director, Volunteer
- Partnership initiatives | - Social events eg bingo, book clubs, etc.
- Support groups for separated couples
- Contact Centres
- Support groups for adoptive parents
- Family activity
- Summer projects
- Respite crèches
- Family support groups
- Children's Services Committees
- Affordable Childcare services | - Parent and toddler groups
- Out-of-school activities
- Children/youth social activities eg drop in centres, youth discos, sports and fitness |

Table 4b Illustration of Alignment between Programmed Activities and Outcomes

Outcomes	Main Focus of Programmed Activities	
	Adults & Parents	**Children**
1. Healthy physically, mentally and emotionally	(i) Organise programmes on health-related topics for parents. (ii) Organise parenting programmes* so that children grow healthy physically and mentally.	(i) Organise High Scope Programme for 0-4 year olds. (ii) Organise youth or sports club.
2. Supported in active learning	(i) Organise adult education courses for parents. (ii) Organise course on how parents can support their children's learning through parenting programmes* or NALA literacy programme (www.literacy.ie).	(i) Organise High Scope Programme for 0-4 year olds. (ii) Pre-school and after-school programmes.
3. Safe from accidental and intentional harm / Secure in the immediate and wider physical environment	(i) Organise personal development programme. (ii) Organise parenting programmes* so that children are safe from accidental and intentional harm. (iii) Organise gardening programme to improve appearance of estate.	(i) Pre-school and after-school programmes should include a 'stay safe' module. (ii) Organise gardening programme to improve appearance of estate.

4. Economically secure	(i) Commission agencies such as MABS, VdP to run programmes on debt, money management, etc. (ii) Commission One Family to run pre-vocational courses (iii) Identify skills on estate that could be bartered.	(i) Organise information programme about options in higher education.
5. Part of positive networks of family, friends, neighbours and the community / Included and participating in society	(i) Run personal development programmes and parenting programmes* to create positive networks. (ii) Organise estate events such as annual family day. (iii) Organise information programme about career options for parents and children.	(i) Organise youth or sports club. (ii) Organise an annual awards ceremony for special achievements in wide range of categories.

*See Table 3 above and Appendix Three.

9. Developing a Local Family Support Strategy

In order to be effective, the strategy in each FRC needs to maintain an overall coherence in terms of a logical link between needs, actions and outcomes. At the same time, the strategy also needs to adapt to local circumstances, taking into account the composition and stage in the lifecycle[126] of each area and the expressed wishes of the community.

A key challenge in localising the strategy is to align actions to outcomes so that the logic of the strategy is coherent and transparent. This process is sometimes called 'logic modelling' because it is based on 'if-then logic'[127] and requires evidence and argument to show that *if* a particular action is undertaken there are reasonable grounds for believing that the desired outcome will *then* be produced. Using this model, Table 5 is a template for preparing the local strategy; in practice, separate versions of this template could be prepared for parents and children.

In light of this template, the local strategy will require a knowledge of family needs in the catchment area, drawing on local consultations and data sources on indicators of need in the domains of disadvantage, education, employment, health, service provision, etc. The local strategy will also require active local participation in matching needs to actions and outcomes, drawing on their own experience and the concepts and evidence contained in this document. Ideally, the process of preparing the local strategy will also facilitate local

participation in setting targets for each outcome; these may be personal targets but they may also be group-based targets for each outcome. For each need and outcome in the local strategy the key question to be addressed is: What action will address this need to bring about the targeted outcome?

As indicated, active participation is a core element in preparing the local strategy since local people are integral to the process of defining needs, deciding on actions, and agreeing on the outcomes and targets they want to achieve. This approach underlines the importance of community development to supporting families, already central to how FRCs work. In preparing the local strategy, it is also important that the best available evidence is used to decide on the most appropriate programmes in each case. In view of that, guidance is offered on how to choose the most appropriate programme(s) for each local strategy (see Appendix Three).

The purpose of this strategy, as indicated above (Section 7), is to improve the well-being of children and their families as expressed through the five national outcomes for children. These five outcomes cover the areas of: (i) health (ii) education (iii) safe from harm and neglect (iv) adequate income and (v) participation in positive networks.

Table 5 Template for Preparing Local Family Support Strategy for Parents & Children

Outcome Area	Needs	Actions		Targets for: -Community -Adults & Parents -Childen
		Developmental	Programmed	
1. Health, physical, mental & emotional				
2. Education and development				
3. Safe from harm and neglect				
4. Adequate income				
5. Participation in positive networks				

10. Staff Competencies Required for Family Support Strategy

Three types of staff competency, or 'practice knowledge'[128], are necessary to implement the family support strategy in order to make sure that actions are effective in delivering outcomes. These competencies are: (i) knowledge (ii) skills (iii) attitudes. Staff in FRCs

already have these competencies but they are made explicit here to ensure a proper alignment between strategy and competency, and to raise awareness of the need for staff to continually reactivate and revitalise these competencies. The knowledge required to implement the strategy includes knowledge about family and family well-being, community development, family support programmes, local services, and legal obligations. Similarly, all staff will require the skills and attitudes listed below in order to develop and implement the strategy.

10.1 Knowledge of Family and Family Well-Being

Most of the knowledge required by staff to implement the strategy is already contained in this document, especially knowledge about families and family well-being. Additional information is provided in the appendices covering the main family support programmes in use and available in Ireland (Appendix Two) and how to select the ones that are most appropriate to each local context (Appendix Three).

10.2 Knowledge of Community Development

The strategy is informed by the principle that each community needs to be actively involved in defining its needs and taking action to achieve better outcomes. The key element of this approach is that local people themselves are involved in the definition and analysis of their needs, using the type of data summarised in Section 5 above. In light of this analysis, they will decide on actions to improve their situation, both individual actions and group actions. The implementation of this approach requires an understanding of the multi-level influences on well-being in which each level – individual, household, estate, county, society - is nested within a wider set of influences. These understandings and the associated skills and attitudes to facilitate this type of analysis are essential to implementing the strategy in each area. These facilitation skills require the capacity to create a group atmosphere which fosters positive interactions, keeps the focus on solutions rather than problems, and ensures that all decisions, as far as possible, have benefits for everyone[129].

10.3 Knowledge of Family Support Programmes

Programmed actions are an important part of the strategy. The strategy contains a list of the main programmes in use and available in Ireland (Appendix Two), and also provides guidelines on how to choose the most appropriate ones (Appendix Three). That is why FRC

staff need to have a solid knowledge of the different programmes and the implications of implementing them in their particular locality.

10.4 Knowledge of Local Services

Knowledge of local services is essential in order that staff can assist families in accessing these services. In addition to knowledge of the different services, it is desirable that staff have the contact details for all key agency personnel and, where possible, to have made direct contact with them. Ideally, this information will be available within the FRC in electronic and hard-copy format, and updated regularly to facilitate easy hand-over from one staff member to another as the need arises. The possibility of engaging local people in the process of assembling data on services may be worth considering as part of the community development process in each area.

In the course of implementing the strategy, staff are likely to identify some parents and / or children who may require a more specialised service in areas such as mental health, psychological assessment, child protection, addiction, domestic violence, etc. Table 6 outlines a possible universal form for making FRC referrals to external agencies.

Table 6 Referral From FRC Programme

Referral From FRC	
Name of person being referred	
Is person being referred an adult or child?	❑ adult❑ child
Date of birth of person being referred	Day ___ Month ___ Year ___
Address of person being referred	
Contact phone number of person being referred	
Service requested for person being referred	
Has person being referred consented to this referral?	❑ yes❑ no
Name of person in FRC making referral	
Position of person in FRC making this referral	
Phone number of person in FRC making referral	
Address of person in FRC making this referral	

10.5 Knowledge of Legal Issues Affecting Families

All services need to operate within the law and it is important for all FRC staff to be aware of their legal obligations, particularly as they affect families and children. Four areas are of particular importance.

The first concerns the protection of children. The key provision in the National Guidelines for the Protection and Welfare of Children is that the HSE and / or the Gardaí 'should always be informed when a person has reasonable grounds for concern that a child may have been abused, or is being abused, or is at risk of abuse'[130]. As part of good practice, each FRC should have its own child protection procedures. It is worth underlining that, under The Protection of Persons Reporting Child Abuse Act, 1998, the law provides immunity from civil liability to persons who report child abuse, provided it is done 'reasonably and in good faith'.

The second area concerns laws protecting the personal rights of each individual to privacy – notably the Data Protection Acts (1988 and 2003) and the Freedom of Information Acts (1997 and 2003) - since these rights are acknowledged in the Constitution[131] and in international law[132]. As a consequence, a resident can request to see any information held about him / her by an FRC; to have it amended where it is deemed incomplete, incorrect or misleading; and to obtain reasons for any decisions made which affects him/her. This implies that particular care is needed in how staff record, share and store information. It also implies that information about a resident is shared only on 'need to know' basis[133].

The third area is acting at all times with the consent of the family. Consent is a fundamental aspect of each person's right to self-autonomy and deciding what happens to them. It is regarded as a basic rule of common law and an absolute right which is enshrined in the Irish Constitution, and in Irish and international law. In healthcare, for example, the practice is that consent must be obtained for a medical examination, treatment or investigation[134]. This applies equally to interventions to address mental health or other difficulties encountered by a person. The form of the consent – whether written or implied – is somewhat less important than the process by which informed consent is given and requires a genuine process of communication where the person is able to decide, on an informed and continuing basis, what they would like to happen to them. In the case of children, informed consent of their parents is necessary; in rarer cases of severe mental illness, the right to act without consent can only be exercised, under the Mental Health Act 2001, 'where the consultant psychiatrist considers that the treatment is necessary to safeguard your life, to restore your health, to alleviate your condition or to relieve your suffering, and you are incapable of giving such consent because of your mental disorder'[135].

The fourth area concerns family law. While family law is itself quite complex, it is important to be aware that the recent passing of the Civil Partnership Act 2010[136] adds a new dimension to family law by granting legal recognition to cohabiting couples. A key provision of the Act is

a redress system which allows a financially dependent cohabitant to apply to court for certain remedies, including maintenance, property, pension adjustment orders, or provision from the estate of a deceased cohabitant.

10.6 Skills and Attitudes

The core skill is for staff to develop and implement a local family support strategy based on the strategic framework described in this document. Table 7 breaks down this core skill into a more specific set of skills and a corresponding set of attitudes associated with each skill.

In addition to these specific skills and attitudes, it is important that FRC staff have a clear understanding of the helping process and what it means to help someone. Helping is a natural part of life and something that arises spontaneously because people help, and are helped, all the time through family, friends, and communities. Everyone is a natural helper and people seek professional help only when all other sources have been exhausted.

Table 7 Skills and Attitudes Required to Develop and Implement Strategy

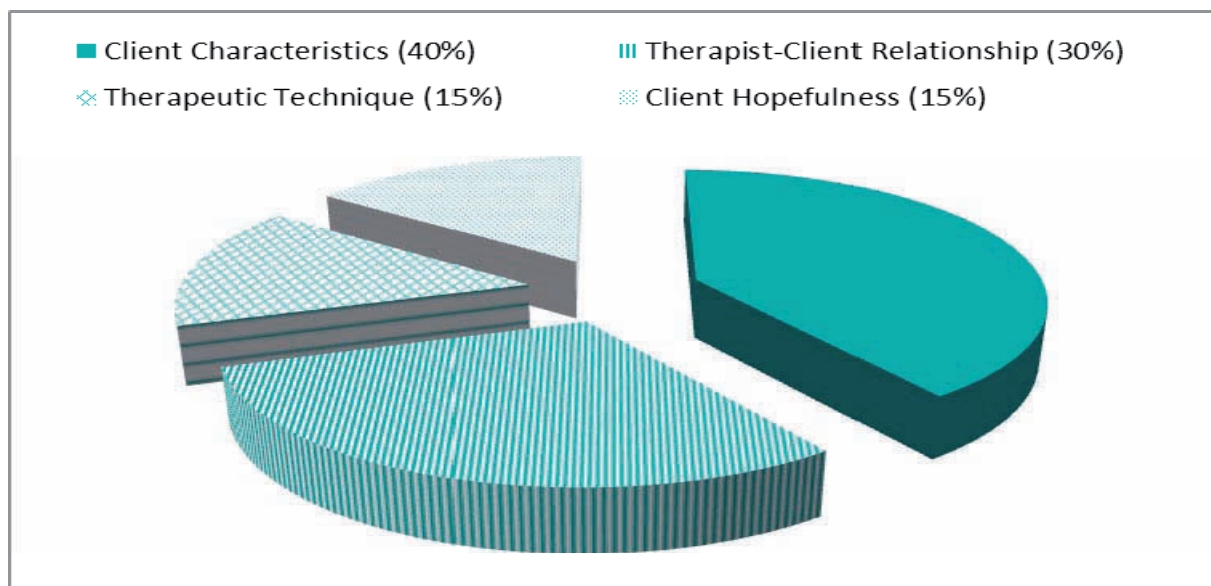| Skills	Associated Attitude and Disposition
Leading and facilitating the community to develop and implement the strategy.	Open while maintaining strategic focus Respectful of diverse and contradictory views Sensitive to group dynamic and keeping the balance between process and outcome Commitment to equality and human rights
Communicating with parents and children, individually and collectively, about the strategy and listening to their concerns.	Building trust and showing loyalty Attentive empathic listening Being genuine in response to concerns Acting to address concerns
Building commitment to the strategy by identifying the beneficial outcomes for parents and their children.	Modelling a positive can-do attitude Creating hopefulness Finding examples to show progress is possible Respecting the boundary that a parent or child may not wish to be part of the strategy
Linking needs, actions and outcomes into the logical framework of the strategy	Clear understanding of rationale for strategy Commitment to the well-being for all residents Commitment to action
Deciding on the most appropriate actions, both programmed and non-programmed.	Intuitive, spontaneous and empathic Open to attracting suggestions Making decisions collaboratively
Working out a realistic timeframe for implementing the strategy	Practical and realistic Determined and committed
Working effectively with FRC staff, Board and volunteers to develop and implement strategy.	Listening mindfully Reinforcing the positive Enjoying team-work

Working effectively with outside agencies to develop and implement the strategy	Building relationships of trust Identifying 'win-win' situations Persevering in face of disappointment Commitment to co-operation and collaboration
Identifying programmed actions, and facilitators to deliver them, that will generate high uptake and impact.	In tune with residents' needs and abilities Consulting widely about what works Understanding the complexity of implementation Recognising that failure to plan is planning to fail
Creating a positive atmosphere that is capable of withstanding difficulties that may arise in developing or implementing the strategy.	Positive and realistic Strong and flexible Trust in capacity of everyone to overcome difficulties
Maintaining flexibility to allow the strategy to change where particular actions are not working effectively.	Showing that the well-being of parents and children is the goal; the strategy is only the means; Valuing learning even when actions are not working effectively.

Common Factors in the Helping Relationship

By definition, the help offered by FRC staff is 'professional help' in the sense that it is not part of the person's informal sources of help from family, friends and other supports. The following research findings are not presented to suggest that FRC staff operate in the role of therapist, but to illustrate the importance of building on the strengths and capacities of those who approach the FRCs in need of help and support.

Research on what determines the effectiveness of professional help (particularly in the case of counselling and psychotherapy) has revealed that all such interventions have something in common which make them similarly effective[137]. These common factors, as summarised in Figure 3, are principally the characteristics of the client and the client-therapist relationship[138]. Remarkably, 'technique' or 'programme', about which so much is written and claimed, contributes a relatively small part to the overall outcome. The main influence comes from what the client brings to the intervention and the way the therapist interacts with the client to create opportunities for change, and triggering a sense of hopefulness that change can be brought about.

Figure 3 Common Factors Associated with Therapeutic Outcomes

Source: McKeown, 2000:9; Compiled from Lambert, 1992; Miller, Duncan and Hubble, 1997, Chapter Two; Asay and Lambert, 1999.

Beginning with the client, it has been observed that: 'It is the client more than the therapist who implements the change process. … Rather than argue over whether or not 'therapy works', we should address ourselves to the question of whether or not 'the client works!' … As therapists have depended more upon client's resources, more change seems to occur"[139]. This insight has led therapists, and other professionals, to a focus on the strengths, resources and resilience which people use to cope with, and overcome problems. At the same time, this approach does not seek to minimise problems since, as the research shows, many vulnerable people and families often need sustained support over a considerable period of time in order to bring about the changes they want.

Turning to the therapeutic relationship, this is seen by many commentators as 'the sine qua non of successful therapy'[140]. It has been suggested that many of the qualities of effective therapist-client relationships – emotionally warm, available, attentive, responsive, sensitive, attuned, consistent and interested - are in fact generic to many relationships both in work and family[141]. The writings of Carl Rogers laid particular stress on the helping relationship by emphasising the need to show clients – and be experienced by clients as showing – unconditional positive regard, accurate empathic understanding, and openness to creative solutions[142]. One review of the literature, based on the findings of over 1,000 studies, recommended three ways to improve the therapeutic relationship:

(1) accommodate the client's motivational level and state of readiness for change;

(2) accommodate the client's goals for therapy; and

(3) accommodate the client's view of the therapeutic relationship[143].

These considerations draw attention to the ordinary, natural and practical ways in which helping occurs[144]. Professional help builds on these qualities and, while specialising in particular areas of difficulty, this supplements rather than replaces the natural helping process. That is why FRCs place particular emphasis on providing support in a way that avoids any hint of stigma or shame. Indeed, this perspective recognises that one of the obstacles frequently encountered in overcoming 'family problems' is the internalised sense of stigma or shame that people often feel about their difficulties. The true skill of the 'helper', itself gained from reflection on one's own life and difficulties, is to reassure people that their difficulties are natural and understandable, and nothing to be ashamed of. Ultimately, this perspective recognises that everyone has the capacity, with some support, to overcome their difficulties and, in many respects, the true essence of helping is to re-ignite this natural capacity to survive and grow.

These qualities have also been identified as attributes of effective 'key working', since the FRC worker may also be the family's key worker: 'For families, the distinguishing features of 'good' key workers were: proactive contact; a supportive, open relationship; a holistic family-centred approach; working across agencies; working with families' strengths and ways of coping; and working for the family as opposed to the agency. When these elements were in place, families clearly felt the service was beneficial and offered a different form of support from other services they received.'[145]

The focus on generic aspects of helping, referred to as 'the common factors framework', is also associated with a growing recognition of the need for a feed-back loop from clients to the service provider in order to ensure that interventions are 'client-directed and outcome-informed'[146]. These two elements - client-directed and outcome-informed – are seen as essential in order 'to engage the clients, heighten hope for improvement, fit client preferences, maximise therapist client fit, and accelerate client change[147]. These aspects of helping are also central to the service delivery model of the Child and Family Support Agency which is characterised by a focus on improving well-being outcomes for children, is child-centred, supports families at all levels of need, and helps to prevent problems by providing universal community-based services[148].

Finally, the focus on common factors is important because it widens the conventional understanding of what is usually meant by 'evidence-informed practice' in working with children and families. In addition to delivering programmes whose effectiveness has already been demonstrated, such as those listed in Table 3, Page 27 (see also Appendix Two), evidence-informed practice also includes the use of common factors associated with better outcomes, particularly effective therapeutic relationships. This wider and more inclusive understanding of evidence-informed practice allows for greater flexibility in responding to the needs of children and families[149] while also suggesting that the uptake of evidence-based approaches in family support and related disciplines such as social care and social work may be more widespread than is generally reported[150].

11. Training Requirements for Family Support Strategy

Training may be required to ensure that staff have the knowledge, skills and attitudes to deliver the strategy confidently and effectively. By its nature, this training must provide staff with a clear conceptual understanding of the rationale for the strategy and the set of skills and attitudes to work with parents and children in a way that builds trust and strengthens their natural capacity to overcome difficulties and live life to the full. The basic minimum requirement is that all staff should feel competent and confident in responding to the different themes and issues listed in Table 8.

Table 8 Staff Training Required to Implement Strategy

Knowledge
What is a family?
Why are families important?
What influences family well-being?
What are the different types of family support?
What is the essence of a helping relationship?
What is a community development approach to helping families?
What are the needs of families in the area?
What outcomes will the strategy seek to achieve?
What actions, programmed and developmental, will produce these outcomes?
What processes need to be put in place to prepare a strategy for supporting families?
How will the strategy be monitored, evaluated and revised?
Are there legal issues to be considered in supporting families?

Skills
How to work effectively as a team to develop and implement strategy
How to link needs, actions and outcomes into a logical strategic framework
How to lead and facilitate local people to develop and implement the strategy
How to communicate with local people, individually and collectively, about the strategy
How to build commitment to the strategy among parents and children
How to work out a realistic timeframe for implementing the strategy
How to decide on most appropriate actions, both programmed and developmental
How to work with external agencies to develop and implement strategy
Attitudes
Clear awareness of self, and one's patterns of thought, feeling and relating
Empathic understanding of how others, especially families, see themselves and the world
Commitment to equality and human rights. Respecting diversity and boundaries
Acting in a way that is positive, practical, pragmatic and for the best outcome for families
Commitment to ensure that *process* leads to *action* and to *outcome*
Openness to collaborative working within FRC and with outside agencies
Taking responsibility for learning through reflective practice and constructive criticism

Most staff currently employed by FRCs already have significant skills, knowledge and experience in community development. Additional training may be required under some of the following headings. Many are generic areas and core to existing activity within FRCs. Where areas of training are additional to those already provided, they should be incorporated into the existing training programmes of the Regional Support Agencies. These agencies have an essential role in providing training, advice and support, and monitoring FRCs on behalf of the Family Support Agency.

12. Supervision and Support for Family Support Strategy

The underlying rationale for the strategy is that close personal relationships, particularly in the family, are central to the well-being of parents and children. For the same reason, it is also important that staff who deliver the strategy have supportive relationships at work in the form of structured supervision and guidance. In other words, supervision is not only about staff accountability, but involves a commitment to nurture and guide staff so that they have the tools to engage successfully with families. As such, supervision is not an alternative to human resource policies; it is a particular form of support necessitated by the requirements of supporting individuals, families and communities. Supervision requires an openness to reflective practice, both individually and as part of a group, and an openness to accept honest and constructive criticism. In the same vein, it implies a healthy relationship to one's weaknesses as well as strengths, and a recognition that this relationship directly influences how one relates to others, including families[151].

Supervision provides an opportunity for staff to reflect upon and cope with the stresses and demands of supporting individuals, families and communities. As such, it is an important aspect of building a safe and healthy climate for staff and should offer the same qualities of care for staff that they, in turn, are expected to offer others, including opportunities for positive change. Naturally, this is not always easy since most people find it difficult to admit, personally or professionally, that they are vulnerable, in need of help, or unsure what to do. The availability of structured supervision communicates the message that there will be times when staff may not know what to do, but that there is someone – at a particular time and place - dedicated to helping them express feelings, solve problems, and find solutions. For this reason, the existing support and supervision practices recommended and maintained by the Regional Support Agencies should reflect the material outlined in Table 9.

Typically, supervision provides an opportunity for staff to reflect, with their supervisor, on questions like those listed in Table 9. Through this process, staff are facilitated to grow, just as, through the strategy, they facilitate individuals and families to grow.

Table 9 Questions for Staff to Explore in Supervision

What are your strengths in terms of working with individuals, families and communities? What do you see as your weaknesses or areas for growth?
What are you bringing to the role of supporting individuals, families and communities from your training, and from your life experiences? How do these things help you - or hinder you - in your work?
What does this work mean to you personally? What are the things about it that you connect to meaningfully?
What are the aspects that challenge you, or even scare or worry you?
How do you deal with the stresses or challenges that arise in supporting individuals, families and communities?
What do you need in your role to do the best work you can do, and to grow in your role? How can supervision meet some of these needs?

Supervision can be one-to-one or in groups. The strategy includes both options but there may be particular merit in regionally-based group sessions since this provides a greater variety in the range of experience available for reflection and learning. The supervisor requires substantial professional experience in working with individuals, families and communities, as well as facilitation skills.

13. Monitoring and Evaluating the Family Support Strategy

The purpose of this strategy, as indicated above (Section 7), is to improve the well-being of children and their families as expressed through the five national outcomes for children. These five outcomes cover the areas of: (i) health (ii) education (iii) safety (iv) income (v) participation. In order to know if the strategy is working it is necessary to monitor and evaluate its performance in each of these areas since that is the basis for its accountability to both the Child and Family Support Agency[152] and the Department of Children and Youth Affairs[153].

Monitoring performance requires a minimum dataset which is prepared annually and enumerates the activities, beneficiaries and resources in each of the five outcome areas. A minimum dataset is the standard tool used to monitor the performance of public programmes and, as the term suggests, is designed to collect the minimum data necessary to give a national overview of the programme while minimising the burden of data collection on those delivering the programme. Minimum datasets also facilitate the setting of targets and assessing whether they are met, including identification of sources of variation in meeting targets.

Table 10 sets out the broad parameters of the minimum dataset for this strategy and the FRC programme generally. It is based on the five national outcomes for children and the corresponding activities to achieve those outcomes (developmental and programmed activities), the beneficiaries of those activities (communities, adults & parents, children) and resources allocated to each outcome area (financial and staff time). A substantial amount of further work is required to turn the template in Table 10 into a user-friendly on-line system of data collection for the FRC programme. The monitoring system for the FRC programme, called SPEAK[154] – has been updated in line with the template in Table 10.

Table 10 Template for Minimum Dataset for FRC Programme

Categories of Data to be collected at end of each year	Outcome Areas				
	1. Health	2. Education	3. Safety	4. Income	5. Participation
Activities in each outcome area: • List the names of main developmental activities • List the names of main programmed activities					
Beneficiaries in each outcome area: **Developmental Activities** • Type of beneficiary (community, adults & parents, children) for each main developmental activity • Characteristics of adults & parents (age group, gender, family status, income support) for each main developmental activity • Characteristics of children (age group) for each main developmental activity					
Beneficiaries in each outcome area: **Programmed Activities** • Type of beneficiary (community, adults & parents, children) for each main programmed activity • Characteristics of adults & parents (age group, gender, family status, income support) for each main programmed activity • Characteristics of children (age group) for each main programmed activity					

Resources for all outcome areas combined: • List the amount of funding from each source • State no. of individual staff and no. of whole-time equivalent staff				
Resource Allocation to each outcome area: • % staff time devoted to developmental activities • % staff time devoted to programmed activities • % staff time devoted to management and administration				

Notes: The full statement of outcome in each area is:
1. Health= Healthy physically, mentally and emotionally
2. Education= Supported in active learning
3. Safety= Safe from accidental and intentional harm / Secure in the immediate and wider physical environment
4. Income= Economically secure
5. Participation= Part of positive networks of family, friends, neighbours and the community / Included and participating in society

In addition to monitoring, it is also necessary to undertake periodic programme evaluations. This is necessary in order to assess the impact of a programme. Unlike monitoring data which is typically 'cross-sectional' in the sense that it provides an annual snap-shot of the programme, evaluation data is typically 'longitudinal' in the sense that it measures change over time by reference to an appropriate baseline or standard. There have been reviews of the FRC programme[155] but no systematic evaluation has been undertaken although an evaluation framework has been prepared for the FSA[156]. Given that scientific evaluations are relatively infrequent because they are also relatively complex and expensive undertakings, the need for an annual review of the FRC strategy is important. The format for each local family support strategy described above (Section 9) – based on the needs, actions, and targets in each outcome area – lends itself to systematic annual review using the questions outlined in Table 11.

Table 11 Evaluation Questions for Annual Review of Family Support Strategy

Question
What evidence is available to show that progress has been made in each of the five outcome areas for children, adults and parents, communities?
Can this evidence be corroborated from more than one source?
If the evidence suggests that little or no progress has been made in some or all of the outcome areas, what are the reasons for this?
What changes are needed to improve the size and sustainability of outcomes in each area?
What are the most important lessons that have been learned from the strategy about how to support families in each of the five outcome areas?

Appendix One: Definitional Material developed by the Family Resource Centre National Forum

This material, which provides important supporting documentation on the role of family support within the Programme, was developed for the Programme by the Family Resource Centre National Forum and agreed with the Family Support Agency in 2011.

Family Resource Centre National Forum (FRCNF)
Family Support Position Paper

Background

There are 106 Family Resource Centres (FRCs) within the national network of centres. Each FRC operates autonomously working inclusively with individuals, families, communities and both statutory and non-statutory agencies. The FRC as a contributor in a participatory process strengthens the capacity of families and communities to identify their own priorities and opportunities (See: Chaskin, 2006:44). Subsequently, collective local integrated responses can be formulated. These can potentially be a "best-fit" in respect of location, timing, setting and changing need with a particular individual (adult or child), family or community to promote positive change.

In the current economic climate family support offers a cost effective option. Interagency co-operation prevents possible duplication and by drawing upon available informal and formal sources of support, both financial and human resources can be maximised. The FRC local dimension means the range of responses may vary from one centre to the next. It is acknowledged that core activities are available nationwide e.g. information and advice at a local level, practical assistance to community groups and education and training opportunities. Perhaps the FRC association with a range of diverse responses "muddies the waters" among the wider population of what family support actually is?

Dolan (2006:11) outlines that governments, agencies, workers and families recognise family support as an effective approach to protect the rights of the family, children and youth and improve outcomes, yet a universal definition is lacking. Dolan (2006) argues that the position of family support in terms of services, policy and organisational contexts would be strengthened through the development of a definition and theoretical underpins. To contribute to this debate Dolan (2006:16) offers the following definition:

> Family support is recognised as both a style of work and a set of activities that reinforce positive informal social networks through integrated programmes. These programmes combine statutory, voluntary, community and private services and are generally provided to families within their own homes and communities. The primary focus of these services is on early intervention aiming to promote and protect the health, well-being and rights of all children, young people and their families. At the same time particular attention is given to those who are vulnerable or at risk.

Dolan (2006) provides 10 practice principles to accompany this definition. Family support practice requires a mixture of description and questioning informed by action, a basis for reflective practice, to promote positive outcomes.

Drawing upon Dolan's (2006) work, a facilitated session was held with a sub-committee of the FRCNF to complete two tasks:

- To draft a working definition of family support
- To list the core elements which are applicable to practice in all FRCs.

It was important that the definition would facilitate the continuous autonomy of the FRC's. But simultaneously, provide a boundary for FRC to operate within, but also sets them apart from other initiatives and services.

Session outcomes
Working definition of community based family support:

> *Supporting families and individuals in communities to identify their family and local needs; to collectively develop holistic responses and enhance participation in wider community life.*

To tease out the wording of the definition:
- "supporting" and "collectively" indicates the FRC in a support and partnership role
- The target group "families"
- The context is the "family" and "communities"
- Purpose: to identify family need and local needs
- Action: planning and implementation of collective formulation of holistic responses
- Anticipated outcome: enhanced participation in wider community life

Core elements
In total six practice principles were named: 1) participation; 2) equality; 3) awareness raising; 4) early intervention; 5) strengths-based and 6) advocacy.

1. Participation:
As a core principle voluntary participation is applied to all FRC activities. By working in this way the feelings, wishes and expectations of individuals as members of a family and a community can be acquired. As a process participation may reinforce and build self-esteem by valuing the inputs of participants (Dolan, 2006). The inclusion of people in decision-making, planning, implementation, review and evaluation of integrated responses intended for individual, family or community level provides a sense of social connectedness and a belief it is possible to make a difference (Evans and Prilleltensky, 2005). As a process the opportunity exists to reflect upon agreed targets, actual outcomes and planning for future practice to enhance the promotion of rights and the well-being of children, young people and families (Dolan, 2006).

2. Equality:
As a principle, equality is applied to all aspects of the FRC by working with the whole community in a transparent and non-stigmatising manner while targeting those most in need (FRCNF, 2009). The conscious application of methods suitable for rural and urban areas endeavours to promote the social inclusion of groups experiencing marginalisation to participate at all levels of FRC including Voluntary Management Committees (FSA et al., 2010).

3. Awareness raising:
To raise awareness within communities of available existing resources or services. Utilising different culturally appropriate communication methods e.g. home visits, media, outreach, leaflet drops and information desks to encourage individuals and families to access potential sources of support
To raise awareness of locally identified needs and possible participation in responding to those needs
To raise awareness of broader society to consider the barriers or structural inequalities that families and communities face and who controls the services and resources that they require (Evans and Prilleltensky, 2005).

4. Early intervention:
Through a proactive approach, integrated partnerships combining inputs from informal and formal supports can be formed. These partnerships agree local responses that work in the home and community contexts, providing valuable protective sources of support. As early interventions these are provided to promote child and family rights and well-being as paramount and prevent the entry or re-entry of children into the child protection system (FRCNF, 2009).

5. Strengths-based:
In the daily lives of children and adults, informal supports and strengths can be drawn from the family unit, the extended family, friends and the community. Formal supports are located within organisations e.g. clubs, schools, churches, health services, justice system. Individuals working in these organisations can be a source of support and strength (Gilligan, 2001). Depending upon the locally identified needs, existing strengths and newly identified strengths can be mobilised from both informal and formal sources to respond to the need and improve outcomes (Dolan, 2006).

6. Advocacy:
When a FRC is not in a position to respond to an immediate issue e.g. homelessness, established networks can be utilised to provide access routes to agencies offering the appropriate service.
At a local, regional and national level by sharing information with practitioners and policy makers regarding family and community challenges and priorities and family interventions which have proven successful. They potentially may exist to inform future practice and policy that promote the rights and well-being of children, young people and families, especially those that experience marginalisation.

Chaskin, R.J. in Dolan, P., Canavan, J. and Pinkerton, J. (Editors). (2006). Family support as community-based practice: Considering a community capacity framework for family support provision in Family Support as Reflective Practice. London and Philadelphia. Jessica Kingsley Publishers

Dolan, P. in Dolan, P., Canavan, J. and Pinkerton, J. (Editors). (2006). Family support: From description to reflection in Family Support as Reflective Practice. London and Philadelphia. Jessica Kingsley Publishers

Evans, S. & Prilleltensky, I. in Ungar M (Editor) (2005). Youth civic engagement: promise and peril in Handbook for working with children and youth: Pathways to resilience across cultures and contexts. London, California and New Delhi. Sage.

Family Resource Centre National Forum. (2009). Suggested ways in which the Family and Community Services Resource Centre Programme can further develop Family Support Services. Ireland. Family Resource Centre National Forum.

Family Support Agency and the Family Resource Centre National Forum (2010). Impact of Family Resource Centres in Ireland. Ireland. Family Support Agency and the Family Resource Centre National Forum.

Gilligan, R. in Horwarth (Editor). (2001). Promoting positive outcomes for children in need: The assessment of protective factors in The child's world reader. Sheffield, University of Sheffield.

Location of FRCs within the 'Hardiker' Model

Family Support Services
Children and families can access services at appropriate levels to meet their assessed needs.

Intensive and long term support for children and families in chronic difficulty

Level 4

Services for children and families with severe difficulties

Level 3

Support Services for children and families in need

Level 2

Indicates referral to Social Services

Universal service and Community Development

Level 1

As FRC's are locally–based and work on the ground with families and children on a daily basis, they are in touch with communities and therefore act as part of a child protection support system whereby support and services are provided to prevent entry / re-entry into the child protection system.

Appendix Two: Programmes for Parents & Children in Ireland

Programme (Listed by Age of Child)	Age of Child	Description	Contact Details
Community Mothers	0-2 years	The Community Mothers Programme aims to support the development of parenting skills, and enhance parents' confidence and self-esteem. It is delivered by non-professional volunteer mothers, known as 'community mothers', who are recruited, trained and supported by Public Health Nurses. Community mothers are recruited to reflect the ethos of the community and visit parents once a month in their own homes, providing information in a non-directive way to foster parenting skills and parental self-esteem.	www.communitymothers.ie www.hse.ie Community Mothers Programme, 1st Floor, Park House, North Circular Road, Dublin 7. Ph: (01) 838 7122 brenda.molloy@mailf.hse.ie
Lifestart	0-5 years	Lifestart is a programme for the parents of 0-5 year old children. The programme is a parent-directed learning programme on child development and comprises a structured month-by-month curriculum of knowledge, information and practical-learning activity for parents. Lifestart is delivered by trained family visitors in the parent's own home. Its rationale is that, by educating parents on how their children grow and learn, this helps parents to support their child's physical, intellectual, emotional and social development.	www.lifestartfoundation.org Lifestart National Office, Church Street, Sligo, Ireland. Ph: (071) 915 1114
High/Scope	0-5 years	High/Scope is an educational system for children from infancy through the pre-school years. It is based on the belief that young children are active learners who learn best from pursuing their own interests while being actively supported and challenged by adults. High/Scope Ireland has a team of trainers who provide training and support for groups working in the community, statutory and independent sectors.	www.highscope.ie Ph: (01) 492 3711 triciamurphy@eircom.net

Parents Plus	(i) 1-6 yrs (ii) 6-11 yrs (iii) 11-16 yrs	Parents Plus was developed in Ireland by John Sharry at the Mater Child and Adolescent Mental Health Service. It consists of three age-related programmes. The focus is to build on parents' strengths and help them to solve discipline problems but also to have more enjoyable and satisfying relationships with their children. The programme includes educational DVD's, a leader's manual, and participant handouts. Homework for the participants is also included in the packs, as well as a text book and a parents' book.	www.parentsplus.ie Parents Plus, c/o Mater Child and Adolescent Mental Health Service, Mater Hospital, Dublin 7. Ph: 086 172 1902 admin@parentsplus.ie
Positive Parenting Programme (Triple P)	0-18 years	Triple P is a parenting and family support strategy that aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. The programme consists of 7 weeks, the first 4 weeks are face-to-face sessions, next 2 weeks are support phone calls and the final week is certification. In Ireland, a significant number of practitioners – including Public Health Nurses, Family Support Workers, Childcare Leaders, Community Mother Volunteers, Community Development Workers and partner facilitators – have been trained and accredited to deliver Triple P to parents.	www.westcd.leaderpartnership.ie www.triplep.net (Practitioners) www.triplep-staypositive.net lwppathlone@eircom.net
Incredible Years	(i) 2-7 (ii) 5-12 years	The programme aims is to improve parenting skills by using video clips, role playing and discussion. The Basic Parent training curriculum is delivered over 12-14 weeks with a two-hour session per week. There are also separate programmes for children and teachers. The programmes are being delivered in Ireland by Archways which was established in January 2007 to promote the rollout and evaluation of the Incredible Years programme in Ireland.	www.archways.ie Archways, Carmac House, Oakfield, Clondalkin, Dublin 22. Ph: (01) 457 6433 info@archways.ie

Strengthening Families	12-18 years	This programme offers support and training to families and is used widely but not exclusively with families who have issues of drugs and alcohol abuse. The entire family must commit to a 14-week programme based around learning skills that will lead to responsible decision-making on issues such as drugs, alcohol and addressing conflict in the home.	www.srdtf.ie
Functional Family Therapy (FFT)	11-18 years	FFT is an evidence based intervention developed in the US. Since September 2007, it is being piloted in Ireland by the Clondalkin Partnership. The programme works with the whole family for this therapy or as many family members as possible.	www.clondalkinpartnership.ie Clondalkin Partnership, Unit D, Nangor Road Business Park, New Nangor Road, Clondalkin, Dublin 22. Ph: (01) 450 8788 pjohnston@clondalkinpartnership.ie

Appendix Three: Guidance on Selecting Programmed Actions

There is general acceptance of the principle that actions such as family support services should only be provided if there is scientific evidence that they produce net benefits for those who receive them. However the application of this principle is often difficult in practice since it depends on what constitutes 'scientific evidence'. If 'top tier' scientific evidence is defined as interventions which 'have been shown, in well-designed randomized controlled trials, to produce sizeable, sustained effects on important outcomes'[157], then relatively few programmes meet this standard. This standard requires more than one randomised-control trial, using psychometrically sound measures and demonstrating positive effects, with at least one significant follow-up. As a consequence, a recent US review, based on this standard, found only two programmes for families with children aged 0-6 which meets this standard of proven effectiveness, despite the existence of 100's of family support programmes[158].
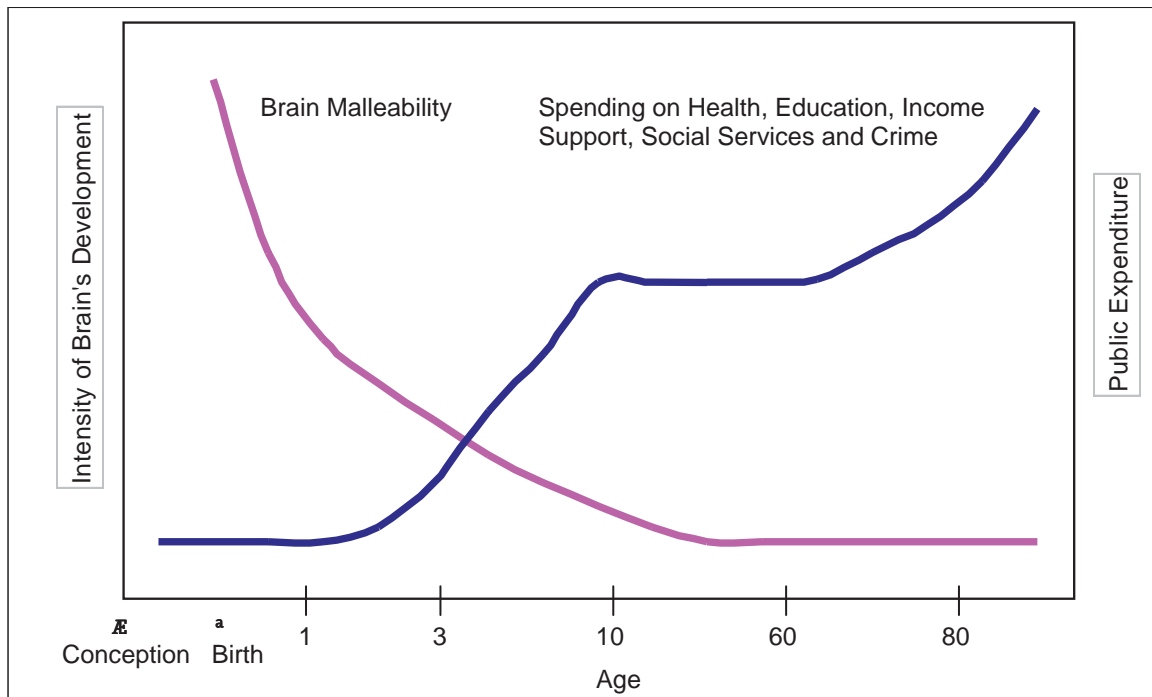
The reason why so few family support programmes meet the 'top tier' standard of scientific proof is that this standard is so high - and the financial resources required to produce it is correspondingly high - with the result that most programmes are not 'proven' in the true scientific sense of the term. Moreover, even when a programme has proven effectiveness, this can only be replicated if it is delivered faithfully according to the manual for that programme and with significant training, support and supervision for staff. In short, finding scientifically proven family support programmes and implementing them is not an easy undertaking.

It is true that many family support programmes meet a lesser standard of proof and show small to modest positive effects. On a scale from 0-1, most family support programmes tend to achieve scores (called effect sizes[159]) in the range 0.2 to 0.5[160]. Effect sizes in this range, though regarded as small, can have substantial implications, particularly where they involve large numbers of children or parents, and when the benefits continue – or grow – over many years. For example, the effect size of the High / Scope Perry Pre-School Programme in the US when participants reached the age of 23 was 0.36[161] but the economic return at age 27 is estimated to be $8 for every $1 invested[162] rising to $17 for every $1 invested by age 40[163]. In the medical field, there are even more dramatic illustrations of how small effect sizes can have considerable practical significance. For example, the effect size of aspirin in reducing heart disease is 0.03, yet is widely prescribed by doctors because the cost of the intervention is cheap and the potential benefits are very large[164].

These considerations need to be borne in mind when choosing a programmed action as part of this strategy since there is some evidence in favour of all the programmes listed in Appendix Two. Moreover, even if the evidence base for a programme is weak this does not imply that it is necessarily a weak programme; it may simply mean that the appropriate studies have not been carried out. Most of the early years programmes in Ireland fit into this category, including Lifestart as well as many pre-school and after-school projects. Equally, programmes for which there is evidence of effectiveness are only likely to remain effective if they continue to be delivered to the highest standard by highly trained, motivated and supervised staff.
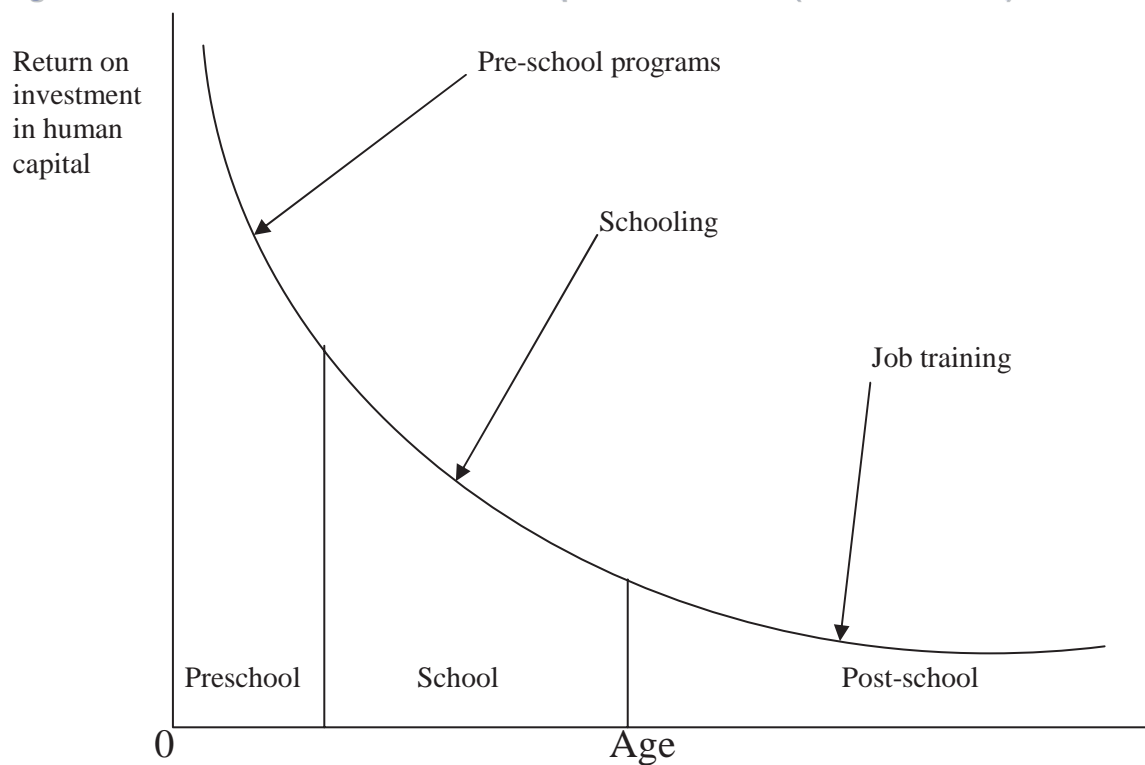
In short, if the decision on programmes is based entirely on evidence of effectiveness, then a case could be made for most of those listed in Appendix Two. That is why other considerations must also be taken into account. One of these considerations is the level of need at different stages of the lifecycle and, within that, the priority to be accorded to families with children in different age categories: 0-6, 7-11, 12-18. It is true that each stage of the life cycle – but especially each stage in the life cycle of a child – has its own risk and protective factors which should be taken into account in deciding on programmes, particularly since the age profile of FRC catchment areas is likely to vary. However this decision should also be informed by the scientific consensus that programmes which target families with children in the 0-6 year-old category offer the best return on investment essentially because they impact on the most important years of the child's development. A synthesis of this knowledge is summarised in Figures A3.1 and A3.2 and shows that all forms of public expenditure are least likely when children are going through these most developmentally important years (0-6) while, correspondingly, the returns from public expenditure tend to diminish as the child grows older[165].

Figure A3.1 Brain Development – Opportunity and Investment

Brain Malleability

Spending on Health, Education, Income Support, Social Services and Crime

Intensity of Brain's Development

Public Expenditure

Æ Conception   ª Birth   1   3   10   60   80

Age

Source: Van der Gaag and Tan, 1998.

Figure A3.2 Rates of return to human capital investment (Heckman 2000)

Return on investment in human capital

Pre-school programs

Schooling

Job training

Preschool   School   Post-school

0   Age

Source: Cunha, Heckman, Lochner, Masterov, 2006.

In deciding on the most effective way to support families, the choice of programmes should also be informed by the solid scientific consensus that the quality of parent-child interactions is one of the best predictors of normal healthy development for a child. Evidence for this was cited above drawing on both attachment theory and the US NICHD Study of Early Child Care. Additional evidence from the NICHD study also draws attention to the importance of 'family characteristics' in shaping outcomes for children and their parents since this is also relevant to the selection of programmes. For example, the NICHD study found that family characteristics – notably parents' education; family income; two-parent family compared to single-parent family; mothers' psychological adjustment and sensitivity; and the social and cognitive quality of home environment – had both a direct influence on child outcomes but also an indirect influence through the quality of mother-child interactions[166]. In other words, child outcomes can be enhanced through programmes which improve the quality of parent-child interactions *and* through programmes which address any of the family characteristics listed above. In short, the overwhelming scientific evidence suggests that programmes which address any aspect of parental well-being – but especially parent-child interactions – is likely to have greater impact on outcomes for both children and parents[167].

Leaving aside scientific considerations, there are also a number of practical considerations which will influence the choice of programmes in the strategy. The first is the suitability and acceptability of the programme to residents since programmes will only work if the intended target group is motivated and interested in participating. This draws attention to the need to consult families before deciding on any programme in order to make sure that it is appropriately tailored to their needs, and delivered at a time which facilitates their participation. Consultation with families may also help identify if particular supports – such as child care - have to be put in place to sustain and maximise participation.

The second practical consideration is that the programme should already be available in Ireland with access to training on how to deliver it. All of the programmes listed in Appendix Two meet this criterion and some also provide facilitators to deliver the programme. The existence of these options allows each FRC to engage in a period of experimentation with different programmes to identify which one(s) meet the particular need of residents. Similarly, there may be merit in commissioning different facilitators of programmes – such as One Family, Barnardos, Lifestart, High / Scope, Archways – to establish what works best in terms of both programmes and models for delivering them.

In summary, the best scientific evidence suggests that the primary focus of the strategy should be on parents, and the parent-child relationship in particular, since this is one of the most powerful influences on the well-being of all family members. It is true that children have needs at all ages but the scientific evidence also suggests that greater weight should be given, other things being equal, to the needs of children in the 0-6 age category. As indicated, local circumstances may indicate some modification to these core principles and the guidance offered here may help create awareness of the implications of these modifications. Table A3.1 summarises this guidance in the form of a set of questions that should be considered when deciding on a particular programme

Table A3.1 Questions to Consider When Selecting a Programme

Questions
Does the programme focus on parent capacity to nurture and support the normal healthy development of the child?
Is the programme suited to the largest age group of children / families in the catchment area?
Has the importance of targeting children aged 0-6 years been considered?
Have the community been consulted about the suitability and acceptability of the programme?
Have practical concerns been considered – such as when the programme is held, availability of childcare, provision of refreshments, etc – to ensure maximum participation in the programme?
Have the training implications of delivering the programme by FRC staff been considered?
What supports would be available for FRC staff if delivering the programme, especially for the first time?
Could the programme be delivered by external facilitators in collaboration with FRC staff?

Bibliography

Ainsworth, MDS., 1991. 'Attachments and other Affectional Bonds Across the Life Cycle', in Parkes, CM., Stevenson-Hindle, J., and Marris, P., (Editors), Attachment Across the Life Cycle, pp.33-51, New York: Tavistock/Routledge.

Allen, G., 2011. Early Intervention: The Next Steps, An Independent Report to Her Majesty's Government, January, London: Cabinet Office.

Amato, PR., and Booth, A., 1997. A Generation at Risk: Growing Up in an Era of Family Upheaval, Harvard: Harvard University Press.

Asay, TP., and Lambert, MJ., 1999. 'The Empirical Case for the Common Factors in Therapy: Quantitative Findings', in Hubble, MA., Duncan, BL., and Miller, SD, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington DC: American Psychological Association, pp.33-56.

Barnett, WS., 1996. Lives in the balance: Age 27 benefit-cost analysis of the High / Scope Perry Preschool Program, Ypsilanti, MI: High / Scope Press.

Barth, RP., Lee, BR., Lindsey, MA., Collins, KS., Strieder, F., Chorpita, .F., Becker, KD. & Sparks, JA., 2012. 'Evidence-based practice at a crossroads: the timely emergence of common elements and common factors', Research on Social Work Practice 22 (1), 109-119.

Barton, Y., and Fitzgerald, M., 1986. 'A Study of Behavioural Deviance in 10 and 11 Year Old Irish Girls in an Urban Area', Irish journal of Medical Science, March, pp.80-82.

Bergin, AE., and Garfield, SL., (Editors) 1994. Handbook of Psychotherapy and Behaviour Change, (4th Edition) New York: John Wiley & Sons.

Bowlby, J., 1979. The Making and Breaking of Affectional Bonds, London: Tavistock.

Bradshaw, J., Stimson, C., Skinner, C., and Williams, J., 1999b. 'Non-Resident Fathers in Britain', in McRae, S., (Editor), Changing Britain: Families and Households in the 1990s, pp.404-426, Oxford: Oxford University Press.

Bray, JH., and Jouriles, EN., 1995. 'Treatment of Marital Conflict and Prevention of Divorce', Journal of Marital and Family Therapy, October, Volume 21(4), pp. 461-473.

Bronfenbrenner, U., and Morris, P., 2006. 'The Bioecological Model of Human Development', in Lerner, RMV., Damon, W., & Lerner, RMS., (Editors), Handbook of Child Psychology, Vol. 1: Theoretical Models of Human Development, 793-828. Hoboken, NJ: Wiley.

Carr, A., 2004. Positive Psychology: The science of happiness and human strengths, Hove and New York: Brunner-Routledge, pp.13-15.

Central Statistics Office, 2010. Survey of Income and Living Conditions (SILC) 2009, November, Dublin: Stationery Office. Available at: www.cso.ie

Centre for Health Promotion Studies, 2007. Survey of Lifestyle, Attitudes and Nutrition in Ireland: Main Report, Galway: Centre for Health Promotion Studies.

Centre of Excellence for Early Childhood Development, 2011. Encyclopedia on Early Childhood Development. Available at: www.excellence-earlychildhood.ca

Cohen, J., 1988. Statistical Power Analysis for the Behavioural Sciences, Second Edition, New Jersey: LEA.

Commission on the Measurement of Economic Performance and Social Progress, 2009. Report. Available at: www.stiglitz-sen-fitoussi.fr

Commission on the Family, 1996, Strengthening Families for Life, Interim Report, November, Dublin: Stationery Office.

Commission on the Family, 1998, Strengthening Families for Life, Main Report, July, Dublin: Stationery Office. Available at: www.welfare.ie

Cunha, F., Heckman, JJ., Lochner, L., Masterov, DV., 2006. 'Interpreting The Evidence On Life Cycle Skill Formation', in Hanushek, EA., and Welch, F., (Editors), Handbook Of The Economics Of Education, Volume 1, Elsevier, Chapter 12, pp.698-747.

Daly, M, 2004. Families and Family Life in Ireland. Challenges for the Future. Report of the Public Consultation Fora. Dublin: Department of Social and Family Affairs.

Denham, 2009. 'McD. –v- L. & anor'. Available at: www.courts.ie

Department of Children and Youth Affairs, 2012. Statement of Strategy, 2011-2014, Dublin: Department of Children and Youth Affairs. Available at www.dcya.ie

Department of Community, Rural and Gaeltacht Affairs, 2007. National Development Plan 2007-2013, Consultation Process for the New Programme Period - Background Paper. Community Development Unit, Dublin: Department of Community Rural and Gaeltacht Affairs.

Department of Health and Children, 1999. Children First: The National Guidelines for the Protection and Welfare of Children, September, Dublin: Stationery Office. Available at www.dohc.ie

Department of Health and Children, 2000. The National Children's Strategy: Our Children – Their Lives, November, Dublin: Stationery Office. Available at www.dohc.ie

Department of Health and Children, 2001a. Quality and Fairness: A Health System For You, Health Strategy, Dublin: Stationery Office. Available at www.dohc.ie

Department of Health and Children, 2001b. Primary Care Strategy: A New Direction, Dublin: Stationery Office. Available at: www.dohc.gov.ie

Department of Health and Children, 2007. The Agenda for Children's Services: A Policy Handbook, Dublin: Office of the Minister for Children and Department of Health and Children. Available at: www.dohc.gov.ie

Department of Health and Children, 2008a. National Strategy for Service User Involvement Dublin: Department of Health and Children. Available at: www.dohc.gov.ie

Department of Health and Children, 2008b. National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, 2008. Dublin: Office of the Minister for Children and Department of Health and Children. Available at: www.dohc.gov.ie

Department of Health and Children, 2009. Report of the Commission to Inquire into Child Abuse, 2009: Implementation Plan, Dublin: Office of the Minister for Children and Department of Health and Children. Available at: www.dohc.gov.ie

Department of Social, Community and Family Affairs, 2000. White Paper on a Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary sector, Dublin: Department of Social, Community and Family Affairs.

Department of Social, Community and Family Affairs, 2007. National Action for Social Inclusion 2007-2016, Dublin: Stationery Office. Available at www.pobail.ie

Duncan, G., Magnuson, K., Boyce, T., and Shonkoff, J., Undated. The Long Reach of Early Childhood Poverty: Pathways and Impacts – Q&A, Harvard: Center on the Developing Child at Harvard University. Available at: www.developingchild.harvard.edu

Dublin Hospitals Group Risk Management Forum, 2006. Guidelines in relation to Obtaining Patient Consent, Dublin: Dublin Hospitals Group Risk Management Forum.

European Court of Human Rights, 1994. Judgement in the Case of Keegan v. Ireland, Strasbourg: European Court of Human Rights.

Every Child Matters, 2003. Presented to Parliament by the Chief Secretary to the Treasury by Command of Her Majesty, September 2003, London: Crown Copyright.

Expert Group on Mental Health Policy, 2006. A Vision for Change: Report of the Expert Group on Mental Health Policy, Dublin: Stationery Office.

Fahey, T. and Russell, H., 2001. Family Formation in Ireland. Trends, Data Needs and Implications. Policy Research Series No. 43, Economic and Social Research Institute, Dublin.

Fahey, T. and Field, A., 2008. Families in Ireland. An Analysis of Patterns and Trends, November, Dublin: Stationery Office.

Family Support Agency, 2005. Submission of the Family Support Agency to the All Party Oireachtas Committee on the Constitution, February 2005, Dublin: Family Support Agency.

Farrelly, T., 2009. 'Evidence-based Practice in Social Care', Share P., and Lalor, K., (Editors), Applied Social Care: An Introduction for Students in Ireland, Second Edition, (pp.150-162), Dublin: Gill & Macmillian.

Field, F., 2010. The Foundation Years: Preventing poor children becoming poor adults, The report of the Independent Review on Poverty and Life Chances, December, London: Cabinet Office. Available at: www.frankfield.co.uk.

Fitzgerald, M., and Jeffers, A., 1994. 'Psychosocial Factors Associated with Psychological Problems in Irish Children and their Mothers', The Economic and Social Review, Volume 25, Number 4, pp.285-301.

Fredrickson, B., 2002. 'Positive Emotions', in Snyder, CR., and Lopez, S., (Editors), Handbook of Positive Psychology, pp.120-134, New York: Oxford University Press.

Geoghegan, 2009. 'McD. –v- L. & anor'. Available at: www.courts.ie

Gilligan, R., 2000. 'Family Support: Issues and Prospects', pp.13-34, in Canavan, J., Dolan, P., and Pinkerton, J., (Editors), Family Support: Direction from Diversity, London: Jessica Kingsley Publishers.

Haase, T., and Pratschke, J., 2005. Deprivation and its Spatial Articulation in the Republic of Ireland: New Measures of Deprivation based on the Census of Population, 1991, 1996, 2002, June, Dublin: Area Development Management Limited [now Pobal]. Available at www.pobal.ie

Haase, T., and McKeown, K., and Pratschke, J., 2008. Children, Families & Neighbourhoods in the Bray and Wicklow Area, Unpublished, Bray: Bray and Wicklow Partnerships.

Haase, T., 2009. The Well-being of Residents in the Liberties Regeneration Area, Unpublished, Dublin: Dublin City Council in association with the Dublin Inner City Partnership and The Digital Hub.

Hardiker, P., 2002. 'A framework for conceptualising need and its application to planning and providing services', pp.49-70 in H. Ward and W. Rose (EDs) Approaches to needs assessment in children's services. London: Jessica Kingsley Publishers.

Harold, G., Pryor, J., and Reynolds, J., 2001. Not in Front of the Children? How Conflict Between Parents Affects Children, London: One Plus One Marriage and Partnership Research.

Howe, D., 1999. 'The Main Change Agent in Psychotherapy is the Relationship Between Therapist and Client', in Feltham, C., (Editor), Controversies in Psychotherapy and Counselling, London: Sage Publications, pp.95-103.

Hubble, MA., Duncan, BL., and Miller, SD., (Editors), 1997. The Heart and Soul of Change: What Works in Therapy, Washington: American Psychological Association.

HSE, 2008. National Strategy for Service User Involvement in the Irish Health Service, Dublin: Health Services Executive. Available at: www.hse.ie

HSE, 2012. National Service Plan 2012, January, Dublin: Health Service Executive. Available at www.hse.ie

Inquiry Team to the Roscommon Child Care Case, 2010. Report to the Health Service Executive, November, Dublin: Health Services Executive. Available at www.hse.ie

Janssen, AL., Macleod, RD., and Walker, ST., 2008. 'Recognition, reflection, and role models: Critical elements in education about care in medicine', Palliative and Supportive Care (), 6, 389–395.

Jeyes, G., 2012. Once in a Generation, Presentation to Conference of National Forum of Family Resource Centres, Navigating the Future, Croke Park Conference Centre, Dublin, 7th November.

Karoly, L.A. et al., 1998. Investing in Our Children. What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions. Santa Monica, California: RAND.

Kelleher, P., and Kelleher, C., 1997. Family Resource Centres: A Report Commissioned by the Department of Social, Community and Family Affairs, June, Dublin: Stationery Office.

Kiecolt-Glaser, J.K. and Newton, T.L., 2001. 'Marriage and Health: His and Hers', Psychological Bulletin.

Lamb, M., 1999. 'Noncustodial Fathers and Their Impact on the Children of Divorce', in Thompson, RA., and Amato, PR., (Editors), The Postdivorce Family: Children, Parenting and Society, pp.105-125, London: Sage.

Layzer, J., Goodson, B., Bernstein, L., & Price C., 2001. National Evaluation of Family Support Programs: Volume A: The Meta-Analysis. April Cambridge MA: ABT Associates Inc.

Leonard, H, 1995. 'The Stroke of a Pen', in Hyde, T., (Editor), Fathers and Sons, Dublin: Wolfhound Press, pp.36-38.

Lord Laming, 2003. The Victoria Climbié Inquiry, Report, January, London: Crown Copyright.

Lynch, K., Fitzgerald, M., and Kinsella, A., 1987. 'The prevalence of Child Psychiatric Disorder in 10 and 11 Year Old Boys in an Urban School', Irish Journal of Psychiatry, Autumn, pp.20-24.

Lunn, P., Fahey, T., and Hannan, C., 2009. Family Figures: Family Dynamics and Family Types in Ireland, 1986-2006, Dublin: Economic and Social Research Institute.

McCarthy, PW., and O'Boyle, CA., 1986. 'Prevalence of behavioural maladjustment in a social cross-section of Irish urban school children', Irish Medical Journal, Vol 79, No 5, pp.125-129.

McCartney, K., and Dearing, E., 2002. 'Evaluating Effect Sizes in the Policy Arena', The Evaluation Exchange Newsletter, Spring, Harvard Family Research Project.

McKeown, K., 2000. Supporting Families: A Guide to What Works in Family Support Services for Vulnerable Families, October, Dublin: Stationery Office. Available at www.doh.ie

McKeown, K., 2001a. Fathers and Families: Research and Reflection on Key Questions, December, Dublin: Stationery Office. Available at: www.doh.ie

McKeown, K., 2001b. 'Families and Single Fathers in Ireland', Administration: Journal of the Institute of Public Administration, Volume 49, No 1, Spring, pp. 3-24.

McKeown, K., Ferguson, H., and Rooney, 2001. Changing Fathers? Fatherhood and Family Life in Modern Ireland, Cork: Collins Press.

McKeown, K., and Sweeney, J., 2001. Family Well-being and Family Policy: Review of Research on Benefits and Costs, June, Dublin: Stationery Office. Available at: www.doh.ie

McKeown, K., and Haase, T., 2006. The mental health of children and the factors which influence it: A study of families in Ballymun. Dublin: youngballymun. Available at www.youngballymun.org.

McKeown, K., and Haase, T., 2007. Understanding the Needs of Children – A Study of Needs and their Determinants in Limerick and Thurles, Unpublished, Dublin: Barnardos.

McKeown, K., Haase, T., Pratschke, J., Lanigan, C., Burke, S., Murphy, N., and Allen, L., 2008. The Well Being of Parents, Children & Neighbourhoods: A National Study of Families in Respond! Housing Estates, Dublin and Waterford: Respond!.

McKeown, K., 2011a. 'Inter-Agency Cooperation in Services for Children and Families: On why a good inter-agency process alone may not guarantee better outcomes', Administration: Journal of the Institute of Public Administration, vol. 59, no. 2 (2011), pp. 27–47.

McKeown, K., 2011b. Framework for Evaluation of Family Resource Centres Programme, December, Unpublished. Dublin: Family Support Agency.

McKeown, K., 2012. 'Inter-Agency Cooperation Between Services for Children and Families in Ireland: Does it improve outcomes?', Journal of Children's Services, Forthcoming.

Mahon, E., Conlon, C., and Dillon, L., 1998. Women and Crisis Pregnancy. Dublin: Stationery Office.

Markman, H.J., 1991. 'Constructive Marital Conflict is not an Oxymoron', Behavioural Assessment, Volume 13, pp. 3-96.

Martin, M., Carr, A., Carroll, L., and Byrne, S., 2005. The Clonmel Project: Mental Health Service Needs of Children and Adolescents in the South East of Ireland: A Preliminary Screening Study, Clonmel: Health Services Executive, Psychology Department.

Meltzer, H., Gatward, R., Goodman, R., and Ford, F., 2000. Mental health of children and adolescents in Great Britain. London: The Stationery Office.

Melhuish, E., Belsky, J., Anning, A., Ball, M., Barnes, J., Romaniuk, H., Leyland, A., and the NESS Research Team, 2007. 'Variation in community intervention programmes and consequences for children and families: the example of Sure Start Local Programmes' Journal of Child Psychology and Psychiatry 48:6 (2007), pp 543–551.

Melhuish, E., and Hall, D., 2007. 'The policy background to Sure Start', in Belsky, J., Barnes, J., and Melhuish, E., (Editors), The National Evaluation of Sure Start: Does area-based early intervention work?, Bristol: The Policy Press, pp.3-21.

Miller, SD., Duncan, BL., and Hubble, MA., 1997. Escape from Babel: Towards a Unifying Language for Psychotherapy Practice, London: WW Norton and Company**.**

Minister for Finance, 2010. Financial Statement Of The Minister For Finance Mr. Brian Lenihan, T.D., 7 December 2010. Available at: http://budget.gov.ie

Minister for Social and Family Affairs, 2007. 'Speech by Seamus Brennan TD Minister for Social and Family Affairs at the Celebration to Mark 100 Family Resource Centres', Croke Park, 6th February.

Mohan, D., Fitzgerald, M., and Collins, C., 1998. 'The relationship between maternal depression (antenatal and pre-school stage) and childhood behavioural problems', Irish Journal of Psychological Medicine, Vol. 15, No. 1, pp.10-13.

Morgan, K., McGee, H., Watson, D., Perry, I., Barry, M., Shelley, E., Harrington, J., Molcho, M., Layte, R., Tully, N., van Lente E., Ward, M., Lutomski. J. Conroy, R. Brugha, R., 2008. SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland. Main Report. Dublin: Department of Health and Children.

Mukherjee, S., Beresford, B., and Sloper, P., 1999. Unlocking key working: An analysis and evaluation of key worker services for families with disabled children, December, York: Joseph Rowntree Foundation. Available at: www.jrf.org.uk

National Advisory Committee on Drugs, 2007. Drug Use in Ireland and Northern Ireland 2002/2003, Drug Prevalence Survey: Sedatives, Tranquillisers or Anti-Depressants Use, Results Bulletin 6, Dublin: National Advisory Committee on Drugs. Available at: www.nacd.ie

National Development Plan 2007-2013, 2007. Transforming Ireland, January, Dublin: Stationery Office. Available at www.ndp.ie

National Economic and Social Council, 2005. The Developmental Welfare State, Report Number 113, May, Dublin: National Economic and Social Council. Available at www.nesc.ie

Nelson, G., Westhues, A., & MacLeod J., 2003. A Meta-Analysis of Longitudinal Research on Preschool Prevention Programs for Children. Prevention and Treatment 6 (31).

NICHD Study of Early Child Care and Youth Development, 2006. Findings for Children Up to Age 4.5 Years, Washington, DC: U.S. Government Printing Office. Available at: http://www.nichd.nih.gov/publications

O'Connor, J., Ruddle, H., and O'Gallagher, M., 1988. Cherished Equally? Educational and Behavioural Adjustment of Children: A Study of Schools in the Mid-West Region, University of Limerick: Social Research Centre.

OECD, 2008. OECD Public Management Reviews: Ireland -Towards an Integrated Public Service. Paris: OECD. Available at www.oecd.org

Ogles, BM., Anderson, T., and Lunnen, KM., 1999. 'The Contribution of Models and Techniques to Therapeutic Efficacy: Contradictions Between Professional Trends and Clinical Research', in Hubble, MA., Duncan, BL., and Miller, SD, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington DC: American Psychological Association, pp.201-226.

O'Rourke, M., and Fitzgerald, M., 1985. 'An Epidemiological Study of Behavioural Deviance, Hyperactivity and Physical Abnormalities in a Dublin Primary School Population', Irish Journal of Psychiatry, Spring, pp.10-16.

Oswald, A.J., and Blanchflower, D., 1999. 'Well-Being Over Time in Britain and the USA', unpublished paper, University of Warwick, November.

Pillinger, J., 2010. Formative Evaluation of the Joint Community Participation in Primary Care Initiative, Executive Summary, May, Dublin: Health Services Executive. Available at: www.hse.ie

Plath, D., 2006. 'Evidence-Based Practice: Current Issues and Future Directions', Australian Social Work, Vol. 59, No. 1, March 2006, 56-72.

Plath, D., 2009. 'Evidence-Based Practice', in Grey and Webb (Editors), Social Work: Theories and Methods, SAGE, Thousand Oaks, pp. 172-183.

Porteus, MA., 1991. 'A Study of Behavioural and Emotional Problems in Irish Primary School Children', The Irish journal of Psychology, Vol 13, No. 3, pp.304-315.

Pratschke, J., Haase,T., and McKeown 2011. Well-being and the Family System: A Structural Equation Model of Individual, Relational and Contextual Influences, Growing Up in Ireland Conference, Trinity College Dublin, 1st December 2011.

Rogers, CR., 1957. 'The Necessary and Sufficient Conditions of Therapeutic Personality Change', Journal of Consulting Psychology, Volume 21, pp.95-103.

Schweinhart, LJ., and Weikhart, DP., 1997. 'The High / Scope Preschool curriculum comparison study through age 23', Early Childhood Research Quarterly, Volume 12, pp.117-143.

Schweinhart, LJ., 2004. 'The High / Scope Preschool Study Through Age 40', Ypsilanti, MI: High / Scope Press. Available at www.highscope.org.

Seligman, M., 2002. Authentic Happiness: Using the New Positive Psychology to Realise Your Potential for Lasting Fulfilment, New York: The Free Press.

Sheikh, AA., 2008. The Data Protection Acts 1988 and 2003: Some Implications for Public Health and Medical Research, HRB Discussion Document, July, Dublin: Health Research Board. Available at: www.hrb.ie

Simpson, GA., Bloom, B., Cohen, RA., Blumberg, S., Bourdon, KH., 2005. U.S. children with emotional and behavioral difficulties: data from the 2001, 2002, and 2003 National Health Interview Surveys. Advance data from vital and health statistics; Number 360, June. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2005. Available at http://www.cdc.gov/nchs/data/ad/ad360.pdf.

Shonkoff, JP., and Phillips, DA., (Editors), 2000. From Neurons to Neighbourhoods: The Science of Early Childhood Development, Washington DC: National Academy Press.

Snyder, CR., and Lopez, S., (Editors), 2002. Handbook of Positive Psychology, pp.120-134, New York: Oxford University Press.

Snyder, CR., Michael, ST., and Cheavens, JS., 1999. 'Hope as a Psychotherapeutic Foundation of Common Factors, Placebos, and Expectancies', in Hubble, MA., Duncan, BL., and Miller, SD, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington DC: American Psychological Association, pp.179-200.

Sprenkle, DH., Blow, AJ., and Dickey, MH., 1999. 'Common Factors and Other Non-technique Variables in Marriage and Family Therapy', in Hubble, MA., Duncan, BL., and Miller, SD., (Editors), The Heart and Soul of Change: What Works in Therapy, Washington: American Psychological Association, pp. 329-359.

Statham, J., and Smith, M., 2010. Issues in Earlier Intervention: Identifying and supporting children with additional needs, March, London: Department for Children, Schools & Families and Thomas Coram Research Unit, Institute of Education, University of London. Available at: www.dcsf.uk.

Statham, J., and Harris, A., and Glenn, M., 2010. Strengthening family wellbeing and community cohesion through the role of schools and extended services, May London: The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO). Available at: www.c4eo.org.uk.

Stone, D., Fitzgerald, M., and Kinsella, T., 1990. 'A Study of Behavioural Deviance and Social Difficulties in 11 and 12 Year Old Dublin School Children', Irish Journal of Psychiatry, Spring, pp.12-14.

Sweeney, J., 1998. Why Hold a Job? The Labour Market Choice of the Low-Skilled. PhD. Thesis, 123, Department of Economics, KU Leuven, Belgium.

Tallman, K., and Bohart, AC., 1999. 'The Client as a Common Factor', in Hubble, MA., Duncan, BL., and Miller, SD, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington DC: American Psychological Association, pp.91-132.

Task Force on the Child and Family Support Agency, 2012. Report of the Task Force on the Child and Family Support Agency, July, Dublin: Government Publications. Available at: www.dcya.ie

Taylor-Powell, E., and Henert, E., 2008. Developing a logic model: Teaching and training guide. Madison, WI: University of Wisconsin-Extension, Cooperative Extension, Program Development and Evaluation. http://www.uwex.edu/ces/pdande

Theodossiou, I., 1998. 'The effects of low-pay and unemployment on psychological well-being: a logistic regression approach', Journal of Health Economics, 17.

Thompson, E., Hanson, TL., and McLanahan, SS., 1994. 'Family Structure and Child Well-Being: Economic Resources Versus Parental Behaviors', Social Forces, 73, 221-242.

Towards 2016, 2006. Ten-Year Framework Social Partnership Agreement 2006-2015, June, Dublin: Stationery Office. Available at: www.taoiseach.gov.ie

Waite, LJ., 1995. 'Does Marriage Matter?', Demography, Volume 32(4) November, pp. 483-507.

Watson, D., 2002. 'Positive Affectivity: The Disposition to Experience Pleasurable Emotional States', in Snyder, CR., and Lopez, S., (Editors), Handbook of Positive Psychology, New York: Oxford University Press, p.115.

Whittaker, J., Harden, B., See, H., Meisch, A., Westbrook, T., 2011. 'Family risks and protective factors: Pathways to Early Head Start toddlers' social–emotional functioning',
Early Childhood Research Quarterly 26 (2011) 74–86.

Williams, J., Greene, S., Doyle, E., Harris, E., Layte, R., McCoy, S., McCrory, C., Murray, A., Nixon, E., O'Dowd, T., O'Moore, M., Quail, A., Smyth, E., Swords, L., and Thornton, M., 2009. Growing Up in Ireland: National Longitudinal Study of Children – The Lives of –Year-Olds, Dublin: Office of the Minister for Children and Youth Affairs. Available at: www.omc.gov.ie

Williams, J., Greene, S., McNally, S., Murray, A., and Quail, A., 2010. Growing Up in Ireland: National Longitudinal Study of Children – The Infants and Their Families, Dublin: Office of the Minister for Children and Youth Affairs. Available at: www.omc.gov.ie

Winkelmann, L., and Winkelmann, R., 1998. 'Why are the Unemployed so Unhappy? Evidence from Panel Data', Economica, 65, February.

Winnicott, D., 1964a. The Child, the Family and the Outside World, Harmondsworth: Penguin Books.

Winnicott, D., 1964b. The Family and Individual Development, London: Tavistock.

Endnotes

1 The Task Force on the Child and Family Support Agency distinguishes two categories of service for children and families: (i) direct or core services which are provided directly or commissioned directly by the Child and Family Support Agency (CFSA) including child protection, family support, public health nursing, speech and language, psychology, etc; and (ii) interface services which are provided by other governmental and non-governmental service providers but which are essential to keeping children safe and promoting their welfare including pre-schools, schools, health services, local authorities, Gardaí, youth services, etc. Given that the FSA will be part of the CFSA from 2013, the FRC programme will be one of the new agency's core services. Regarding interface services, the Task Force states: 'These services will be aligned with the CFSA in a defined and structured way with mutual accountability for agreed processes and deliverables.' (Task Force on the Child and Family Support Agency 2012:ix and 28). The overall vision informing this approach is summarised in the final paragraph of the Task Force's Report: 'The CFSA brings all agencies that work with vulnerable children and families together while establishing formal relationships with services that also work with children within a wider remit. The CFSA represents a national approach which facilitates a new way of working. Children and families are placed firmly at the centre of the systems network. All services for children will be considered part of this system and staff working with children will perceive themselves as operating within a single system for children.' (Task Force on the Child and Family Support Agency 2012:40).

2 The Department of Social Welfare, founded in 1947, has undergone a number of changes in its name, as follows: Department of Social Welfare (1947–1997); Department of Social, Community and Family Affairs (1997–2002); Department of Social and Family Affairs (2002–2010); Department of Social Protection (2010–present). In addition to the name-change in March 2010, some functions previously carried out by the Department – notably social inclusion and family policy including FRCs - were transferred to the re-named Department of Community, Equality and Gaeltacht Affairs. Following the change of government in 2011, this Department was disbanded and the FSA is currently responsible to the newly established Department of Children and Youth Affairs. Significantly, since March 2010, the word 'family' no longer appears in the name of any Government Department.

3 Kelleher and Kelleher, 1997.

4 Commission on the Family, 1998:16.

5 Commission on the Family, 1998:16.

6 Commission on the Family, 1998:16.

7 National Development Plan 2007-2013, 2007.

8 Minister for Social and Family Affairs, 2007, Speech by Seamus Brennan TD Minister for Social and Family Affairs at the Celebration to Mark 100 Family Resource Centres, Croke Park, 6th February.

9 Half of all FRCs (53) are in the 'Eastern Region' comprising: Carlow, Cavan, Dublin, Kildare, Kilkenny, Laois, Leitrim, Longford, Louth, Meath, Monaghan, Offaly, Tipperary, Waterford, Westmeath, Wexford and Wicklow. The other half (53) is in the 'Western Region' comprising: Clare, Cork, Donegal, Galway, Kerry, Limerick, Mayo, Roscommon, and Sligo.

10 'The experience of family living is the single greatest influence on an individual's life and the family unit is a fundamental building block for society' (Commission on the Family, 1996:13; see also 1998).

11 'The family generally affords the best environment for raising children and external intervention should be to support and empower families within the community' (Department of Health and Children, 2000:10). In relation to services, the National Children's Strategy states: 'As well as developing new ways of working between mainstream services, it will also be necessary to create more effective links between community services and the special child welfare, child mental and physical health, and juvenile justice services. This approach will require closer working relationships

and more innovative approaches to how schools, health services, local youth and community groups and local libraries and other leisure and cultural bodies plan and deliver their services. This type of coherent service provision is still relatively underdeveloped in Ireland.' (Ibid:45).

12 'Supporting and complementing the many ways in which the immediate family protects and cares for children is the central function of child health and child welfare services' (Department of Health and Children, 2007:17). In relation to services, the agenda for children's services states: 'Services exist to complement, reinforce and extend the capacity of families and communities. Just as families meet the full range of children and young people's needs (emotional, intellectual, social, cultural and material), so too must there be a wide range of services available to children and those who care for them. These need to be provided at a series of levels of need and matched services. Families with more complex needs require more complex services, for which the State must take greater responsibility' (Ibid:23).

13 'We are committed to the principle of supporting families as the basis for ensuring child health and welfare. It is a fundamental belief that loving families, who set clear boundaries for their children, provide the most effective environment for children to grow into full members of society, equipped to play their part as citizens of a modern democratic society with the skills and aptitude to work and learn flexibly, and to embrace change throughout their lives. However, some children do not receive adequate care and protection therefore legislative powers such as emergency, interim and full care orders, as well as supervision orders where a child is deemed to be at risk, are utilised when required to ensure that child protection plans are implemented in full.' (HSE, 2012:58).

14 'Strategic Objectives: 1. Develop, strengthen and align policies, legislation and resources in order to achieve better outcomes for children and young people and provide support for parents and families.' (Department of Children and Youth Affairs, 2012:6).

15 'The Task Force's vision is that the scope of services provided directly by the CFSA [Child and Family Support Agency], or linked with it in a defined and structured way, should range from support to families in the community to highly specialised interventions where children have been identified as requiring out of home care. … The Task Force believes that family support plays a central role in promoting children's well-being'. (Task Force on the Child and Family Support Agency, 2012:25 and 88).

16 'The 'people-centred' health-care system of the future will have dynamic, integrated structures, which can adapt to the diverse and changing health needs of society generally and of individuals within it. These structures will empower people to be active participants in decisions relating to their own health' (Department of Health and Children, 2001a:18). In relation to family support services, the strategy states: 'The dominant focus in child care services since the early 1990s has been on the protection and care of children who are at risk. More recently, the policy focus has shifted to a more preventive approach to child welfare, involving support to families and individual children, aimed at avoiding the need for further more serious interventions later on.' (Ibid:71).

17 'Primary care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being' (Department of Health and Children, 2001b:15). The primary care strategy envisages that: 'Primary care needs to become the central focus of the health system. The development of a properly integrated primary care service can lead to better outcomes, better health status and better cost-effectiveness. Primary care should therefore be readily available to all people regardless of who they are, where they live, or what health and social problems they may have.' (Ibid:7).

18 'The community development model or the process of empowering and "strengthening community action" is important so that people can gain greater control over their lives, have greater access to information, develop supportive relationships and skills in decision making and the ability to access resources. The challenge for health promotion is to work with communities and not for communities' (Department of Health and Children, 2000:49).

19 'The approach to the strategy is based on three levels of involvement … Individual service users: involvement in their own care; Community: involvement in local service delivery and development; National: strategic policy informed through involvement of service user organisations in partnership with health care professionals' (HSE, 2008).

20 'The overall aim of the NAPinclusion [National Action Plan for Social Inclusion 2007-2016] is to build viable and sustainable communities, improving the lives of people living in disadvantaged areas and building social capital. Therefore tackling disadvantage in urban and rural areas remains a key priority' (Department of Social, Community and Family Affairs, 2007:60).

21 'In the Government's vision of society, the ability of the Community and Voluntary sector to provide channels for the active involvement and participation of citizens is fundamental. An active Community and Voluntary sector contributes to a democratic, pluralist society, provides opportunities for the development of decentralised and participative structures and fosters a climate in which the quality of life can be enhanced for all. This is a key point. The Government regards statutory support of the Community and Voluntary sector as having an importance to the well being of our society that goes beyond 'purchase' of services by this or that statutory agency. The Government's vision of society is one which encourages people and communities to look after their own needs very often in partnership with statutory agencies but without depending on the State to meet all needs' (Department of Social, Community and Family Affairs, 2000:9-10).

22 'Community development is about promoting positive social change in society in favour of those who benefit least from national and global social and economic developments…(it) seeks to challenge the causes of poverty and disadvantage and to offer new opportunities for those lacking choice, power and resources' (Department of Community, Rural and Gaeltacht Affairs, 2007).

23 'To guide and support the organisation in carrying out its mandate, the DYCA has adopted the following values. It will … be child- and youth-centered, with children, young people and families at the heart of its work. Childhood and youth will be respected and valued as important life stages.' (Department of Children and Youth Affairs, 2012:6).

24 'In fulfilling its statutory role, the Agency ensures that … it provides mechanisms to engage with children, families and communities regarding the design and quality of service provision.' (Task Force on the Child and Family Support Agency, 2012:7).

25 This was the thinking which informed the setting up of the Sure Start programme in the UK. 'What I learned from visits to successful early years programmes and local communities was that it was necessary, in the case of early years at any rate, to involve local people fully in the development and management of the programme if it was to take root and not simply be seen as another quick fix by middle-class social engineers' (Glass, cited in Melhuish and Hall, 2007:10).

26 Sure Start is a broad-based programme of supports for the families of children in early years (0-6) in disadvantaged areas in the UK and has a similar community-based management structure to FRCs.

27 'More empowerment in programmes was related to greater positive impact on maternal acceptance for mothers of 9-month-olds; …. and more empowerment was related to greater success in fostering stimulating home learning environments for 36-month-olds.' (Melhuish, Belsky, Anning, Ball, Barnes, Romaniuk, Leyland and the NESS Research Team, 2007:548).

28 Melhuish, Belsky, Anning, Ball, Barnes, Romaniuk, Leyland and the NESS Research Team, 2007:549.

29 'The fact that … maternal acceptance was related to having a higher proportion of health-related staff is consistent with findings linking health-agency leadership to programme effectiveness' (Melhuish, Belsky, Anning, Ball, Barnes, Romaniuk, Leyland and the NESS Research Team, 2007:549).

30 This initiative was established by the Combat Poverty Agency (now part of the Social Inclusion Division in the Department of Social Protection) and the Consumer Affairs Section of the HSE, in collaboration with HSE's Directorate for Primary Community and Continuing Care (PCCC). It comprised 19 projects and was part of the rollout of the Primary Care Strategy (Department of Health and Children, 2001) and the National Strategy for Service User Involvement (Department of Health and Children, 2008a).

31 Pillinger, 2010:xi.

32 Article 41.1 of the Constitution states: 'The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law'. Article 41.3 states: 'The State pledges itself to guard with special care the institution of Marriage, on which the Family is founded, and to protect it against attack'.

33 It is worth remembering that the concept of 'de facto family' has no standing in Irish law. This was clarified by the Supreme Court in December 2009. According to Justice Geoghegan (2009): 'I find nothing wrong with the rather useful expression "de facto family" provided it is not regarded as a legal term or given a legal connotation. But as the Latin makes clear it connotes merely a factual situation and not a legal concept.' Similarly, Justice Denham (2009): 'There is no institution in Ireland of a "de facto" family. As Hamilton C.J. stated in W.OR. v. E.H. [1996] 2 I.R. 248 at p.265:- "A de facto family, or any rights arising therefrom, is not recognised by the Constitution or by any of the enactments of the Oireachtas dealing with the custody of children." The term "de facto family" has arisen as a shorthand method of describing circumstances where a couple have lived together in a settled relationship for some time with a child. Such a set of relationships are relevant in considering the welfare of the child. There is no institution of a de facto family.'

34 The United Nations definition of the family states: 'Any combination of two or more persons who are bound together by ties of mutual consent, birth and/or adoption or placement and who, together, assume responsibility for, inter alia, the care and maintenance of group members, the addition of new members through procreation or adoption, the socialisation of children, and the social control of members' (Cited in Daly, 2004).

35 Article 8 of the European Convention on Human Rights states: ' Everyone has the right to respect for his private and family life, his home and his correspondence'. In subsequent judgements, the European Court established that the notion of the "family" in this article is not confined solely to marriage-based relationships and may encompass other de facto "family" ties where the parties are living together outside marriage. A child born out of such a relationship, for example, 'is ipso iure part of that "family" unit from the moment of his birth and by the very fact of it. There thus exists between the child and his parents a bond amounting to family life even if at the time of his or her birth the parents are no longer cohabiting or if their relationship has then ended' (European Court of Human Rights, 1994:3).

36 This approach is consistent with the approach outlined by the Family Support Agency (FSA) in its submission to the All Party Oireachtas Committee on the Constitution in February 2005. In that submission, the FSA noted that The Family Support Agency Act 2001 does not define the family but its strategic plan 'acknowledged the diversity of family life in Ireland today' while its work was not restricted to 'the family based on marriage'. The submission acknowledged that 'the family based on marriage … provides a stable framework for spouses and their children and that society as a whole and the State benefit from the support spouses give to each other'. The submission suggested that 'consideration could be given … to using the term family life . … . Family life includes a broad range of relationships and focuses on the relationship between the people involved in creating family life rather than the legal structure from which that family life emanates' (Family Support Agency, 2005).

37 Williams, Greene, McNally, Murray and Quail, 2010:31.

38 According to Fahey and Field (2008:36): 'In Ireland, studies of women who were pregnant outside marriage have shown that such women live in a wide range of partnership circumstances. In one large-scale study (Mahon et al. 1998), which gathered information on over 2,000 women who were

pregnant in 1996, 35 per cent of the sample were unmarried but only 11 per cent described themselves as 'single' (that is, as uninvolved in any ongoing relationship). Over 25 per cent (that is, over two-thirds of those who were unmarried and pregnant) reported that they were in a stable relationship of some kind (7.5 per cent cohabiting, 9 per cent 'going steady' and 9 per cent 'engaged'). Furthermore, whatever the relationship status of the mothers at time of giving birth outside marriage, there are indications that large proportions enter into marriage within a few years of the birth of the child, though it is not possible to say how often the man that they eventually marry is the father of the child (Fahey and Russell, 2001).

39 The full title of the Act is: Civil Partnership and Certain Rights and Obligations of Cohabitants Act, 2010.

40 McKeown and Sweeney, 2001:64-65; McKeown, 2001a:44; 2001b:4-5; see also McKeown, K., Ferguson, H., and Rooney, 2001. The distinguished writer, Hugh Leonard, who was reared by adoptive parents, wrote about the consequences of not knowing his father after discovering that the stroke of a pen took the place of his father's name on the birth certificate. He wrote that: "If my mother had thought to invent a name for my father, my own life would certainly have been different. … I have always been a cuckoo in any and every Irish nest. …I say this as a simple reality" (Leonard, 1995:36-38). Many similar accounts bear testimony to the abiding presence of the absent father.

41 Commission on the Family, 1996:13-14.

42 The evidence reviewed comes from six large data bases in four different countries (US, UK, Germany, Belgium and Ireland), two of them covering a period of more than a quarter of a century (see McKeown and Sweeney, 2001:Chapter Five). Some of the more significant 'cross-sectional studies' include the General Social Survey in the US (Oswald & Blanchflower, 1999), the Eurobarometer Survey in the UK (Oswald & Blanchflower, 1999), and the ESRI's Survey of Income Distribution, Poverty and the Use of State Services (Sweeney, 1998). Significant 'panel' studies, which involve multiple interviews with the same randomly chosen respondents over a period of time, include the German Socio-Economic Panel Survey (Winkelmann and Winkelmann, 1998), the British Household Panel Study (Theodossiou, 1998) and the Panel Survey of Belgian Households (Sweeney, 1998).

43 Waite, 1995:499

44 Bray and Jouriles, 1995; Kiecolt-Glaser and Newton, 2001

45 Kiecolt-Glaser and Newton, 2001.

46 Ibid It is also recognised that men and women respond differently to marital distress which sometimes takes the pattern of 'demand-withdrawal' whereby women's demands in a relationship are met by their partner's withdrawal in the face of those demands because he feels unable to meet those demands (Markman, 1991; 1994).

47 See, for example, Bowlby, 1979; Winnicott, 1964a; 1964b.

48 NICHD Study of Early Child Care and Youth Development, 2006:23; for other reviews, see Centre of Excellence for Early Childhood Development, 2011.

49 A noteworthy finding of this research, particularly in the context of two-parent households, is that greater involvement by fathers has direct benefits for the child but also indirect benefits in the form of an improved relationship between the parents; this arises because the parent-parent relationship, according to one leading team of US researchers, 'is bound up with virtually every dimension of offspring well-being' (Amato and Booth, 1997:22). This view is echoed by another researcher who suggests that, again in the context of two-parent households, involved fathering promotes positive child development in the following way: 'the benefits obtained by children with highly involved fathers are largely attributable to the fact that high levels of paternal involvement created family contexts in which parents felt good about their marriages and the child care arrangements they had been able to work out' (Lamb, 1999). At the same time, there is also evidence that the impact of parent-parent relationships on child well-being is considerably more pronounced in conventional two parent families

compared to stepfamilies as one review of the research suggests: 'The differences between intact and stepfamilies suggest that stepfamilies do not necessarily function in the same ways as first-marriage families. The parents' partnership does not have such a direct influence on the parent-child and sibling relationships, and stepchildren have a comparatively strong influence on parental behaviour, especially in the early years' (Harold, Pryor and Reynolds, 2001:5).

50 For example, the Government's health strategy adopted the WHO definition of health as: 'a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity … a resource for everyday life, not the objective of living; it is a positive concept emphasising social and physical resources as well as physical and mental capacity' (Department of Health and Children, 2001a:15).

51 Expert Group on Mental Health Policy, 2006:16

52 This perspective has been articulated by Martin Seligman, one of the founders of field of positive psychology, as follows: 'For the last half century psychology has been consumed with a single topic only – mental illness – and has done fairly well with it. Psychologists can now measure such once-fuzzy concepts as depression, schizophrenia, and alcoholism with considerable precision. We now know a good deal about how these troubles develop across the life span, and about their genetics, their biochemistry, and their psychological causes. Best of all we have learned how to relieve these disorders. ... . But this progress has come at a high cost. Relieving the states that make life miserable, it seems, has made building the states that make life worth living less of a priority. But people want more than just to correct their weaknesses. They want lives imbued with meaning, and not just to fidget until they die. … . The time has finally arrived for a science that seeks to understand positive emotion, build strength and virtue, and provide guideposts for finding what Aristotle called the "good life"' (Seligman, 2002:xi).

53 This perspective has been articulated by an international commission on how to measure economic progress which was set up by the President of France, Nicolas Sarkozy: 'The time is ripe for our measurement system to shift from measuring economic production to measuring people's well-being. … . Emphasising well-being is important because there appears to be an increasing gap between the information contained in aggregate GDP data and what counts for common people's well-being. This means working towards the development of a statistical system that complements measures of market activity by measures centred on people's well-being and by measures that capture sustainability. … . To define what well-being means a multidimensional definition has to be used. … . At least in principle, these should be considered simultaneously: (1) material living stands (income, consumption and wealth); (2) health; (3) education; (4) personal activities including work; (5) political voice and governance; (6) social connections and relationships; (7) environment (present and future conditions); (8) insecurity of an economic as well as a physical nature. All these dimensions shape people's well-being, and yet many of these are missed by conventional income measures (Commission on the Measurement of Economic Performance and Social Progress, 2009:12-15). In keeping with this, the Minister for Finance announced in the Budget Speech on 7th December 2010 that: 'The Government has committed to the introduction of a new national performance indicator to allow a variety of quality of life measurements to be assessed and reported on a regular basis, complementing traditional economic data. This will be used to guide policy development. It will allow the public to assess the progress being made across a range of indicators.' (Minister for Finance, 2010).

54 It is true that well-being appears to be associated with certain states and circumstances, both internal and external, but these are not constant over time or between individuals. For example, income is usually associated with well-being but its influence on well-being varies between people and can change according to context and circumstances. This suggests that well-being, as the term implies, is a quality of being itself; to be is to be well. Well-being is experienced because it already exists, not because it is created anew. Indeed it could not be experienced unless it already existed, and would not be sought unless it was known to be part of our nature. In the same way as educators speak of intelligence as being revealed through the process of learning and unlearning, so well-being is manifested by removing obstacles which block one from experiencing it. This perspective is important because it underlines how well-being is like the sun; it never ceases to shine even though we speak of it as rising and setting, and of shining only when the sky is cloudless. Similarly, well-being

always shines but thoughts and feelings can cloud it over. This is the metaphysical foundation of positive thinking because it allows life's adversities to be framed as passing difficulties rather than permanent deficits, and to recognise that since well-being is the condition which sustains life itself, everyone is already well but just not fully aware of it.

55 McKeown and Haase, 2007; Haase, McKeown and Pratschke, 2008; McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008; Haase, 2009.

56 GUI is based on two cohorts of children: 8,570 nine-year old children on whom data was collected 'between September 2007 and June 2008' (Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009, p. 16); and 11,100 nine-month old children on whom data was collected 'between September 2008 and April 2009' (Williams, Greene, McNally, Murray and Quail, 2010, p. 21).

57 Pratschke, Haase and McKeown, 2011.

58 For recent reviews, see: Allen, 2011; Statham and Smith, 2010; Field, 2010.

59 The overall effect size of the High Scope Perry Pre-School Programme in the US when participants reached the age of 23 was 0.36 (Schweinhart and Weikhart, 1997; Schweinhart, 2004; Schweinhart, Montie, Xiang, Barnett, Belfield, Nores, 2005). 'At age 14, reading and math scores improved by 0.33 standard deviations, a very significant achievement given that the US achievement gap in reading and math gaps between low-income and middle-income children at kindergarten entry is about 0.50 standard deviations' (Barnett, 2011, p. 975).

60 The evaluation of Early Head Start found that 'overall impacts were modest, with effect sizes in the 10 to 20 percent range, although impacts were considerably larger for some subgroups, with some effect sizes in the 20 to 50 percent range. The overall pattern of favourable impacts is promising, particularly since some of the outcomes that the programs improved are important predictors of later school achievement and family functioning' (Mathematica Policy Research, 2002:xxv).

61 The effect size of high quality pre-school for children at the age of 11, according to the Effective Pre-School and Primary Education Project, was: 0.23 for pro-social behaviour, 0.25 for self-regulation, 0.29 for English, 0.34 for Mathematics (Sammons, 2010, pp. 128-130).

62 The effect size of Sure Start when children were five years old, was 0.12 for Body Mass Index and 0.10 for physical health; for parents, it was 0.24 for harsh discipline, 0.29 for chaos in the home and 0.27 for home learning environment (National Evaluation of Sure Start Team, 2010, p. 29).

63 The effect size of Springboard on children's strengths and difficulties was 0.30; for parents, it was 0.23 for communication between parent and child (McKeown, Haase and Pratschke, 2006).

64 'The lifetime rate of return to the High Scope Perry Pre-School Programme in the US – based on data to age 40 – is estimated to be between 7% and 10%, above the post-World War II stock market rate of return on equity which is about 5.8%' (Heckman, Moon, Pinto, Savelyev and Yavitz, 2009).

65 'Proximal processes' is the term used in the bioecological model of human development to refer to interactions between the developing child and the person, objects and symbols in its immediate external environment. These proximal processes are the 'primary engines' of the child's developmental outcomes – whether in terms of competence (intellectual, physical and socio-emotional) or dysfunction (difficulties maintaining control and integration of behaviour across situations) - and are influenced by characteristics of the child (disposition, including previous developmental outcomes), its environment (both immediate and remote), and stability since 'proximal processes cannot function effectively in environments that are unstable and unpredictable across space and time' (Bronrenbrenner and Morris, 2006, p. 820).

66 One of the most important aspects of personality is the parent's positive and negative affect. Note that positive and negative affect - understood as habitual ways of thinking and feeling - are two independent aspects of the personality, not polar opposites; each person has elements of both, and can be simultaneously strong or weak on both. Positive emotions are typically associated with an action-orientation, geared towards pleasure and reward, and is regarded by psychologists as adaptive to procuring resources for survival. Negative emotions are typically associated with a withdrawal-orientation, geared towards avoiding pain and other undesirable consequences, and is also regarded

by psychologists as adaptive for survival by keeping out of danger. Positive emotions are also related to extraversion and sociability, and to cheerfulness, enthusiasm and energy, while negative emotions are related to fear / anxiety, sadness / depression, and anger / hostility. Both these dimensions mirror optimism and pessimism and, whether one is a 'strategic optimist' or a 'defensive pessimist', both have a role to play in personality, and both have their strengths and limitations. However, in view of the research finding that positive emotions have a positive influence on overall well-being - and negative emotions have a negative influence - it is worth emphasising the importance of cultivating positive emotions. The good news about positive emotions is that they are not very dependent upon external circumstances, as the leading researcher in this field has observed: 'People do not require all that much – in terms of material conditions, life circumstances, and so on – to feel cheerful, enthusiastic, and interested in life. Thus, one need not be young or wealthy or have a glamorous, high-paying job in order to be happy. This, in turn, suggests that virtually anyone is capable of experiencing substantial levels of positive affectivity' (Watson, 2002:115). This understanding of positive emotions, and happiness generally, resonates with a much larger and older body of knowledge based on the insights of diverse philosophical and wisdom traditions.

67 Experts tend to explain the link between poverty and well-being, particularly as it relates to child development, as follows: 'Poverty is important because economic disadvantage may have cascading effects on many aspects of family life. … . Simple associations between childhood poverty and later achievement and well-being do not prove that low family income itself causes these differences. Nevertheless, several recent, sophisticated studies indicate that income may, in fact, be an active ingredient in improving younger children's later achievement and adult productivity. What's new in the research on income and child achievement is the importance of early income. … . Yet we also know that toxic stress can be triggered by an array of circumstances, perhaps including poverty but also through exposure to violence, parental substance abuse and mental illness, and serious child maltreatment. Thus, dramatic improvements in the long-term outcomes of children in poverty may also depend on treating other causes of toxic stress in their lives.' (Duncan, Magnuson, Boyce and Shonkoff, Undated).

68 As already indicated, the NICHD Study of Early Child Care and Youth Development (2006:23-25) found that one of the most important and consistent predictors of child cognitive and social development was 'the quality of the mother-child interactions'. However this study also found that the quality of mother-child interactions as well as the child's cognitive and social development were simultaneously influenced by the mother's socio-economic status and by her positive personality. 'In general, mothers who were more educated, lived in more economically advantaged households, experienced fewer symptoms of depression, and had more positive personalities were more likely to provide the type of mother-child interactions that were linked to better developmental outcomes for the Study children. Many of these predictors of positive mother-child interactions were also independently related to child well-being - meaning that children had better outcomes when these features were present, regardless of the mother-child interaction. So, children did better overall if their parents were more educated, when they lived in more economically advantaged families, and when their mothers experienced fewer or no symptoms of depression and had more positive personalities'.

69 The ecological perspective on child development is associated with the name of Uri Bronfrenbrenner (1917-2005) who identified four types of nested systems which influence the development of each child: the microsystem (family, school, peer group, neighbourhood, and childcare environments), the mesosytem (connections between immediate environments such as the child's home and school), the exosystem (external environments such as parent's workplace which indirectly affect development), and the macrosystem (the larger cultural context such as the national economy, public policy, culture, etc). According to ecological theory, if relationships in the immediate microsystem break down, the child will not have the tools to explore other parts of his/her environment (see Bronfrenbrenner and Morris, 2006) . Similarly, children looking for the affirmations that should be present in the child-parent relationship will seek attention in inappropriate places and ways, such as adolescents who display anti-social behavior, lack of self-discipline, and inability to provide self-direction. As a result of Bronfenbrenner's work, child development is now understood as inherently multi-dimensional and multi-disciplinary whereas previously child psychologists studied the child, sociologists examined the family, anthropologists the society, economists the economic framework of the times, and political scientists the political structure.

70 This was underlined in a recent review as follows: 'effecting change in a distal variable [indirect influence] will not necessarily lead to change in child outcomes, unless it is followed by change in proximal variables [direct influence]. Interventions that are based on addressing distal variables – such as welfare benefits to reduce child poverty – need to ensure that change is also happening at the proximal level if they are to be effective in improving outcomes for children. This also means that identification of risk status on the basis of distal variables (such as living below the poverty line) will result in less accurate ascertainment of 'true' risk, and poorer predictive validity. Distal variables are more easily measured, but do not represent the real complexity of risk for children as their main impact on children is via their influence on other, more proximal, variables' (Statham and Smith, 2010). Building on this distinction, another review drew out the following implications for child and family policy: 'there is much more beyond just improving short-term family incomes in determining the life chances of poor children. A healthy pregnancy, positive but authoritative parenting, high quality childcare, a positive approach to learning at home and an improvement in parents' qualifications together, can transform children's life chances, and trump class background and parental income. A child growing up in a family with these attributes, even if the family is poor, has every chance of succeeding in life. Other research has shown that the simple fact of a mother or father being interested in their children's education alone increases a child's chances of moving out of poverty as an adult by 25 percentage points' (Field, 2010, p. 8).

71 The HSE National Service Plan 2012 states: 'It is a fundamental belief that loving families, who set clear boundaries for their children, provide the most effective environment for children to grow into full members of society, equipped to play their part as citizens of a modern democratic society with the skills and aptitude to work and learn flexibly, and to embrace change throughout their lives. However, some children do not receive adequate care and protection therefore legislative powers such as emergency, interim and full care orders, as well as supervision orders where a child is deemed to be at risk, are utilised when required to ensure that child protection plans are implemented in full.' (HSE National Service Plan 2012, p. 58)

72 This was underlined in a recent review as follows: 'effecting change in a distal variable [indirect influence] will not necessarily lead to change in child outcomes, unless it is followed by change in proximal variables [direct influence]. Interventions that are based on addressing distal variables – such as welfare benefits to reduce child poverty – need to ensure that change is also happening at the proximal level if they are to be effective in improving outcomes for children. This also means that identification of risk status on the basis of distal variables (such as living below the poverty line) will result in less accurate ascertainment of 'true' risk, and poorer predictive validity. Distal variables are more easily measured, but do not represent the real complexity of risk for children as their main impact on children is via their influence on other, more proximal, variables' (Statham and Smith, 2010). Building on this distinction, another review drew out the following implications for public policy on child poverty in the UK: 'there is much more beyond just improving short-term family incomes in determining the life chances of poor children. A healthy pregnancy, positive but authoritative parenting, high quality childcare, a positive approach to learning at home and an improvement in parents' qualifications together, can transform children's life chances, and trump class background and parental income. A child growing up in a family with these attributes, even if the family is poor, has every chance of succeeding in life. Other research has shown that the simple fact of a mother or father being interested in their children's education alone increases a child's chances of moving out of poverty as an adult by 25 percentage points' (Field, 2010:8).

73 As one review concluded: 'The evidence is strongest for targeted programmes that follow a clear protocol, but that address multiple issues rather than having a single focus, and can be varied according to individual need and professional judgement' (Karoly, et al, 1998).

74 According to one review: 'the great driving force for deciding the future of children is their parents. No policy designed to break through the glass ceiling that is firmly in place over the heads of all too many children can succeed without parents. The very best governments, communities and families can do is to support parents to enable them to be even more effective agents of change for their children. But communities and governments do have other roles they must play if we are radically to improve the life chances of poorer children' (Field, 2010:18). Another review also confirms the importance of parenting and the corresponding lack of interventions to support it: 'Despite the wealth of evidence on the importance of good parent-child relationships to child well being, and on the

negative impact of inter-parent conflict and adult relationship problems (both more likely to occur in circumstances where there are other difficulties), there are few preventive interventions that have aimed to strengthen family relationships, or to address these aspects of risk' (Statham and Smith, 2010:28). A third review identified parents as key to the learning outcomes of children: 'Engaging parents in supporting learning in the home is the most successful way of raising student achievement and is where schools should focus their efforts in supporting parents' (Stratham, Harris and Glenn, 2010:1). A final review summarised the state of knowledge as follows: 'we know that the early home learning environment is the single biggest influence on a child's development – more important than material circumstances or parental income, occupation or education. Indeed, the quality of a child's relationships and learning experiences in the family has more influence on achievement than innate ability, material circumstances or the quality of pre-school and school provision' (Allen, 2011:57).

75 'Drop-out rates from parenting programmes such as the Webster-Stratton programme tend to be of the order of 50% or higher, and where such information is available, it is clear that there is social patterning in drop-out, with more disadvantaged parents less likely to complete the course' (Statham and Smith, 2010:29).

76 In line with the philosophical understanding of well-being outlined above, negative thoughts and feelings overshadow the sense of wellness and create the experience of not being well. This typically arises through thoughts that particular situations are unwanted and unavoidable (such as feeling negative or having financial difficulties), and may be further compounded by the thought that they are also undeserved or unfair. Interventions typically explore what other possibilities may exist within these thought patterns such as reducing the tendency to polarise perceptions (into only negative or only positive), or increasing the options of how one relates to them (other than complete rejection or complete acceptance). As a consequence, new possibilities of thought and action, both individual and collective, can emerge which help reduce the overshadowing effect of these thoughts on well-being. This process may be unique to each individual or group and, while insights may sometimes come quickly, it may need support to sustain them – and the associated thoughts and behaviours which they trigger – in order to overcome the power of external circumstances and internal conditioning.

77 See, for example, www.beckinstitute.org

78 Seligman, 2002.

79 For example, feelings about the past can be changed by questioning the ideology that the past determines the present, and by cultivating forgiveness and gratitude towards past events. Feelings about the present can be changed through living mindfully, savouring the present, and cultivating one's natural strengths, while positive feelings about the future can be increased through hope and optimism. See, for example, Snyder and Lopez, 2002; see also www.beckinstitute.org

80 Fredrickson, 2002.

81 Carr, 2004.

82 For more information, visit the Positive Psychology Center at www.positivepsychology.org and links.

83 A similar conclusion emerged from a recent review of the literature on child outcomes which observed that socio-economic indicators "have relatively limited utility as guides for designing effective interventions because they tell us relatively little about the causal mechanisms that explain their impacts on child development. Thus, researchers and service providers are focusing increasingly on the importance of within-group variability and individual differences among children and families". (Shonkoff and Phillips, 2000:354. This is also the clear conclusion from a study of 114 mothers and their children (aged 3-23 months) in Early Head Start in the US which concluded that while 'family risks' (comprising lack of resources, maternal depression and parental stress) are 'highly influential' on children's social-emotional outcomes, their influence is indirect and mediated through the mother's sensitivity to the child (as measured by acceptance, responsiveness and warmth). 'Parenting quality, in this case maternal sensitivity, can be construed as the mechanism through which these risk factors impinge on children's functioning. From a resilience perspective, such findings suggest that children

who are reared in high-risk contexts are not doomed to adverse outcomes. Specifically, the experience of parental warmth and responsivity can place these children on a more positive developmental trajectory. Thus, early interventions programs such as Head Start and Early Head Start, while working to increase the economic self-sufficiency of parents, could also promote positive child outcomes by intervening in their families to reduce parental stress and to enhance parenting quality' (Whittaker, Harden, See, Meisch and Westbrook, 2011:84-85).

84 See Field, 2010; Statham and Smith, 2010; Stratham, Harris and Glenn, 2010; Allen, 2011.

85 The ecological perspective on child development is associated with the name of Uri Bronfrenbrenner (1917-2005) who identified four types of nested systems which influence the development of each child: the microsystem (family, school, peer group, neighbourhood, and childcare environments), the mesosytem (connections between immediate environments such as the child's home and school), the exosystem (external environments such as parent's workplace which indirectly affect development), and the macrosystem (the larger cultural context such as the national economy, public policy, culture, etc). According to ecological theory, if relationships in the immediate microsystem break down, the child will not have the tools to explore other parts of his/her environment (see Bronfrenbrenner and Morris, 2006) . Similarly, children looking for the affirmations that should be present in the child-parent relationship will seek attention in inappropriate places and ways, such as adolescents who display anti-social behavior, lack of self-discipline, and inability to provide self-direction. As a result of Bronfenbrenner's work, child development is now understood as inherently multi-dimensional and multi-disciplinary whereas previously child psychologists studied the child, sociologists examined the family, anthropologists the society, economists the economic framework of the times, and political scientists the political structure.

86 'The at risk of poverty rate identifies the proportion of individuals who are considered to be at risk of experiencing poverty based on the level of their current income and taking into account their household composition. It is calculated as the percentage of persons with an equivalised disposable income of less than 60% of the national median income. The at risk of poverty rate …. using the 60% threshold is the internationally recognised measure' (Central Statistics Office, 2010:36).

87 'Enforced deprivation refers to the inability to afford basic identified goods or services. It is reported at the household and not the individual level, but it is assumed that each person in a household where a form of deprivation was reported experienced that form of deprivation ' (Central Statistics Office, 2010:54). The deprivation rate is based on two or more of the following 11 items of enforced deprivation: without heating at some stage in the last year due to lack of money; unable to afford a morning, afternoon or evening out in the last fortnight; unable to afford two pairs of strong shoes; unable to afford a roast once a week; unable to afford a meal with meat, chicken or fish every second day; unable to afford new (not second-hand) clothes; unable to afford a warm waterproof coat; unable to afford to keep the home adequately warm; unable to afford to replace any worn out furniture; unable to afford to have family or friends for a drink or meal once a month; unable to afford to buy presents for family or friends at least once a year.

88 'If an individual experienced two or more of these eleven basic deprivation items due to inability to afford them, and was also identified as being at risk of poverty, then the individual is defined as being in consistent poverty ' (Central Statistics Office, 2010:54).

89 Department of Health and Children, 2001a:61

90 See notably, McKeown and Haase, 2006; McKeown and Haase, 2007; McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008.

91 Shonkoff and Phillips, 2000: 251.

92 Morgan, McGee, Watson, Perry, Barry, Shelley, Harrington, Molcho, Layte, Tully, van Lente, Ward, Lutomski, Conroy, Brugha, 2008:76.

93 Williams, Greene, McNally, Murray and Quail, 2010:46.

94 National Advisory Committee on Drugs, 2005.

95 Williams, Greene, McNally, Murray and Quail, 2010:53.

96 Williams, Greene, McNally, Murray and Quail, 2010:65.

97 Williams, Greene, McNally, Murray and Quail, 2010:134.

98 Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:58

99 Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:75

100 Fitzgerald and Jeffers, 1994; O'Connor, Ruddle and O'Gallagher, 1988; McCarthy and O'Boyle, 1986; Porteus, 1991; O'Rourke and Fitzgerald, 1985; Lynch, Fitzgerald and Kinsella, 1987; Barton and Fitzgerald, 1986; Stone, Fitzgerald and Kinsella, 1990; Mohan, Fitzgerald and Collins, 1998; Martin, Carr, Carroll and Byrne, 2005.

101 Meltzer, Gatward, Goodman, and Ford, 2000.

102 Simpson, Bloom, Cohen, Blumberg and Bourdon, 2005.

103 Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:92-93.

104 Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:118.

105 Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:124-125.

106 Based on a nationally representative sample of 9-year olds in the Growing Up in Ireland National Longitudinal Study of Children (Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:37).

107 Based on households with one or more children under the age of 20 years in the 2006 Census of Population (Lunn, Fahey and Hannan, 2009:80).

108 According to the Growing Up in Ireland Study, data on the sample of 9-year olds collected between September 2007 and June 2008, revealed that in two-parent households, 47% were dual-earners, 44% were single earner households and 9% were no earner households (Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009; estimates derived from Figure 3.2:38).

109 Williams, Greene, Doyle, Harris, Layte, McCoy, McCrory, Murray, Nixon, O'Dowd, O'Moore, Quail, Smyth, Swords and Thornton, 2009:82-83

110 Bronfrenbrenner and Morris, 2006:824.

111 The deprivation index was developed by Trutz Haase and Jonathan Pratschke (Haase and Pratschke, 2005) and is available at www.pobal.ie.

112 www.pobal.ie

113 See for example, Stathan and Smith, 2010:21-24.

114 This is based on Gilligan (2000), and is similar to the Hardiker model (2002) except that this distinguishes four levels of need and service: Level 1 (services for all families and children), Level 2 (services for families and children who are vulnerable), Level 3 (services for families and children who have chronic or serious problems), Level 4 (services for families and children where the family has broken down temporarily or permanently).

115 'Primary family support aims to prevent the emergence of family problems. This type of family support is often area based working on a voluntary basis with a wide range of families. It might include a visit from a public health nurse and operates on the principle of prevention and early intervention.' (Task Force on the Child and Family Support Agency, 2012:89).

116 'Secondary family support tends to be aimed at families with challenges who often recognise the issues and work in partnership with agencies to achieve change. This level of family support seeks to identify and intervene at an early stage in the onset of problems. The assumption underpinning intervention at this stage is that the need for more intensive or specialist interventions including out of home placements for children can be avoided.' (Task Force on the Child and Family Support Agency, 2012:89).

117 'Tertiary family support occurs at a higher level of need and is often considered as remedial in that it includes intensive interventions by professionals addressing severe social or personal problems. Such interventions might include domestic violence or substance abuse programmes or might involve children being placed out of home. It might involve working with children in care or support them to return home after a period in care. Secondary and tertiary family support is sometimes known as targeted family support.' (Task Force on the Child and Family Support Agency, 2012:89).

118 This was highlighted in a report into system failures around the death of a child, Victoria Climbie, in England: 'It is not possible to separate the protection of children from wider support to families. Indeed often the best protection for a child is achieved by the timely intervention of family support services. The wholly unsatisfactory practice demonstrated so often in this inquiry, of determining the needs of a child before an assessment has been completed, reinforces in me the belief that 'referrals' should not be labelled 'child protection' without good reason. The needs of the child and his or her family are often inseparable. … From the evidence I heard I conclude that it is neither practical nor desirable to try to separate the support services for children and families from that of the service designed to investigate and protect children from deliberate harm' (Lord Laming, 2003). In Ireland, the more recent report on the Roscommon case reached a similar conclusion: 'It has long been accepted that families are the best place for children to grow and develop. The policy of Prevention and Early Intervention has been accepted as offering the best chance for children whose families require extra support to ensure they can grow and develop within a safe family environment. … A targeted family support service aimed at working with families with young children should be developed for this part of County Roscommon. Any model introduced needs to be appropriate to a rural/town setting. It is of course acknowledged that any such service must work actively with families, communities and local services. Some elements of services already in the area could be subsumed into such a service' (Inquiry Team in Roscommon Child Care Case, 2010:89-90).

119 'Tertiary family support occurs at a higher level of need and is often considered as remedial in that it includes intensive interventions by professionals addressing severe social or personal problems. Such interventions might include domestic violence or substance abuse programmes or might involve children being placed out of home. It might involve working with children in care or support them to return home after a period in care. Secondary and tertiary family support is sometimes known as targeted family support' (Task Force on the Child and Family Support Agency, 2012:89).

120 The most recent statement of this policy is in the report of Task Force on the Child and Family Support Agency: 'The Task Force recommends that the service delivery model [for the Child and Family Support Agency] makes use of a shared national service outcomes framework both for its own directly delivered services but also as the tool for its role in promoting integrated planning and working in respect of children's services with those providers outside of core services. In other words, the service delivery model should be focused on improving well-being and outcomes for children based on the five national outcomes.' (Task Force on the Child and Family Support Agency, 2012:xii; and 37-38).

121 The Agenda for Children's Services (Department of Health and Children, 2007), building on the National Children's Strategy (Department of Health and Children, 2000), sets out seven national

outcomes that all children in Ireland should achieve. These seven outcomes are reduced to five in the report of the Task Force on the Child and Family Support Agency (2012:xii; 6; 37-38).

122 These outcomes are similar to the five outcomes in England's Green Paper entitled Every Child Matters (2003): (i) being healthy: enjoying good physical and mental health and living a healthy lifestyle; (ii) staying safe: being protected from harm and neglect; (iii) enjoying and achieving: getting the most out of life and developing the skills for adulthood; (iv) making a positive contribution: being involved with the community and society and not engaging in anti-social or offending behaviour; (v) economic well-being: not being prevented by economic disadvantage from achieving their full potential in life.

123 Allen, 2011:119-135.

124 Allen, 2011:119-135.

125 http://toptierevidence.org/. According to the US-based Coalition For Evidence-Based Policy, the term 'Top Tier' is defined as 'Interventions shown in well-conducted randomized controlled trials, preferably conducted in typical community settings, to produce sizeable, sustained benefits to participants and/or society' (http://toptierevidence.org/). Correspondingly, 'Near Top Tier' refers to' interventions shown to meet all elements of the Top Tier standard in a single site, and which only need one additional step to qualify as Top Tier – a replication trial establishing that the sizeable, sustained effects found in that site generalize to other sites' (http://toptierevidence.org/).

126 The concept of life cycle was explicitly introduced into public policy by the National Economic and Social Council in 2005 as a way of assessing how well the state addresses the needs of citizens during the three life cycle stages of childhood, working age and old age. The value of the concept is that it provides a 'fundamental standpoint from which to judge the adequacy and effectiveness of overall social protection is to assess the risks and hazards which the individual person in Irish society faces and the supports available to them at different stages in the life cycle. The life cycle also provides a good framework for choosing among competing priorities and mobilising the social actors to implement the Developmental Welfare State' (National Economic and Social Council, 2005:xxii). In 2007, the concept was used a part of the social partnership agreement, Towards 2016 (2006), and explained as follows: 'the lifecycle approach is a new framework within which to address key social challenges by assessing the risks and hazards which the individual person faces and the supports available to them at each stage in the life cycle. …the life cycle approach adopts the perspective of the person as the centrepiece of social policy development. … . The lifecycle approach also offers the potential of a more streamlined, outcomes-focused approach (Towards 2016, 2006:40; see also National Development Plan 2007-2013, 2007).

127 The term 'logical' is used in this context to refer to 'logic model' which is a way of thinking about how activities and outcomes are connected to form a coherent strategy or programme. The following is a standard explanation of how logic models work in practice: 'Many who use logic models talk about them as a series of "if-then" sequences. … . If you have certain resources, then you will be able to provide activities, produce services or products for targeted individuals or groups. If you reach those individuals or groups, then they will benefit in certain specific ways in the short term. If the short-term benefits are achieved to the extent expected, then the medium-term benefits can be accomplished. If the medium-term benefits for participants/organizations/decision-makers are achieved to the extent expected, then you would expect the longer-term improvements and final impact in terms of social, economic, environmental, or civic changes to occur. This is the foundation of logic models and the theory of causal association. Such "if-then" relationships may seem too simple and linear for the complex programs and environments in which we work. However, in working out these sequences, we uncover gaps in logic, clarify assumptions, and more clearly understand how investments are likely to lead to results' (Taylor-Powell and Henert, 2008).

128 Practice knowledge comprises the knowledge, skills and competence to practice in an area of work; it could be family support, social care, social work, nursing, medicine, etc. It is characterised by knowing how to do something and involves having the appropriate understanding (based on what is known and the limits of what is known in that field), using appropriate skills (such as having the range of tools required for the task and knowing how and when to use them), and acting with competence

(notably the capacity to act in different roles and contexts, with insight to self and others, and learning continuously from experience).

129 Some of the key success factors in the facilitation of groups include: (i) the need to pay attention to the 'task' of the group (what is to be done) as well as the 'process' of the group (how it is done) in order to maintain a balance between focusing on processes and focusing on outcomes; (ii) creating goodwill which enables the group to be cohesive through fostering positive and enjoyable interactions while also allowing for the expression of difference and difficulties; (iii) creating openness within the group so that weaknesses as well as strengths can be acknowledged and addressed; (iv) acknowledging the importance of attentive listening so that there is a true appreciation of different perspectives and the possibility of learning from the other; (v) recognising that building a family support strategy needs to address 'hard' issues (such as structures and resources) as well as 'soft' issues (such as personal and professional attitudes, skills and relationships); (vi) an appreciation that developing a strategy involves learning about what works and how it works; but it is also about unlearning and letting go of assumptions and beliefs that are not supported, and may even be contested, by evidence (see McKeown, 2011a; 2012).

130 Department of Health and Children, 1999:37.

131 The Constitution does not specifically refer to the right to privacy but case law has defined it as 'an unremunerated constitutional right' which inheres in each citizen by virtue of his human personality (see Sheik, 2008:20). Article 40(1) of the Constitution states: 'All citizens shall, as human persons, be held equal before the law'. Article 40(3) also states: 'The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen'.

132 The right to privacy is stated explicitly in the Universal Declaration of Human Rights (Article 12): 'No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.' It is also stated explicitly in the European Convention for the Protection of Human Rights and Fundamental Freedoms (Article 8): '(1) Everyone has the right to respect for his private and family life, his home and his correspondence. (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'

133 National Guidelines for the Protection and Welfare of Children (1999:41) state: "All information regarding concern or assessment of child abuse should be shared on a 'need to know' basis in the interests of the child".

134 'It is important to appreciate that securing informed consent is a process – not an administrative task. Merely "getting a consent form signed" is not what it is all about. The consent form is simply documentary evidence that consent has been obtained. It is the reality of consent that is crucial. A consent form signed without a process of communication during which the patient has learned about his/her illness and treatment options and reached a point where they can decide, on an informed basis to proceed with, restrict, or decline the proposed intervention has little, or no value.' (Dublin Hospitals Group Risk Management Forum, 2006:2).

135 www.citizensinformation.ie

136 The full title of the Act is: Civil Partnership and Certain Rights and Obligations of Cohabitants Act, 2010. The Act has not yet been enacted but is expected to come into force in 2011 (See Citizens Information at www.citizensinformation.ie).

137 These are based on over 50 meta-analytic studies which themselves are a synthesis of over 2,500 separate controlled studies (Asay and Lambert, 1999).

138 The other two factors are therapeutic technique and client hopefulness, each of which are estimated to contribute about 15% to outcomes (see McKeown, 2000:Chapter Three). Therapeutic

technique seems to work best when, through sensitive and intelligent questioning, it helps the client to gain insight about their situation while simultaneously helping to restore their problem-solving abilities (Miller, Duncan and Hubble, 1997, Chapter Seven; Ogles, Anderson and Lunnen, 1999). By contrast, hopefulness seems to operate more as a 'placebo effect' in the sense that many interventions – therapeutic, medical, even religious – are known to have a beneficial effect simply by virtue of the client's belief that they are effective. In other words, these 'rituals' – such as the ritual of going for help – have the effect of restoring hope in the possibility of improvement which, in turn, has the effect of "mobilising their intrinsic energy, creativity and self-healing potential. Personal agency is awakened by technique" (Tallman and Bohart, 1999, p.100). Conversely, hopelessness is when people feel they can do nothing to improve their situation or when they feel there is no alternative; in other words, they are unable to pursue their goals because their generative capacity for "agency" and "pathfinding" has been lost (Synder, Michael and Cheavens, 1999, pp.180-181).

139 Bergin and Garfield, 1994:825-826.

140 Sprenkle, Blow and Dickey, 1999:334.

141 'It seems no coincidence that so many of the elements of the effective therapist-client relationship appear similar to the 'good enough' parent-child relationship' (Howe, 1999:99).

142 Rogers, 1957.

143 Hubble, Duncan and Miller, 1997:Ch.4; Duncan 2010. An excellent source of information on therapeutic effectiveness is available at: http://heartandsoulofchange.com

144 McKeown, 2000.

145 Mukherjee, Beresford, and Sloper, 1999:1.

146 Barth, Lee, Lindsey, Collins, Strieder, Chorpita, Becker, and Sparks, 2012.

147 Barth, Lee, Lindsey, Collins, Strieder, Chorpita, Becker, and Sparks, 2012:114.

148 Task Force on the Child and Family Support Agency, 2012:xii-xiii and 37-38.

149 'Rather than expecting practitioners to choose either manualized practices or common factors/elements, a "both/and" perspective should be embraced. … . Flexibility in engaging clients is central to an outcome-informed approach. Treatment should be adapted to meet a client's characteristics and preferences, including the therapists own style and methods. Fidelity here means assessing the client's perspective of the treatment to insure that the client's goals are being met and, if not, changing course. In this way, fidelity does not mean staying true to a treatment manual, but staying true to the client's goals in the treatment process' (Barth, Lee, Lindsey, Collins, Strieder, Chorpita, Becker, and Sparks, 2012, p. 113).

150 It is reported that evidence-based programmes are not widely used in social work (Plath, 2006; 2008; Barth, Lee, Lindsey, Collins, Strieder, Chorpita, Becker, and Sparks, 2012) or social care (Farrelly, 2009).

151 The similarity between how one relates to oneself and how one relates to others is based on the understanding in developmental psychology that a person's sense of self and others derives from the primal relationship between the child and the primary care-giver, usually the mother. As a result of this relationship, 'the infant develops expectations of the caregiver's behaviour and complementary beliefs about himself or herself. For example, an infant who has experienced a history of contingent responsiveness from a primary caregiver will develop a model of that caregiver as available, and expect such behaviour. That child will also develop a complementary sense of self that he or she is worthy of responsive care. … More generally, these internalised working models are seen as providing a framework for future interaction, resulting in a repetition of the early attachment relationship' (Bronfrenbrenner and Morris, 2006:816). The three main types of attachment that are formed in childhood and influence adult relationships are: secure attachment, insecure-avoidant attachment, and insecure-anxious attachment (Bowlby, 1979; Ainsworth, 1991). A secure style is

where others are regarded as reliable and available and is associated with a warm, positive and reassuring style of interaction. An insecure-avoidant style is where others are regarded as uninterested or unavailable and is associated with an interaction style that is cold, competitive and controlled. An insecure-anxious style is where others are seen as unreliable or difficult and leads to an interaction style characterised by anxiety, stress and lack of confidence. These core concepts are widely used to explain different patterns of interaction among adults but are also used to help those who work in the caring professions (doctors, nurses, social workers, family workers, etc) to become more aware of their interaction style and how it relates to their experiences of attachment (see for example Janssen, Macleod and Walker, 2008).

152 The Task Force Report on the Child and Family Support Agency (2012:16) emphasised the need for a performance management framework to ensure that all services are accountable and to create a 'performance dialogue' between Government Departments and Agencies, mindful of the OECD (2008:247) observation that this dialogue tends to be missing in Ireland. In addition, the Task Force recommends that accountability needs to shift from its traditional focus on inputs and processes 'to one that focuses on desired outcomes and realistic measurable targets' (Ibid).

153 One of the strategic objectives of the Department of Children and Youth Affairs is to 'monitor and evaluate performance through strong governance and accountability systems in respect of responsibilities of the Department and its agencies' (Department of Children and Youth Affairs, 2012:6 and 15-16).

154 SPEAK is an acronym for Strategic Planning, Evaluation And Knowledge-networking System. The system comprises a series of computerised forms or screens for data entry and a database for storing quantitative and qualitative information.

155 For example, Kelleher and Kelleher, 1997.

156 McKeown, 2011b.

157 http://toptierevidence.org/; see also the US-based Coalition For Evidence-Based Policy at: http://www.evidencebasedpolicy.org.

158 http://toptierevidence.org/.

159 The effect size is a simple way of measuring the impact of a programme by standardising and comparing the difference between the baseline and follow-up, or between an experimental and control group. It involves subtracting the mean at baseline from the mean at follow-up and dividing by their pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. The convention established by Jacob Cohen (1988), and referred to as 'Cohen's d', is that a coefficient between 0.2 and 0.5 indicates a small effect, between 0.5 and 0.8 indicates a moderate effect, and above 0.8 indicates a large effect.

160 Layzer, Goodson, Bernstein and Price, 2001; see also Nelson, Westhues and MacLeod, 2003.

161 Schweinhart & Weikhart, 1997.

162 Barnett, 1996.

163 Schweinhart, 2004.

164 Cited in McCartney & Dearing, 2002.

165 In the UK, a recent report recommended: 'that the United Kingdom should adopt the concept of the foundation years from 0 to 5 (including pregnancy), and give it at least the same status and recognition as primary or secondary stages. Its prime objective should be to produce high levels of 'school readiness' for all children regardless of family income' (Allen, 2011:46). This recommendation is based on wide review of the importance of the early years including the finding that: 'babies are born with 25 per cent of their brains developed, and there is then a rapid period of development so that by the age of 3 their brains are 80 per cent developed'(Allen, 2011:xviii).

166 NICHD Study of Early Child Care and Youth Development, 2006:25.

167 Naturally, this does not imply that interventions such as quality child care do not have beneficial effects. Rather, the implication is that interventions to improve 'family characteristics' and parent-child relationships are likely to have more beneficial effects in light of the NICHD finding that these have a 2-3 times stronger association with child outcomes compared to child care (NICHD Study of Early Child Care and Youth Development, 2006:25).

Family Support Agency