# Making Reform Work for Children

## A National Analysis of Social Care and Health Services for Children and Families

National Forum for Directors of Children and Family Services

December 2004

# MAKING REFORM WORK FOR CHILDREN

## A NATIONAL ANALYSIS OF SOCIAL CARE AND HEALTH SERVICES FOR CHILDREN AND FAMILIES

*"There is currently a growing public debate about children, about their care, behaviour and aspirations and about what the future holds for them. There is increasing recognition of the richness and complexity of their lives and how that can impact both positively and negatively on the lives of others. There is also an acknowledgement of past failures in meeting children's needs and the continued existence of barriers which inhibit some children from realising their full potential. There is a recognition that present challenges and past mistakes must be faced openly so that further progress can be made."*

National Children's Strategy - Our Children - Their Lives (2000)

# Contents


| | | |
|---|---|---|
| | Foreword | 3 |
| 1. | Overview | 5 |
| 2. | Context for current services for children and families in the Health Boards | 9 |
| | 2.1 Historical Context | 10 |
| | 2.2 The Statutory and Policy Context | 11 |
| | 2.3 Current Service Provision | 11 |
| | 2.4 Strengths in the System | 14 |
| 3. | Analysis of current services for children and families in the Health Boards | 17 |
| | 3.1 Strategic | 18 |
| | 3.2 Structural | 19 |
| | 3.3 Services | 20 |
| | 3.4 Staffing | 21 |
| | 3.5 Cultural/Social | 22 |
| | 3.6 Systems | 23 |
| 4. | Messages from research and/or international perspectives | 25 |
| 5. | Steps towards a future model of service | 35 |
| | 5.1 Principles and indicators of success | 36 |
| | 5.2 Tasks and analysis for the future model | 37 |
| 6. | Appendix 1 - Membership of the National Forum for Directors of Children and Family Services | 40 |
| | Appendix 2 - Statutory responsibilities in community care, child care and family support services | 41 |
| | Appendix 3 - Principles that should underpin any future model of service | 60 |
| 7. | Bibliography | 61 |

## FOREWORD

This paper was produced on foot of an invitation from the HSE change management team in June 2004 to the National Forum for Directors of Services to Children and Families to contribute to the analysis of the existing services for children and families in the context of the Reform and Modernisation Programme (2004).

The National Forum for Directors is a group of Health Board Directors and other aligned positions with regional responsibility for children and families services, established in February 2002 to enable conjoint initiatives and responses to policy formulation and service developments, as well as the planning and evaluation of services to children and families. By sharing and promoting models of best practice it provides an opportunity for shared learning and aims to provide continuity and consistency of response to national issues pertaining to children and families services. It was well placed to produce an analysis of the strengths and challenges in the existing children and families system.

An early draft of the document was widely circulated among colleagues in children and families services and in the wider health and social services to check for accuracy and completeness of the analysis. It was also proofed against national and international evidence and research to ensure a broad lens and accurate compass.

The document should be regarded as a working document and read in conjunction with other key national documents such as the National Health Strategy, *Quality and Fairness* and the National Children's Strategy, *Our Children - Their Lives*; in addition to other supporting documents prepared by individual boards or agencies.

The National Forum for Directors welcomes the proposed Reform and Modernisation Programme and acknowledges the exciting opportunities in it for children and families services to be reshaped and reformed. It is timely and much needed, and we found energy within the services for quite radical refocusing. We also wish to place on record the significant challenges that this modernisation will bring given the analysis in this paper. Considerable attention will have to be paid to leading, planning and sustaining this change process to deliver the outcomes identified. The members of the Forum are enthusiastic to participate in this process and hope that this document provides a strong initial contribution to making the reforms work for children and families.

On behalf of the group,

Nuala Doherty
Chairperson

Michèle Clear
Secretary

December 2004

# Overview

*"Achieving the goals and objectives set out in the National Children's Strategy will require changes in the way we plan and manage the delivery of services for children. An ambitious and cross-cutting plan of action has been set down which will only be achieved with the fullest collaboration and co-operation between government departments, the statutory and voluntary agencies and the research community in working with and supporting families and children."*

**The National Children's Strategy - Our Children - Their Lives (2000)**

Chapter 1

# 1. OVERVIEW

This paper has been prepared by the National Forum for Directors of Children and Families for the Interim Health Services Executive in order to contribute to their analysis of the current services provided by health boards and other agencies to children and families nationally. For the purposes of this paper the term 'children and families services' will be used to describe the range of services sometimes referred to as child care but intended to include the wider range of family and youth services. The paper identifies the issues specific to children and families services that need to be addressed in the current reform process.

The historical, legislative and policy context for the development of children and families services in the health boards and other agencies is set out at the start of the paper. It goes on to identify current service provision and highlight some strengths in the current system, and, most importantly, it offers an analysis of the existing system from a strategic, structural, service, staffing, social/cultural and systems perspective. The emerging themes are then researched against national and international perspectives with particular emphasis on extracting the evidence of what has worked in responding to the social care needs of children and families. The paper concludes by identifying a number of future indicators of success, and tasks and analysis to assist with developing the model for the way forward.

The development of the paper resulted in lively debate, honest and forthright exchanges of different views and experiences and in-depth analysis of the reality of planning and delivering services on the ground in the Irish health and social care services context. What emerged was a consensus on the complexity of the area of children and families services and an agreement that health boards and their agencies are only one of the key players in the delivery of services to children and families. The Departments of Education and Science, Health and Children, Social, Community and Family Affairs, Justice, Equality and Law Reform and their agencies are all core government departments with varying remits for children and families.

The history of children and families services in the health boards, outlined in Section Two, is one that emerges from generic community care services in the 1990s, which were responding to new statutory and legislative developments giving the health boards responsibilities for the safety and welfare of children. Over the past decade, an increasing raft of legislation, regulation and standards, underdevelopment of services and the limited availability of some staff resources have resulted in the development of specialist children and families services which are essentially focused on and dominated by the task of child protection. These structures and processes were largely adopted from neighbouring jurisdictions: countries which have a heavy emphasis on child protection and investigation systems and who are themselves experiencing considerable difficulties with this model of service (see *Every Child Matters, 2003).* The particular problems with the current system in the areas of governance and accountability, lack of clarity in relation to management structures, staff recruitment and retention problems, poor co-ordination etc. are described in detail in the further sections of this paper.

The complexity and potential for fragmentation, duplication and overlap was identified in the National Children's Strategy. It acknowledged some improvements in co-operation on certain issues between departments since the appointment of a Minister for State with special responsibility for children but also set out the need for a framework for the co-ordination and integration of activity in areas that cut across departmental and agency boundaries. The new framework for the implementation of the strategy included a Minister for Children, with overall responsibility for co-ordinating children's policy, and the establishment of a National Children's Office to support and advise the Government and the Minister for Children in relation to the implementation of the strategy, to provide a major boost to managing cross-departmental issues and to be the catalyst within the Government's administrative system for ensuring inter-departmental co-operation and the integration of activities on children's issues. More than three years on, the limited success of these structures in developing a seamless strategic approach is indicative of the complex and challenging nature of the task of implementation. It is worth noting that there is agreement that the National Children's Strategy and the National Health Strategy do both provide the vision, the

framework and much of the national strategic architecture required for the future direction of services to children and families; however, the challenge was and remains to be meaningful implementation at planning, management and service delivery level.

The current fragmentation and poor co-ordination of services at local health board level is a mirror of this national picture and cannot be resolved in a health services reform programme alone or independent from the development of effective cross-departmental and inter-agency structures. Local co-ordinating agencies such as the County Development Boards and County Child Care Committees could maximise their contribution to children and families services if there was a clear national direction, with less fragmentation of children's services, both within the health boards and throughout all agencies with a remit for children and families. In health boards currently, services for children and families are delivered through a number of programmes, departments and agencies, e.g. generic Community Care, Primary Care, Child Care and Disability Care groups, as well as in health promotion, mental health services and in the acute hospital services. This fragmentation of services and the resulting frustrating and negative effect on families is inefficient, ineffective and unsafe. Careful attention will have to be paid to integrating all services for children and families in the reform process.

A core emerging message from the analysis of the current Irish system is that the primary purpose of services to children and families must be to support children and families and that by promoting their welfare, well-being and health, children will be safer. Child protection work needs to be reintegrated into and with other children and families services while acute and targeted services need to be embedded into universal services so that child protection is not separate from supportive and empowering services for families.

Chapter 5 in this working document sets out a number of critical success factors for any future model of services and identifies a number of tasks and further analysis to assist with the advancement of the future model. These include being clear about the mandate, amount and capacity for change; reviewing existing primary and secondary legislation; scoping the resources available to the new system and mapping existing services and data available.

Over and above this there is a need to promote ongoing learning, particularly that which is critical to service design.

# Context for current services for children and families in the Health Boards

"An important structural problem is evident in the way in which agencies have been established as a 'part-solution' rather than a more radical 'full-solution' which would address the interrelated nature of the system. This often leads to a dilution of the effectiveness of system critical functions, hidden and poorly used pockets of expertise and an inappropriate location of functions. Our findings reflect the need for comprehensive structural reform."

**Audit of Structures and Functions in the Health System - Prospectus 2003**

Chapter 2

# 2. CONTEXT FOR CURRENT SERVICES FOR CHILDREN AND FAMILIES IN THE HEALTH BOARDS

## 2.1 Historical Context

For the purpose of this document we have looked at the historical context from the setting up of the eight regional health boards in 1970, while also acknowledging that the history of child care in Ireland certainly precedes this time. The community care team structure in health boards was developed on the basis of the McKinsey report, *Towards Better Health Care: Management in the Health Boards (1971)*, commissioned by the Tánaiste and Minister for Health, Erskine Childers, T.D. in 1970. This envisaged a horizontally integrated approach to service delivery by the full range of community based services. The managers of those services were to be co-ordinated in the community care team under the direction of the Director of Community Care and the Medical Officer of Health. McKinsey described the purpose of the 'Care of Children Sub-programme' as being

*"to care for children in the community roughly between the ages of 6 weeks and 16 years. It will include the school health service, immunisations, general medical services, including identification of emotional disturbance, dental, ophthalmic and oral services, care of 'problem' children and care of handicapped children in the community".*

McKinsey emphasised the importance of having middle and senior management posts filled by *"people with professional training"*. Also emphasised was the importance of integrating professional and administrative responsibility at the various management levels, so that the Director of Community Care would have *"direct management control over the professional services providing community care"*. However, a number of issues arose in the implementation of this model that ultimately saw it being significantly modified. These included:

- The replacement of the Directors of Community Care and Medical Officers of Health by General Managers
- The move to a Care Group model of service planning and delivery.

It is interesting also to note the comment a decade later within the Community Care Review Report by Inbucon Management Consultants, commissioned by the Community Care Review Steering Committee of the Department of Health in March 1982, that the social work service in health boards *"was principally introduced to protect the interests of children in care"*.

Prior to the *Child Care Act, 1991* there was a limited statutory basis for service delivery. During the 1970s, as social workers were recruited by the new health boards they provided a broad based generic social work service, which included child welfare and protection. However the scope and scale of the issue was quite limited at this stage. Over the following two decades there was a dramatic increase in the number of referrals of child abuse to social work departments. National statistics show that in 1984 there were 88 referrals; in 1989 there were 1,242 referrals; by 2001 this had risen to 5,994. This increase reflected and was a symptom of a societal process that saw an awakening to the reality of child abuse.

Social work departments in health boards were key players in this process, assuming responsibility for the investigation of cases of child abuse and providing appropriate interventions. These departments were constrained in this function by a number of issues including those in regard to the absence of a statutory legislative and policy framework, national or regional plans or an overall agreed model of provision. Some of these issues were further identified in the reports of a series of investigations of high profile child abuse cases, starting with the *Kilkenny Incest Investigation* (McGuinness, 1993) and all of these issues are developed further throughout this document.

A number of initiatives were taken to address the identified issues. These included the development of child care legislation and regulations, additional management posts and a significant increase of resources. This was carried out, however,

without the benefit of national strategic planning for children at an inter-departmental level. It is this lack of national and local planning, including human and financial resource planning, and the resulting ad hoc incremental development of services that has led to a number of the current difficulties.

The Child Care 'Care Group' was developed, supported by the Child Care Manager post, with an increasing emphasis on meeting statutory obligations and developing specialist child protection services. This separation from the generic community children's services, including child health services, continued through the 1990s and was reinforced by the absence of funding and development of the generic, universal children's services. There were some exceptions to this where Children and Families Care Groups were established, which included both Child Care and Child Health, including Child and Adolescent Mental Health.

### 2.2 Statutory and Policy Context

Health boards have a range of statutory responsibilities in regard to children, some of which are stated below. What is notable is that there has been a significant increase in primary legislation, regulation and standards since 1991 (see Appendix 2), which has driven the direction of children and families service provision. It should be stated that there is a range of legislation, both within the wider health context, e.g. disability and mental health, and outside health, e.g. education, that has direct impact on children's lives but is outside the scope of this paper.

A health board:

- "shall promote the welfare of children in its area who are not receiving adequate care and protection" *(Child Care Act, 1991 Part 2 Sect.3(1))*
- "shall provide child care and family support services" *(Child Care Act, 1991 Part 2 Sect. 3(3))*
- "where it appears to a health board that a child who resides in its area requires care or protection that he is unlikely to receive unless he is taken into care, it shall be the duty of the health board to take him into care" or "where appropriate" it shall be the duty of the health board to make application for a care order *(Child Care Act, 1991 Part 2 Sect. 4) or a* supervision order *(Child Care Act, 1991 Part 4 Sect. 16)*
- "where it appears to a health board that a child in its area is homeless - the board shall take such steps as are reasonable to make available suitable accommodation for him"*(Child Care Act, 1991 Part 2 Sect.1)*
- "shall appoint a person to convene a family welfare conference" *(Children Act, 2001 part 2 Sect. 7 - not yet commenced)*
- "shall send a representative to the station as soon as practicable" (where a child in custody on suspicion of having committed an offence may be in need of care or protection) *(Children Act, 2001 Part 6 Sect. 59 (1) – not yet commenced)*
- "where is appears to an immigration officer or an authorised officer that a child under the age of 18 years, who has either arrived at the frontiers of the State or has entered the State, is not in the custody of any person, the officer shall, as soon as practicable, so inform the health board in whose functional area the child is and thereupon the provisions of the *Child Care Act, 1991*, shall apply in relation to the child." *(Refugee Act, 1996, Section 8(5)(a).*

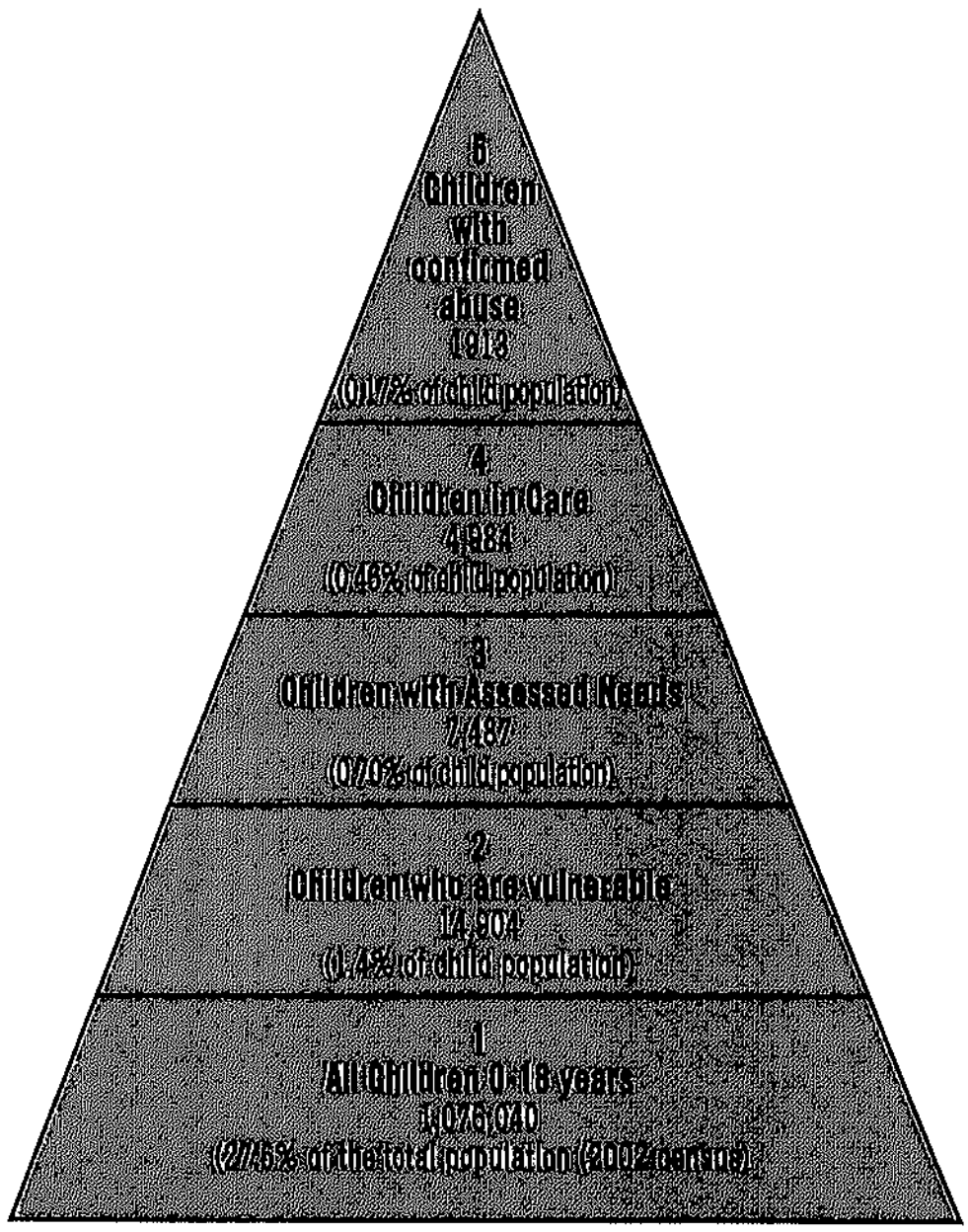
### 2.3 Current Service Provision

In order to fulfil these and other responsibilities health boards are required to provide a range of services directly or indirectly by commissioning other agencies on their behalf, which

- identify children and families in need (some activities are proactive, e.g. PHN visits to all new born babies, and others reactive, e.g. social work response to a child protection concern).
- promote the welfare of children who are not receiving adequate care and protection, e.g. social and personal health education work with schools, crisis pregnancy, sexual health strategies etc.

- co-ordinate information relating to children in its area not receiving adequate care and protection, e.g. population profiling, reviews and evaluations, performance indicators, care plan reviews, case conferences.

Hardiker at al. (1991) have provided a useful framework to describe the continuum of needs for children and families. For the purposes of this document an adapted model is outlined below to demonstrate the numbers of children known to the child protection services of the Boards within a continuum of need. It should be noted that this is a much more limited presentation of need because it only represents statistics gathered nationally from the minimum dataset and is further limited by the absence of information from other statutory and non statutory agencies working with vulnerable children. There is the possibility that some children counted in the numbers at lower levels may also be included in the higher levels from 3 to 5. It has therefore not been possible to represent the broader numbers that would be described in the original Hardiker model.




2. Children who are vulnerable refers to those children reported to the social work service during 2003.
3. Children with Assessed Need refers to the portion of the 12663 children assessed by the social work service during 2003 as having ongoing needs.
4. Children in Care refers to all those in foster, residential or special care at the end of 2003.
5. Children with Confirmed Abuse refers to the portion of the 12663 children assessed by the social work service during 2003 where there was confirmed abuse/neglect.

**All figures are taken from the Department of Health & Children Minimum Dataset 2003.**

The range of targeted, statutory services provided within children and families include:

- family support services
- early years services - preschools/nurseries/crèches
- family welfare conference services
- assessment of child abuse referrals
- adoption services
- emergency/medium/long term care placement in residential and foster care
- special/secure care
- after-care services
- homeless services
- assessment and care for separated children seeking asylum and children moving to and from other jurisdictions
- supporting services working with women and children experiencing violence
- community based therapeutic services, e.g. psychology, speech and language etc.

It is worth setting out here the most available current expenditure as of year end 2003 by the health boards nationally for a large portion of the range of children and families services described above.

Table 1

| | | €m |
|---|---|---|
| **Foster Care Allowances** | | 73,008,456 |
| **Residential Care** | Mainstream | 87,451,343 |
| | High Support/Special Care | 25,421,782 |
| | Special Arrangements | 13,257,983 |
| **Community Based Family Support** | | 45,751,325 |
| **Legal Fees** | | 9,817,137 |
| **Total Others*** | | 118,952,513 |
| **TOTAL** | | **373,660,539** |

*This category is inclusive of Child Protection, Violence against Women, Youth Homelessness and other miscellaneous categories. It does not include the range of services that children and families may receive such as Child & Adolescent Psychiatry, Community Based Therapuetic Services ets. as these are not part of the budget in most of the Board's children and family services.

The above expenditure is inclusive of the very significant increased resources that have come into the children and families revenue budgets of the boards through the annual Letters of Determination from 2000 to 2004 and the table below sets out the additional allocations in all years from 2000 and 2004 in summary format for the purposes of noting the significant areas targeted by the Department of Health & Children in these allocations and the overall percentages they represent of additional funding in the last four years.

- Foster Care at €38m and 26% of total national development allocation since 2000
- Special Care and High Support at €23m and 25% of total national development allocation since 2000
- Youth Homelessness at €14m and 10% of total national development allocation since 2000
- Family Support at €15m and 10% of total national development allocation since 2000
- Legal Fees at €5m and 4% of total national development allocation since 2000

| | | €m | % of Total |
|---|---|---|---|
| **Letters of Determination 2000-2004** | | | |
| **Alternative Care** | Residential | 4,563,500 | 3.2% |
| | High Support | 13,505,000 | 9.3% |
| | Special Care | 9,717,000 | 6.7% |
| | Foster Care | 37,889,021 | 26.2% |
| | SSI recommendations/After Care | 3,540,619 | 2.4% |
| | Special Arrangements | 3,262,000 | 2.3% |
| **Inter Country Adoption** | | 1,680,157 | 1.2% |
| **Child Protection & Welfare** | Children Bill/Act | 10,150,868 | 7.0% |
| | Child Protection | 3,170,060 | 2.2% |
| | Video Recording | 1,072,000 | 0.7% |
| | Children First Guidelines | 6,200,785 | 4.3% |
| **Pre School** | Pre School | 2,204,000 | 1.5% |
| | Pre School Inspection | 1,540,000 | 1.1% |
| | Childminder notification | 1,523,224 | 1.1% |
| | Child Care | 26,000 | 0.0% |
| **Family Support** | Family Support | 6,880,722 | 4.8% |
| | Springboard | 6,737,000 | 4.7% |
| | YAP | 1,350,000 | 0.9% |
| **Youth Homeless Initiative** | | 14,213,092 | 9.8% |
| **Information Management** | | 1,016,790 | 0.7% |
| **Violence Against Women** | | 4,153,947 | 2.9% |
| **Legal Costs** | | 5,230,000 | 3.6% |
| **Victims of Past Abuse** | | 2,538,000 | 1.8% |
| **Other Service Developments** | | 1,007,000 | 0.7% |
| **Unaccompanied Refugee Minors** | | 1,587,000 | 1.1% |
| **TOTAL** | | **144,757,785** | |

The wider range of children's services also include the following which are not included in the financial analysis above:

- child health services
- mental health services
- disability services
- services for children and families with substance abuse problems
- services for children with complex physical health problems.

### 1.4 Strengths in the System

While the argument for the need for modernisation and change in the health services reform documents are applicable to services for children and families, cognisance should also be taken of the strengths in the existing system. The National Children's Strategy, with its core emphasis on a child-centred approach and whole-child perspective, sets out an excellent strategic vision that must be brought forward into any future system. This is reinforced and underpinned by the National

Health Strategy with its emphasis on health and social gain, and its focus on addressing inequalities, responsiveness and appropriate care, high performance and the need to target preventative approaches and develop family support services.

Most recently, the Programme of Action for Children initiative, under the HeBE, identified the need for a more co-ordinated and integrated national approach in health to promoting the health and welfare of children and supporting their families. The Programme of Action for Children is attempting to develop a single integrated health services framework for all children and its deliberations and findings should be examined for the purposes of any reform programme.

Any strategic change process should also capture and build on the existing strengths in the current delivery system. Examples of some positive initiatives and service developments, in no order of priority or significance, are:

- The Family Welfare Conference service with its emphasis on including and empowering families.
- The potential of the National Child Care Information Project to deliver good quality information essential to planning and delivering good services.
- The development of inspection and monitoring services and processes, e.g. the Social Services Inspectorate and the Pre-Schools Inspection service.
- The predominance of in care placement of foster care and relative foster care with at least 80% of young people in care placed in foster care and, within foster care, increasing numbers placed with relatives.
- The County Child Care Committees, which have brought a focus to early years services and which provide a mechanism for inter-sectoral planning.
- The addition of community based high support services to meet the more complex needs of some young people.
- The presence of a Youth Homelessness Strategy and associated action plans emphasising early intervention and multi-disciplinary and inter-sectoral working.
- The current National Review of Family Support Services towards the development of an agreed national strategy for early intervention/prevention services.
- Building on research and evaluation initiatives that reinforce services that are needs led and outcomes focused, e.g. national and local evaluations of Springboard, Teen Parent Support Initiatives, Youth Advocacy Project, Family Welfare Conference etc.
- The ability within the system to respond to unplanned and emerging needs, e.g. Services for Separated Children Seeking Asylum.

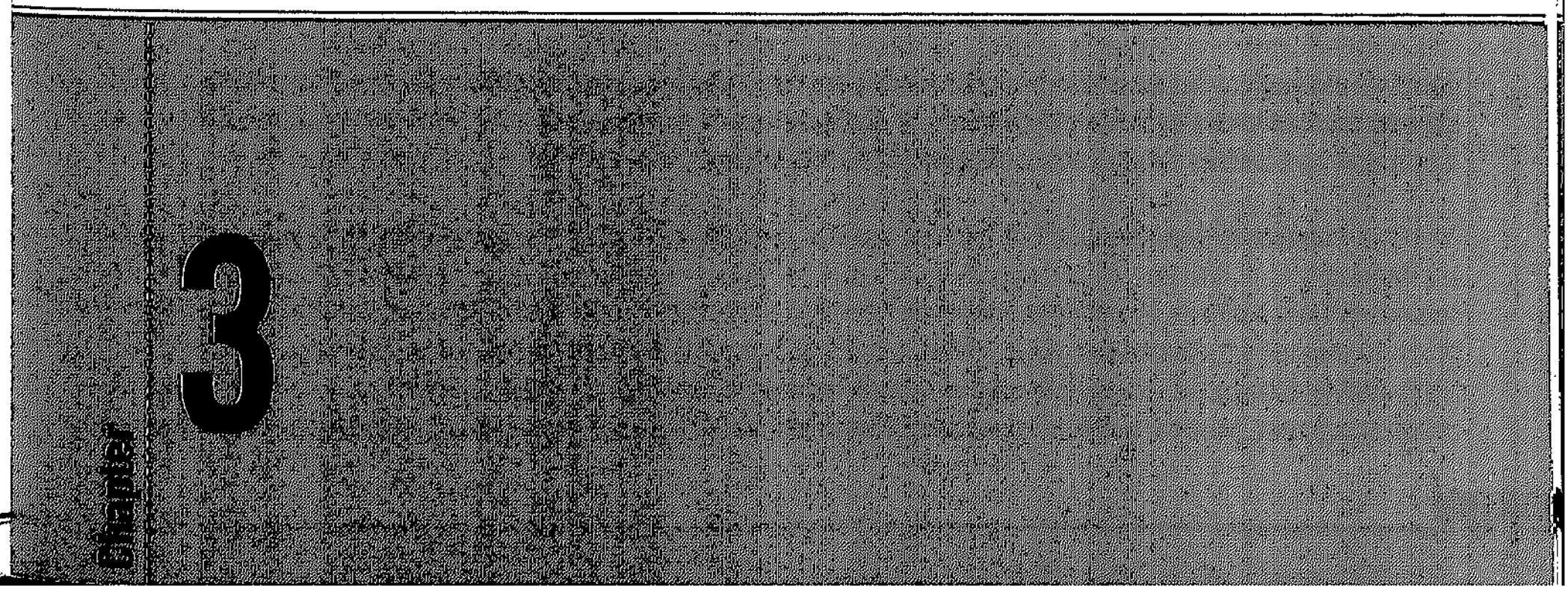
Uniquely in the statutory services, there is a legislative requirement for each health board to carry out and to produce a report on an annual review of the adequacy of the range of children and families services, which is adopted by the board and signed off by the Child Care Advisory Committee. In addition, as with other care groups, there has been considerable development in the area of service planning, as well as mechanisms for monitoring and evaluation such as performance indicators, quarterly reviews and the interim dataset.

It is worth stating that children and families services do currently have a well-developed strategic direction with a number of the key engines of change identified. With the essential architecture in place the challenge in the reform programme is largely to give effect to this and enable this strategic vision to manifest itself at service delivery level for both service users and staff.

# Analysis of current services for children and families in the Health Boards

"The National Children's Strategy is a major innovation for Irish social policy. It is not a report on the lives of children in Ireland but a means to intervene in their lives in a way that will enhance their status and improve their quality of life. This is the first time an attempt has been made to draw together policies and measures from so many departments into a coherent strategy for future action."

**The National Children's Strategy - Our Children - Their Lives (2000)**



# 3. ANALYSIS OF CURRENT SERVICES FOR CHILDREN AND FAMILIES IN THE HEALTH BOARDS

The detailed analysis below of the current environment will evidence how the findings in the Brennan and Prospectus reports and the vision and goals as set out in the National Health Strategy are directly applicable to children and families services.

## 3.1 Strategic

"The National Children's Strategy is a major innovation for Irish social policy. It is not a report on the lives of children in Ireland but a means to intervene in their lives in a way that will enhance their status and improve their quality of life. This is the first time an attempt has been made to draw together policies and measures from so many departments into a coherent strategy for future action."

The National Children's Strategy - Our Children - Their Lives (2000)

Between the mid-1970s and the late 1980s children and families services experienced minimal development. The significant public and political attention to child protection concerns in the early 1990s led to the raft of legislation described above and the injection of relatively significant resources. These additional resources allowed for the development of services but the capacity of the planning and delivery infrastructure was limited resulting in incremental rather than planned service development, with varied interpretation and implementation of legislation nationally.

The National Children's Strategy has provided a strategic framework nationally for the future planning of all children's services. In addition, the National Health Strategy has further specified the detailed strategic direction in terms of an emphasis on the whole child and child-centeredness in terms of responsive, reflective and accountable services. It also stresses the importance of a continuum of services with targeted services embedded within universal services. Despite the addition of this and, all in the last five years, of the National Children's Strategy, *Children First, Best Health for Children, and Best Health for Adolescents*, business processes are still poorly developed and/or integrated and there is a significant need for better governmental cross-departmental planning. A range of national policy documents, guidelines and standards have been launched with no agreed implementation or change management frameworks, e.g. national foster care standards. This has resulted in continued non-standardised and varied levels of service provision across the country despite the presence of all of these strategic documents.

Arising from the National Children's Strategy, the National Children's Office and the National Children's Advisory Council were established as "*engines for change*". However this change framework as contained within the Strategy has not provided the essential central organisational engine with operational responsibility and authority for an integrated approach to service delivery.

Therefore the current health reform programme must provide an opportunity to highlight the need for effective cross-departmental and cross-agency working in order to maximise service co-ordination, integration and resource utilisation of all children and families services across all agencies and departments.

### 3.3 Structures

> "We have identified two major structural weaknesses in the health service. These are:
> - No single institution or person is responsible for the day-to-day management of the service as an integrated national entity; management and control is too fragmented.
> - The absence of clear accountability for relating clinical and other inputs to outputs."
>
> Commission on Financial Management and Control Systems in the Health Service (2003).

The current structural arrangements in community children and families departments contribute to confusion with regard to roles, responsibilities, communication, integration and delegated authority. It is stressful and frustrating for staff, opaque and unwieldy for service users and contributes to inefficiencies in resource utilisation. As identified in the Prospectus report, "*complex and fragmented structures are an obstacle to achieving improvements*", as has been the case in children and families services.

The children and families services management structures vary across boards. The broad generic model of executive management applies across the service; however, the senior specialist grades of Child Care Manager (local level) and Director (regional level) have no line management responsibility for service delivery (with some exceptions). As a result management and accountability for planning and delivery of services is separated and mandates against cohesive planning and delivery. In addition, tensions exist between the direct management of services and central accountability. This is contributed to by the arrangements for budget holding, whereby those who are regarded as ultimately responsible for specific services may neither line manage nor hold the budgets for the services delivered. Directing policy change and ensuring cost effective services can therefore be problematic.

The scope, scale and size of the children and families departments have increased dramatically in the last decade. This complexity has also been added to by the multi-disciplinary and multi-service nature of the work. Although some additional first line management posts have been developed to meet the increased demands, there have been no additional operational management structures to respond to this increased complexity and diversity and to take responsibility for the capacity of service to meet demand. As a result significant decisions for the organisation and for the children and families using the services are being made at a front-line supervisory level, which has exacerbated the lack of integration and planning of services. The vital function of staff supervision in the service has diminished in this process with a consequent impact on service quality.

Services for children and families are provided within a multi-disciplinary environment through teamwork. However, the team management structures are uni-disciplinary at present and do not facilitate this team working approach.

Service integration both internally and externally is poor, resulting in fragmentation, duplication and fundamentally unsafe systems. Internally, the links with related children's services (child health, disability service, child psychiatry, therapies etc.) have loosened with the changes in community care team structures. Externally, the formal integrating structures that have been more recently established (Child Care Advisory Committee, Child Protection Committee, Youth Homelessness Services Forum) have variously struggled to establish a meaningful and effective integrating role.

Regionally and nationally the range of children and families services provided by the broad range of statutory and non-statutory providers are planned and delivered ad hoc in an increasingly fragmented manner within professional and operational silos. This would also include the increase in the number of organisations and agencies with a remit in the area of children's services such as the Special Residential Services Board, the Social Services Inspectorate, the National Disability Authority, The National Children's Office etc. In addition, new services have been continuously added without systematic review of the range of existing services and potential for reorientation. In terms of the statutory provision, the current models

of service delivery are inflexible and unresponsive to the emerging needs of children and families, e.g. the lack of formalised out-of-hours service responses to children and families in need.

## 3.3 Services

"A specialised infrastructure was put in place from the early 1990s where the dominant focus was on child protection and on fulfilling statutory responsibility to identify children at risk. While these services were both necessary and important, awareness has grown in recent years of the need to target preventive approaches and in particular to develop and expand family support services."

National Health Strategy - Quality and Fairness (2001)

A child protection driven service has placed almost total resources into investigating, assessing, monitoring, removing, and caring for children outside of their families. This has resulted in a service which is crisis driven, overburdened, unable to cope with reports, and increasingly involved in and with legal systems, where there is insufficient time to support and assist families to change and services that are unable to meet the needs of children in their care. The effect of this is services that do not enjoy the full confidence of colleagues in health, education or the wider community. This protection and investigative driven service does not support the involvement of service users in design or evaluation, resulting in services designed to fit the organisation rather than the child. It also may not promote a strengths-based empowerment approach that prioritises the resilience of children and their families. Many staff in front line health and social services working with children find the work extremely stressful and unrewarding

The key issue for service development is that child protection has dominated at the expense of early intervention/prevention and family support services and also universal child health services. Prevention and early intervention in family support services is the key strategic imperative leading to evidenced successful outcomes; however, family support services are the least developed and most under resourced area of provision. In this regard there is an expectation that the recent review of family support services undertaken by the Department of Health and Children will provide an evidence base for an informed national strategy on family support services. In the last decade services have been challenged by increasing cultural diversity, rising consumer expectation, increased awareness of the consequences of failing to manage risk and possible litigation, and the increasing complexity of family and social structures. Service development in this area must be given clear strategic direction, supported by appropriate management and organisational structures, and shaped by nationally agreed policy and procedures. It is worth noting that some boards have started to look at models of multi-disciplinary early intervention services currently deployed in other sectors, e.g. disability.

Where there has been significant development of family support services, this has largely taken place in the non-statutory sector, commissioned on behalf of the boards, with the result that statutory child care provision is increasingly focused on the child protection and care services. This trend did not result from any strategic direction but rather from resource constraints in the statutory sector. There are very few large-scale non-statutory providers in this service area but recent developments with new and emerging providers, e.g. Youth Advocacy Programme (YAP) and Extern, are offering new opportunities for partnership in dealing with children with more challenging behaviour.

As mentioned earlier services have developed in an incremental ad hoc way and there is a need to apply more governance and monitoring mechanisms to ensure that the current service base is designed to meet identified need and is outcome focused. Governance arrangements should be regulated by service level agreements in the statutory and non-statutory sectors, with the same level of performance measurement and accountability. This type of governance would also offer an opportunity for a service that would have some level of uniformity or standard to address current issues in relation to the identified presence and/or diversity of responses to families within and between boards.

Service planning has been constrained by the absence of clear strategic direction and deficits in management structures identified above. Service development has been largely 'top down' and driven by external forces. The influence of the High Court in the development of special care and high support services is a case in point and demonstrated in terms of the huge investment in these areas since 2000 in terms of revenue and capital approximately €23 million and €35 million respectively and by a further €10 million being spent on legal costs annually.

Consumer involvement in service development remains to be progressed. Special consideration needs to be applied to this process given the special needs of the consumer group, which is largely comprised of children and disadvantaged families.

The poor internal integration with medical services, both acute and community based, creates a significant gap in service provision, which must be addressed.

## 3.4 Staffing

"Building and enhancing management capacity will be central to the ability of the health system to deliver the kind of organisational change required by Quality and Fairness. High turnover rates, low morale and high stress levels can be improved through the effective management of people."

Action Plan for People Management in the Health Services (2002)

Historical developments described above have created a service that is perceived by staff and potential staff as being crisis oriented, stressful, and therefore not attractive as a long-term career. Lack of human resource planning, performance management and job rotation policies have allowed more experienced social work staff to populate specialist second level services (fostering, adoption, training), with the 'heavy end' child protection posts being filled by graduates and overseas recruits. High staff turnover does not support service quality with a client group whose outcomes are enhanced by trust and stability. In addition, it is very difficult to either attract or retain other core disciplines, such as speech and language therapists, psychologists or medical officers, to this area.

Most child care and family support services require a multi-disciplinary input but are provided within the context of a uni-disciplinary social work department. Management structures must reflect the multi-disciplinary staffing profile. Team working and partnership activity needs to be endorsed as the preferred way of working and resources should be linked to delivering seamless services.

Leadership capacity is essential to support the change process and considerable priority must be given to strengthening the workforce, building leadership capability and improving overall performance. Management training and capacity building is an imperative in the future delivery of services. There is also a need to strengthen capability to manage and lead significant change and to work effectively in a team and partnership environment.

This is a service that potentially offers many and varied opportunities for staff to make valuable contributions and to have satisfying and successful careers. The scope, scale and variety of the service require sophisticated and targeted human resource management policies and procedures. There is a need to dialogue with the current and any possible new education and training providers in relation to developing and supporting staff, and there is also the potential to build on the initiatives arising from the Action Plan for People Management and the work of the Office for Health Management.

## 3.5 Cultural/Social

"There is a need to take more deliberate and assertive action in addressing health inequalities. Trends indicate that without decisive intervention, the gap in health between the rich and the poor will continue to widen. The Health Strategy must prioritise supporting the disadvantaged to improve their health status."

The National Health Strategy - Quality and Fairness (2001)

There is considerable evidence supporting a relationship between poverty, deprivation, and child neglect and abuse. A lot is also known about the identification of vulnerable and at risk groups and the benefits of early and pre-crisis interventions. An understanding of the supportive role of local communities, extended family networks and childhood resilience has added to our ability to work effectively in partnership with families to empower them to make change. Some of the challenges in the reform process are to build on the existing planning capacity; to enhance needs assessment planning to target inequalities at an early stage and to develop an outcome focused approach supported by strong monitoring and evaluation mechanisms.

Whilst the guiding philosophy of strategic planning, underpinned by legislation and policy, is to develop and deliver child-centred services, there is evidence that services are often designed around the needs of professional groups, departments and organisations rather than children. It is extremely difficult and challenging to hold a child focus in an otherwise adult planned and controlled service. Meaningful child and parent involvement in the design and evaluation of services must be a real objective, as well as more proactive involvement through consumer panels.

This paper addresses elsewhere the multi-departmental, multi-agency and multi-professional landscape in which services to children and families are delivered. Developing an understanding of other agencies' roles, perspectives and cultures takes time and focus, and in the over-stretched and pressurised environment of children and families services it is sometimes not possible to give effect to this breadth of understanding and practice. Working with other agencies and with the voluntary and community sector, who may have different priorities, is core to delivering services to children and families. The mechanisms to enhance this way of working must be addressed in the reform process with particular reference to common frameworks for needs assessment and service planning.

Any change management process will need to take a partnership approach to their work. The mechanisms for delivering this approach are already available through the local and regional partnership committees in each of the boards. This partnership approach with the trade unions will be particularly important in actively supporting services to children and families.

Specific groups are particularly marginalised in their experience of receiving health and social services. For example, Traveller children and families, and children and families from minority ethnic groups, experience particular barriers when accessing services. Giving effect to valuing and respecting cultural diversity will be particularly important in the reform process.

In broad terms staff beliefs and expectations are largely predicated upon a desire to work proactively and preventively in the best interests of the child. This expectation is supported by legislation and national children's policy. This strong underlying culture, which is entirely appropriate, needs to be focused and harnessed by clear strategic direction that gives equal emphasis to prevention and protection. Otherwise, the current predominance of the statutory legal imperative to ensure only the short-term safety of the child will pertain.

## 3.6 Systems

"Children's lives will be better understood; their lives will benefit from evaluation, research and information on their needs, rights and the effectiveness of services."

The National Children's Strategy - Our Children - Their Lives (2000)

"A number of steps will be required to support and develop the quality agenda. Prioritising investment in information systems will be a pre-requisite to the planned shift to an evidence-based approach to decision making at all levels - policy, clinical or managerial - in the health system."

The National Health Strategy - Quality and Fairness (2001)

The National Health Strategy recognised that achieving its very first goal, better health for everyone in terms of promoting and improving everyone's health and reducing health inequalities, is based on the concept of population health, i.e. promoting the health of groups, families and communities, as well as addressing individual health problems. It acknowledged this would have some system-wide implications in terms of information systems, human resources and research.

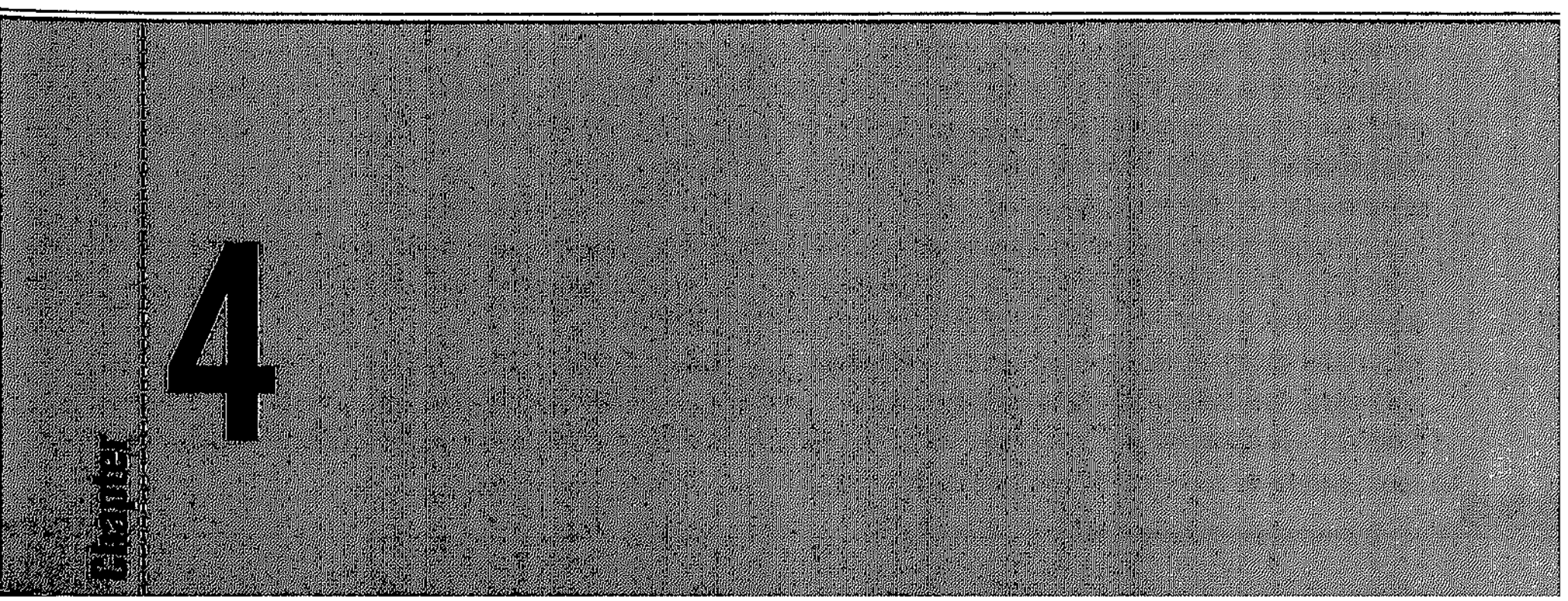
A number of service characteristics (child protection, statutory regulation, complex and varied cases) contribute to the requirement for tight management in terms of policies, procedures, information and systems in order to ensure high service quality. Formal systems, rigorously applied, are required to ensure that a range of service data is routinely available through the organisation to facilitate effective planning, delivery and monitoring of quality services. There is a need for better intelligence on demographics, deprivation and how it assists in service planning, and evaluation. In addition, the need for consistent and timely information in relation to service provision is critical for the management and development of services and has been consistently lacking in children and families services. The current initiatives in relation to agreed national definitions and a single child care information system are welcome but there is a need for cross-agency information systems and a broader approach to information gathering and sharing which captures the wider remit of services to children and families. This could be achieved through a subset of the national population health approach proposed in the National Health Strategy.

The measurement of outcomes for clients and users of children and family services is at an embryonic stage of development and requires considerable future focus. The capacity to monitor service performance, evaluate effectiveness for users, report on service quality and determine value for money are also at early stages of development in current systems and need considerable prioritisation, capacity building and focused assistance in order to deliver on them. There will need to be an awareness that the system's requirement for integrated and co-ordinated care, information sharing etc., will have to be balanced with the need to respect the child and /or their family's right to privacy.

# Messages from research and/or international perspectives

"Comparison allows you to unpickle yourself in the pickling jar and see that there is a different kind of life"

R.D. Laing



# 4. MESSAGES FROM RESEARCH AND/OR INTERNATIONAL PERSPECTIVES *

The previous sections of the report, in terms of how we got to where we are now, and the resulting issues in terms of the planning, evaluation, commissioning and delivery of services to children and families, fall under a number of repeating themes. For the purposes of comparison and an understanding of the experience of others at a national and international level, these themes were researched against current reports and reviews, not only in terms of the issues themselves, but also, importantly, of what is evidenced to have worked in responding to the needs of children and families at risk. A summary of the overall findings is detailed below.

- ***The requirement for the model of children and families services to be aligned at the macro level with the broader social services and state approach to children and families and the development and delivery of these services to be as integrated and co-ordinated as possible within and between the statutory and non-statutory health and non-health related services.***

  Systems analysis of child protection and welfare services across countries and continents has been carried out and holds important messages for Ireland's system and its future development. Child protection systems and approach to delivery of services to children and families are generally linked to wider social and economic systems and welfare systems. Spratt (2001) notes a basic 'schism' reflecting opposing positions in child welfare - one characterises a family support orientation and one characterises a child protection orientation. Gilbert (1997) and Hill, Stafford and Lister (2002, p.6) argue that countries with a 'child protection' focus, such as England, Canada, Australia and North America tend to be more legalistic in approach, delaying intervention and applying resources at the investigative 'front-end' of the child protection process. Alternatively, European countries such as Germany, Denmark, Sweden, Finland, the Netherlands and Belgium were found to have a 'family service' orientation, placing a greater emphasis on prevention and the provision of early support services. These countries' systems have developed more slowly, are embedded within a broader system of universal welfare, and work in solidarity with parents. Hetherington (2002) notes that the English speaking countries, including Ireland and the UK, are generally child protection focused and crisis oriented, reflecting a legalistic approach that is distrustful of state intervention. Countries such as New Zealand have developed a hybrid system, with elements of both child protection and family support orientations (Connolly, 2004).

  Phipps (2001) compared values, policies and outcomes in relation to the well-being of young people in the USA, Canada and Norway. Children in Norway are better off than children in the USA or Canada, in that they have less asthma, are less likely to have accidents, are less likely to experience activity limitations and are less likely to be anxious or frightened.

  The observations she makes towards explanation of the differences are: that Norwegians spend much more money on redistribution of income, child related programmes in Norway are much more likely to be universal, and Norway has supportive (and more effective) measures to encourage people in poverty to access and stay in employment (e.g. generous day care, maternity/paternity leave and time off for sick children). Kamerman and Kahn (2001) note that the Scandinavian countries have long been considered child and family policy leaders in the OECD world, with their stress on universal and comprehensive social policies, the provision of generous social benefits and a goal of gender equity. Social expenditure on children and families constitutes the highest proportion of GDP (5-6%) in OECD countries. Even after a period of slight retrenchment in the 1990s, Sweden and Denmark renewed their emphasis on universal service provision and quality care. Measures to increase the employment and earning capacity of parents are key to any successful policy to reduce child poverty (Vleminckx and Smeeding, 2001; Solera, 2001). Support for women, particularly low skilled mothers, to enter the workforce, including adequate parental leave programmes and child care provision, are important and have been cited as one of the key reasons for Sweden's low child poverty rate (Vleminckx

* The Forum requested Dr Pat Dolan and Ms Bernadine Brady to produce an analysis of research, on which this is based.

and Smeeding, 2001). The combined impact of economic, employment, child welfare and family policies, allied with outcomes from high quality care and education services, have produced positive outcomes in these countries.

It has been argued that the current Irish system of service delivery is fragmented, with duplication and overlap within and between boards, and between health boards and other agencies/services. Certainly, as indicated in both the Springboard evaluation (McKeown, 2001) and the Commission on the Family (1998), there may be an emerging trend towards development of services in disadvantaged communities, which may bring with it many services operating out of the one community but not necessarily co-ordinated. There are also agencies working with families 'disjointedly' to the extent that specific services have been developed with the primary objective of ensuring professionals 'come together to work better together for children'. This was evident in two Irish service evaluations in respect of Springboard (McKeown, 2001) and, more recently, the Youth Advocacy Programme (O'Brien et al., 2004). These trends indicate the need for greater co-ordination of child and families services, with effective cross-department and inter-agency involvement.

The significant lessons in this regard are that a macro level systems analysis of any country's services is needed to understand how the broader social services and state approach impacts on the health and welfare and well-being of children and families. This level of analysis is also required before one or more aspects of its provision can be transported to Ireland. Also that delivering health and personal social care services to children and families is a complex task and requires considerable dedicated planning and strategic development in close collaboration with other statutory and non-statutory agencies and providers.

| Differences between Anglo-American and West European Systems | | |
|---|---|---|
| BROAD TYPE OF SYSTEM | UK-North American-Australian | Continental West European |
| COUNTRIES COVERED AT SEMINAR | Australia, Canada, Scotland, England | Belgium, Sweden, France, Germany |
| TYPE OF WELFARE STATE | Tendency to residual and selective provision | Tendency to comprehensive and universal provision |
| PLACE OF CHILD PROTECTION SERVICES | Separated from family support services | Embedded within and normalised by broad child welfare or public health services |
| TYPE OF CHILD PROTECTION SYSTEM | Legal, bureaucratic, investigative, adversarial | Voluntary, flexible, solution-focused, collaborative |
| ORIENTATION TO CHILDREN AND FAMILIES | Emphasis on individual children's rights Professional's primary responsibility is for the child's welfare | Emphasis on family unity Professionals usually work with the family as a whole |
| BASIS OF THE SERVICE | Investigating risk in order to formulate child safety plans | Supportive or therapeutic responses to meeting needs or resolving problems |
| COVERAGE | Resources are concentrated on families where risks of (re)abuse are immediate and high | Resources are available to more families at an early stage |

Source: International Perspectives on Child Protection - Report of a Seminar held in March 2002, Hill, Stafford and Lister, Centre for Child & Society, University of Glasgow

| Contrast in Welfare State and Child Protection Systems | | |
|---|---|---|
| COUNTRIES | UK - American | Belgian |
| GENERAL WELFARE STATE APPROACH | Residual | Universal |
| STATE-CITIZEN BASIS | Individualism | Solidarity |
| VIEW OF CHILD ABUSE | Resulting from individual pathology | Linked to common social and parenting problems |
| APPROACH TO CHILD ABUSE | Authoritarian and punishment orientated | Helping families |
| CONTEXT FOR DEALING WITH CONCERNS | Expectation to report cases and deal with families in segregated ways | Confidentiality and health promotion |
| RESPONSES TO REFERRALS | Investigation and collation of information | Immediate help |

Source: International Perspectives on Child Protection - Report of a Seminar held in March 2002 Hill, Stafford and Lister, Centre for Child & Society, University of Glasgow

- ***The requirement for the model of child protection services to be developed and delivered as an integral part of the overall model for children and families services.***

Barter (2001) has argued that, internationally, child protection systems are experiencing a multi-dimensional crisis and are ill-equipped to deal with the contemporary pressures facing child welfare. The public perception of child welfare services has been undermined by reports documenting the failure of the state to protect children. From their analysis of 35 British child death reports, Reder, Duncan and Gray (1993) identified a number of trends: namely, flawed inter-agency communication, considering events as isolated incidents that do not contribute to the whole picture, workers accommodating poor standards of parenting; and, despite extensive involvement with agencies, poor fragmentation of services resulting in the system's failure to protect children. Connolly (2004) highlights that in New Zealand, a number of high profile child deaths have made practice become more risk averse, and more dependent on procedural mechanisms to standardise practice. Like in many other countries, child welfare services have been unable to employ and retain trained staff.

Irish and international research suggests that a narrow response to the investigation of child safety has been at the expense of a family-centred response (Thorpe and Bilson, 1998; Buckley, 2003; Spratt, 2001) and that the majority of

welfare needs are not addressed in the process of child abuse and neglect investigations. One thing we know is that the notion of child protection 'acting alone' as a child welfare system certainly does not work (Laming, 2003). Services are required that both protect the child and support the family (Connolly, 2004). This warrants fresh approaches to working with child protection within a wider framework of family support in a 'needs led' context rather than a 'one size fits all' approach (Hardiker et al. 1991; Rogers, 2003; Cleaver and Walker, 2004; Colligan and Buckley, 2004). Tomison 2004) identifies the need to effectively integrate statutory child protection services within a wider family support approach as the issue confronting child welfare in the 21st century.

- ***The requirement for the design and delivery of services to children and families to be oriented towards intervention rather than assessment, targeted at early intervention and designed as flexible service delivery models.***

If one accepts that basically the role of children and families services is to meet need effectively and as early as possible, one can easily see how for some families who attend services (voluntarily or involuntarily) their experience can be a frustrating one (Cleaver and Freeman, 1995; Farmer and Owen, 1995) and that they often find the structure of existing child and family services interventions frustrating and/or sometimes unhelpful (Colligan and Buckley, 2004; Pecora et al., 1997). One basic problem may be that time spent on ensuring accurate assessment is not matched to actual time spent on interventions to address needs once identified. Gardner's (2003) research into families' experience of the child protection system in the UK found that they were unsatisfied rather than dissatisfied with social workers and they needed more of the intervention rather than seeing professionals as being intrusive. Buckley's Irish research (2003), p.175) found that, while a number of parents indicated their satisfaction with the level of service and the quality of relationships they had with their social workers, "there were many examples of poor communication, insensitivity and lack of symmetry between the expressed needs of the parent and the response of the system". Buckley found that once 'child abuse' was ruled out, the family ceased to concern the child protection services, even though it was, in some cases, left with serious problems that were likely to impact on the children's welfare. Research across two health board regions in Ireland produced a similar finding in respect of the perception of parents using child care services (Dolan and Holt, 2002) generally and, from more recent research, in more specifically designated child protection services (Colligan and Buckley, 2004).

In Northern Ireland, Evans' (2001) review of child protection services found the emphasis on child protection skewed both in the actual help provided to children and families (which tended to be sparse) and the success of interventions (which tended to be inconsistent). Conversely, more recent research by Heenan (2004) within this specific health trust and in the light of the review, has highlighted the potential of a wider attention to children/families at risk by meeting their needs in what she calls 'community social work practice' in a designated team. Connolly (2004) makes the point that an investigative child protection system expends resources on higher-level investigations of all notifications, which has meant that lower risk notifications have had to wait for service, being left unattended and assigned to waiting lists. Many countries have found that as low risk families remain unsupported, their situation exacerbates and they return as high risk cases, meaning that important opportunities are lost for secondary prevention work. Also, the 'one size fits all' approach does not respond well to families whose needs change over time, making effective and timely responses to their needs difficult (Whittaker and Maluccio, 2002). Furthermore, if one looks at how services respond to the issue of child neglect, not alone is the definition of degree of significance of harm down to professional judgement (Horwath, 2001) but whether an intervention is provided to a family may differ between services in local community care areas and regional health board areas (McKeown et al. in paper). Horwath (2001) has highlighted that throughout the late eighties and nineties, compared to both sexual and physical abuse, child neglect in the UK and in parts of Ireland has been put somewhat on the back burner by professionals, including social workers. This has also been suggested by Parton (1997) and has become known as the 'neglect of neglect'.

Although some oversimplification is inevitable when making broad statements about national systems, let alone groupings of systems, an analysis across systems, as represented broadly in the tables above, identifies a sharp contrast in approaches and also a basis for examining how different models offer a variety of approaches. This

examination could indicate how the principles and details of the child protection systems are linked to the wider socio-economic contexts and the nature of the social welfare systems.

- ***Evidence from national and international research in relation to what works in addressing these issues.***

A body of literature has emerged over the past decade which stresses that **child protection services should be embedded in supportive and family oriented services and close to/part of other universal and early intervention/prevention services.** Key proponents in the UK include Ghate and Hazel (2002), Jack and Jordan (1999); and in the USA, Pecora (1995), Whittaker and Garbarino (1983) and Whittaker (1993; 1997). It is argued that vulnerable families are more likely to use universal/early intervention services they perceive as helpful, rather than those perceived as stigmatising. Connolly (2004) notes that, while countries may have different traditions with respect to child protection orientation, there is consensus about the need for greater service co-ordination in child protection networks in western systems of child care (Tomison and Stanley, 2001). The UK Green Paper *Every Child Matters* (2003) addresses the need for early intervention services, a greater focus on improving communication between agencies, the need for a common assessment framework ensuring that lead professionals take primary responsibility when more than one agency is involved, and the integration of professional activity through the development of multi-disciplinary teams. Writers agree that better co-ordinated services have the potential to provide more effective assessments of family need and to develop prevention services that protect children from reoccurring child abuse and neglect. Furthermore, limited resources can be more effectively targeted and roles clarified (Connolly, 2004; Bell, 1999). Thus, according to Scott (1995, p.85), child protection services become "merely one component in a complex web of child and family services at the primary, secondary and tertiary levels of prevention". Prospectively, this suggests that **the co-ordination of child and family services with effective cross-department and inter-agency involvement requires development of appropriate structure to support and deliver services effectively** (Parton, 1997). For example Foyle Trust, Northern Ireland, as part of the children services programme, the 'New Beginnings initiative' is working steadily towards a more comprehensive approach to service planning inclusive of family support building based on the UK assessment framework (UK Department of Health, 2000).

Family support services are generally targeted at 'at risk' families, with socio-demographic factors such as teenage pregnancy, unemployment, poverty, alcohol/drug use or other factors that increase the possibility of poor child and family outcomes. Lyons, Collins and Staines (2001) note that, while a large body of evidence exists to show the effectiveness of family support services with these 'at risk' groups, insufficient research has been conducted to prove the effectiveness of universally available family support services. However, there is a growing global recognition of the need to provide universally available services in the early years. For example, the Early Years Study (McCain and Mustard, 1999) in Canada advocates the provision of universal services for all young children. The Healthy Steps programme in the USA is a universal early intervention programme. As most problems will emerge from the general population, as opposed to those labelled as at high risk, universal services can act as a useful non-stigmatising means of identifying families in need of extra help. Because families don't fall neatly into the categories of 'at risk' or 'not at risk', families in need but not targeted may risk missing out on vital services, while those in receipt of services may feel stigmatised:

> *"universal surveillance of the entire population is vital to the detection and prevention of problems as there exists no other effective means of predicting where and when difficulties will occur. No screening instrument can ever be sufficiently precise to identify risk groups"* (Dingwall, 1989, cited by Elkan et al., 2000).

Offord et al. (1998) identified advantages and disadvantages associated with universal and targeted services. They concluded that the most effective method was a combined approach - a universal programme, complemented by a targeted programme for those identified as needing more support. While providing universal support would be more expensive in the short-term, commentators believe that the long-term benefits to the child and society will eventually lead to savings in the future, although these are difficult to cost (Lyons, Collins and Staines, 2001).

In the USA, Compas et al. (1993) and Whittaker (1999); in New Zealand Munford and Saunders (2003) and in Australia Gillian Calvert (2002) have argued for a much more simplistic approach which matches meeting need to identifying and supporting those who are in the best position to provide and deliver a service. Calvert has strongly supported a move away from any 'turf war' ownership behaviour by services protecting self-interest or perceived wisdom, to services delivered on the basis of common sense and a proven track record around what actually works. For example, Compas et al. (1987; 1993) argue that families who need services are those who experience negative non-chance life events for which they need help. They suggest that rather than extensive enquiry into the pathology of problems, professionals (and families) may be better served by working prospectively on reducing the number of non-serendipitous life events which the family suffer through a pragmatic programme of prevention and intervention. This includes identifying factors which cause problems and working with the family on removing the risk factors or changing them so that they are no longer a danger.

However, any such change towards more effective approaches can only work when matched to a robust model of service planning. **Delivering health and personal social care services to children and families is a complex task and requires considerable dedicated planning and strategy translated into operational action.** A strategic framework for service delivery should incorporate a 'mixed economy of help' for parents and children (Riordan, 2001) that has the capacity to blend a mixture of formal (statutory and voluntary organisations) and informal supports (family, friends, neighbours, communities, churches and other local networks) (Tracy and Whittaker, 1990). What is paramount is that service delivery is organised in a way that not alone balances between assessment and intervention phases, but functions in differing ways that meet need across specific domains (preventive, early intervention and residual), including:

- Services delivered by geography (where needed)
- Services delivered by age and maturation of children (regularly needed)
- Services delivered by adversity (known to be needed)
- Services delivered when sought by families (needed by demand).

Just as the emergent model of assessment of need built on matching interventions with outputs and outcomes is now well recognised as the way forward for children services (Cleaver and Walker, 2004), so also could this approach be applied at a macro level in service planning and organisation, as recently advocated by Combat Poverty (2003) and the and the Best Health For Children Reports (Best Health for Children, 2002; National Conjoint Health Committee, 2003). As Cooper et al. (2003) suggest, not alone does the organisation of child protection need to be more than the isolated activities of social services, but rather it should encompass "community ownership", involving quality assurance that robust principles of child welfare adopted by services are delivered to families. They further suggest that such principles should include:

- Increased professional authority and autonomy
- Increased accountability for individuals and teams
- Formal and informal forums for professionals and practitioners to take a step back and reflect on and discuss difficult cases and situations
- Greater involvement of communities in management and decisions
- Diversity of forums of delivery of welfare and points of access for children and families.

There are those who argue that child care service interventions should be organised so that in addition to meeting the needs of families, work is done to help the child or family cope with repeated risk by building individual and family resilience (Gilligan, 2001; Schoon and Bynner, 2003; Clarke and Clarke 2003). Importantly, Rutter et al. (1998) have identified eight key factors for resiliency building in children which can be targeted in child care practice, for example self-esteem building in a child as part of his/her programme to change/cope with acting out behaviours in school.

- ***Strengths in the existing systems supported by research or strong evaluation/core messages from key pieces of national/regional research.***

In line with the 'refocusing debate', intervention approaches indicate a shift in emphasis towards community and family as a site of and a key resource to intervention (O'Brien et al., 2004. Community based, family centred, strength based systems have been endorsed as effective methods of dealing with families experiencing difficulties, and young people displaying signs of aggression, criminal behaviour and mental health problems (MacKinnon-Lewis et al, 2002). Home visiting, day care / preschool, home / community and multi-systemic therapy programmes were all considered to be generally effective. Dahlberg, Potter and Lloyd (2001) note that family based programmes comprising early interventions offer the best evidence of effectiveness in working with young people at risk.

MacLeod and Nelson (2000), in a review of 56 programmes, found evidence to support the view that an empowerment approach is critical in interventions for vulnerable families. Four-fifths of parents in the *Supporting Parenting* study (Riordan, 2001) favoured open access support services for parents and children that meet parents' needs as defined by parents themselves. On a similar vein, Ghate and Hazel's (2002) research among parents in poor environments in the UK found that parents want services that allow them to feel 'in control', meet their self-defined needs and build on the existing strengths of parents and their communities.

A number of US and UK studies have demonstrated the value of structured, participative pre-school programmes (Roberts and McDonald, 1999). These programmes, such as the Perry Pre-school, High Scope and Head Start Programmes, combine a variety of methods - high quality day care incorporating aspects of pre-school education, parent education, home visiting and other methods - to improve outcomes. Evaluations showed that children who attended these programmes had significantly better outcomes than those who did not: for example, better academic achievement, less teenage pregnancy rates, and higher earnings later in life (Yoshikawa, 1994; Hertzman and Wiens, 1996).

Research into social support interventions for new mothers, including home visiting, has shown positive results in terms of parenting behaviour compared to parents who did not participate in the interventions. McKeown (2001) highlights that home-based early intervention programmes for vulnerable families can reduce the barriers to service provision that arise due to child care, transport or motivation and provide a source of social support to the parent and family. Home visiting programmes have been found to be effective by some studies, but not all, in raising self-esteem, parenting skills and confidence in disadvantaged parents, as well as reducing rates of childhood injury (Elkan et al., 2000; McAuley et al., 2004). MacMillan et al. (1994) concluded that long-term home visiting was effective in the prevention of child physical abuse and neglect among families with one or more of three risk factors: single parenthood, poverty and teenage parent status. The former Eastern Health Board's Community Mothers Programme, which is based upon a sharing of experiences between the parent and the home visitor, called a Community Mother, was considered by evaluators to be 'sound, practical and effective' (Johnson et al., 1993). As a result of the programme, children were more likely to have received all primary immunisations, to be read to daily and to have a better diet.

Also in an Irish context, evaluation of the Teen Parents Support Initiative showed that the project, which assessed and responded to the needs of young parents, was successful in helping them with parenting, helping them as young adults and making their lives better (Riordan, 2002). Similarly, research by O'Connor (1999) in the Mid-West indicates that parenting can be enhanced through models of support. In the USA, longitudinal research of 13,000 adolescents (universal and targeted populations) by South and Haynie (2004), focusing on their friendship needs as a factor in coping, produced important understanding of how young people cope. Their study found that apart from issues of mobility, e.g. changing schools or residence, having at least one close friend or family confidant was key to coping with disruption in life. Although this study was conducted within a mental health context, its results have resonance for professionals and service interventions for children taken into care, or those in crisis within local community contexts. At face value it highlights the need for professionals to support and ensure that young people work on successfully maintaining at least one core relationship in their life, be it with a family member or a friend.

Similar successful simple practice approaches are also strongly advocated through inter-agency working within the "Connexions Strategy" by Cole et al. (2004). Khoo et al. (2002), in a comparative study of Swedish and Canadian child welfare, advocate practical approaches that move away from the debate around child welfare versus child protection. They suggest that this has led in part to past failures and that orientation should rely on social interventions in known cases of child maltreatment. Through a simple range of question and answer approaches their research has resonance for worker/agency practice.

Yoshikawa (1994) suggests that it is not the number of services offered to families that has an impact on family wellness and child maltreatment, but the way the components are integrated and sequenced. MacLeod and Nelson (2000) found evidence to support the role of multi-component programmes, such as family resource centres, in providing integrated and sequenced responses to the needs of children and families at different stages of their developmental pathways. Gardner's (2003) study of NSPCC community based family projects found that users of the projects developed confidence and active support to use local resources, including professional help. Professionals said they received more appropriate referrals if they had good links with one another and with community groups. Gardner believes that this important transfer of skills and knowledge between the levels of the support network potentially improves the 'community climate': the safety and supportiveness of the community for children. A similar culture of collaborative intervention applies within the family welfare conference model currently under development in Ireland (Marsh and Crow, 1998); O'Brien, 2001).

The evaluation of Springboard (McKeown, 2001), one of the most high profile Irish family support interventions in recent years, found a clinically significant reduction in difficulties among one-quarter of all children attending the service and a five fold reduction in their perceived risk of abuse. A quarter of parents improved their parenting capacity, while four in ten reduced stress and strengthened their support networks. Nine out of ten parents felt that their life was 'better' or 'much better' since coming into contact with Springboard. Furthermore, the Health Boards estimated that the service halved the number of children at moderate to high risk of being abused or going into care. The evaluators concluded that the strategy of tackling child protection concerns through a family support approach worked well and "points the way towards more effective and holistic forms of intervention with vulnerable families" (p.119). The role of such interventions in tackling inter-generational family problems is also acknowledged.

A review of studies (Lyons et al., 2001), which examined the evidence for early intervention in preventing physical child abuse, identified a number of components of successful programmes, i.e.

- Early identification and/or screening of families referred through a universal system - ideally during the perinatal period
- Initiation of support services during pregnancy or shortly after birth
- Voluntary participation
- In-home service provision
- Case management support - formal supports for families
- Provision of parenting education and guidance.

With regard to interventions with young people deemed 'out of control' or 'at risk', Farrington and Welsh's (2003) meta-analysis of 40 well designed studies of family focused prevention programmes found significant, sustainable impacts on delinquency from the programmes included. The importance of collaboration by services relating to the youth's life is emphasised as an effective means of reducing known risks of delinquency and enhancing protective factors in the areas of a child's life (Jenkins et al., 2003). Evaluation of both the Eastern Regional Health Authority's (ERHA 2004) and Western Health Board's (O'Brien et al. 2004) Youth Advocate Programme (YAP), a community based 'wraparound programme' with young people at risk, found that the programme was largely effective and brought about a positive change in all twenty-three cases reviewed in at least one life category. A number of young people, who had been previously referred to and accepted as referrals by a high support care unit, were accepted onto YAP and did not enter high support care. Among the success factors identified in the evaluation are its non-statutory and flexible nature, the relationship between the advocate and young person, and immediacy of service.

Bearing in mind the link between social exclusion and child abuse/neglect, Weiss (2001) has outlined models for community capacity building which includes both individualised service delivery to families engaged in child protection and wider community development models. This approach is particularly noteworthy as it advocates dealing with both the immediate issues of risk and the wider, longer-term needs of families and communities that have caused them to come to the attention of services in the first place. It should also be remembered that disadvantaged individuals may not live in the most disadvantaged areas, highlighting that area focused strategies designed to address child welfare issues always need to be combined with other policies and services able to reach disadvantaged children and their families wherever they live (Jack, 2004).

While there is a body of research, as illustrated, supporting the case for family support interventions, a number of studies have been less conclusive. For example, Gomby et al. (1999) found that some but not all home visiting models produce benefits in parenting and the prevention of child neglect. They state that home visiting programmes cannot meet the needs of all children and families; other service strategies are also required. Chaffin et al.'s (2001) valuation of client outcomes among a group of 1,601 moderate to high risk clients of family preservation and family support programmes found that programme types designed to meet families' basic concrete needs and programmes using mentoring approaches were more effective than parenting and child development oriented programmes. Centre based services were found to be more effective than home based services, especially among higher risk parents. McAuley et al.'s (2004) evaluation of the HomeStart programme did not find evidence of long-term outcomes from the service. Likewise, Sundell and Vinnerljung's (2004) three-year outcomes study of the family welfare conference service in Sweden found that the perceived benefits of the service did not translate into better long-term outcomes. These findings underline the need for ongoing research and testing of models and approaches in different contexts.

- ***Staffing and Management Issues***

Research and evaluation has underlined the importance of how interventions are staffed and managed. Connolly (2004) points out that workers need to be supported in the demanding work that they do, with good supervision that helps them to work through the complex dynamics of violence and abuse. Enough workers are needed to respond to the demands of front-line practice; and they must be well trained. Resources need to be found to support good inter-agency and inter-sectoral communication and collaboration.

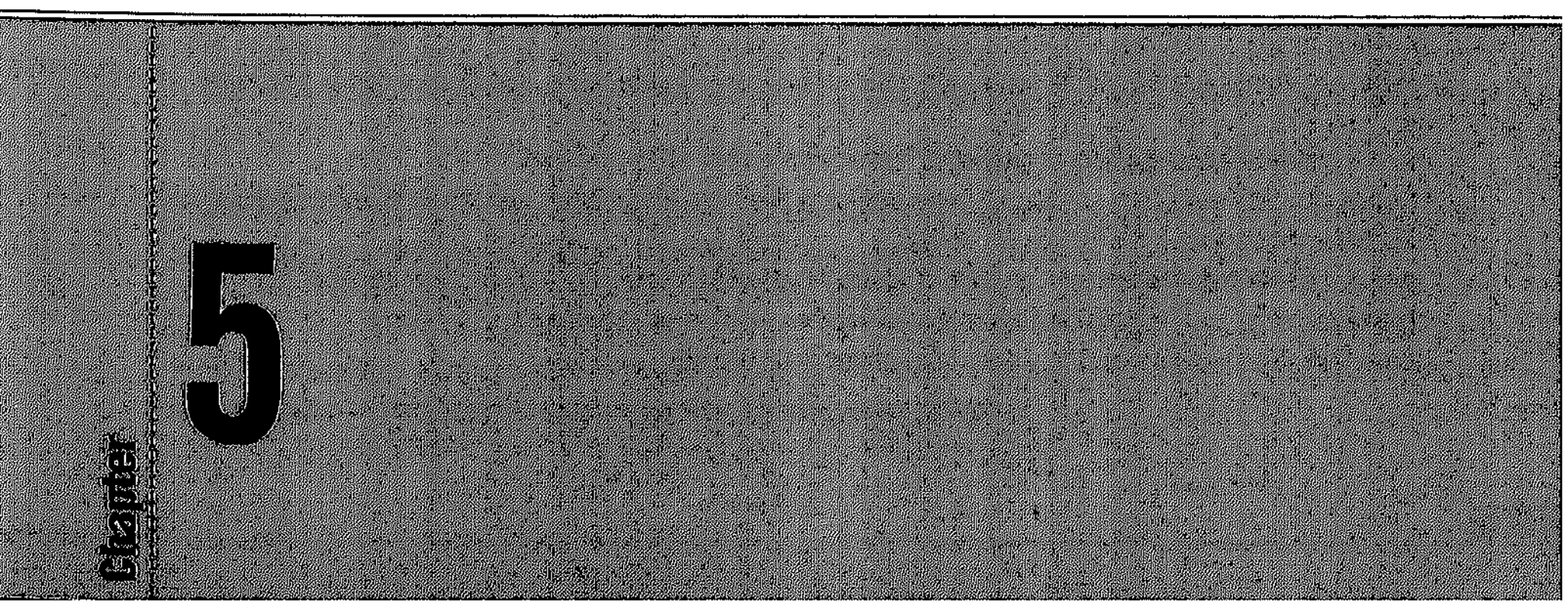
Good practice factors such as the approach and presentation of staff, planning, evaluation, cultural competence and other factors are necessary in services (Department of Health and Children, 2004). For example, the style of working of the professional is now well-recognised as a key factor in the success of the intervention (Ward and McMahon, 1998). For anyone of us in need how we are helped is crucial, but how we perceive the way help is offered may be of equal importance. For example mentoring is a simple positive relationship-based adult-child friendship volunteer support programme. Tierney et al.'s (1995) extensive control study in the USA found that befriending children in need in a 'caring way' can in itself have wider benefits in the context of their experience of adversity. The Western Health Board/Social Services Inspectorate evaluated model of self-appraisal for family support staff shows, albeit tentatively, the importance of style of working of staff in helping families (Social Services Inspectorate, 2003). Thus, from the perspective of management, organisationally, how staff are both supported and monitored is a key factor in service planning, given this centrality of 'human performance' in working with families. Apart from how workers work with families, how workers work with other workers in their own agency and in other service settings is also important (Thoburn et al., 1995). Workers who collaborate with other professionals are more likely to be able to help families better. In the past, the consequences of professional failure to collaborate have been well documented.

Assessment of outcomes to ensure that services are meeting needs is an important aspect of service provision. According to Jenkins et al. (2003), the most effective programmes display signs of efficient information systems and close monitoring, are community orientated and focus on skills such as "cognitive reasoning, problem solving, interpersonal relations and values clarification" (p. 329).

# Steps towards a future model of service

"This is the beginning of a long journey which will present challenges for all of us, but from which we must not flinch. We will be called upon to make common cause across professional boundaries and with reformed structures and services to create the means by which the needs, interests and welfare of children can be better protected and advanced. Underpinning this must be not just the resources but an attitude that reflects the value that our society places on children and childhood."

**Every Child Matters - Presented to Parliament by the Chief Secretary to the Treasury**



# 5. STEPS TOWARDS A FUTURE MODEL OF SERVICE

In developing this document there has been considerable debate and discussion in relation to the issues and way forward for the strategic development, operational management and provision of children and families services. The review of the national and international literature and research along with the analysis of the current system in the context of the reform goals and modernisation agenda assist us to identify broad next steps towards a future model of service.

## 5.1 Principles and indicators of success

The future for children and families services lies in a national strategic approach to the planning and delivery of services, informed by an agreed set of principles. Principles clearly identified and internalised will form the foundation for the ethos and culture of the service approach to children and families and are a critical element of the organisational change agenda. The principles can be informed from existing frameworks including the UN Convention on the Rights of the Child, the National Children's Strategy, the National Health Strategy and, importantly, the existing child care legislation, which mirrors some abiding principles in relation to child-centeredness, own family is best etc. There is considerable coherence in these documents, which is illustrated in the diagram in Appendix 3.

A number of critical indicators of success of the future model also emerged from the analysis and are scoped below not in any order of priority.

- Services are delivered according to the principle of subsidiarity, e.g. that a service should be provided and delivered at the lowest level of intensity and at the lowest level in the hierarchy compatible with providing an effective and efficient service.
- Services match identified needs and are outcome focused. Outcomes are clearly identified and measurable and services are accountable to meet them with local freedom and maximum flexibility about how they will be provided.
- Services are adaptable and supportive to children and families, ensuring that any specialisation is responsive to need.
- Services are delivered using a strengths based model developing the capacity of the child and/or the family.
- Services are designed, developed and evaluated in consultation with service users.
- Services have a strong community development basis, co-ordinating the activities of health with that of other agencies.
- Services are staffed by enabled, trained and motivated staff.
- Services are based on evidence, well researched, monitored and evaluated.
- There is a single executive management structure with clear lines of responsibility and accountability replicated across all community care areas.
- There is a single framework/unified business process for all services for children and their families, responding to the identified needs of children and their families (including child health, disabilities etc.) and integrated with adult health, e.g. mental health, and all non-health children services, e.g. education, social, community and family affairs etc.
- There is clarity and transparency in relation to resource utilisation at service level.
- No child or family waits for a service, i.e. some service is available immediately and the right service follows within a reasonable time frame.
- There is a whole system approach - no child or family moves unnecessarily through multiple services.
- Information about children and families is shared between services as appropriate.
- People work in an environment that shows inter-professional respect.

## 5.2 Tasks and analysis for the future model

This document was developed by the National Directors group and as part of this process the analysis was checked out for accuracy and completeness with colleagues in children and families services and in the wider health and social services. What was striking in the discussions and feedback received was not only the amount of concurrence with the analysis but also the energy and commitment to the reform process with its potential to deliver on this vision. What is important is to make rapid progress and build on this momentum.

A number of tasks and analysis are required to advance the future model:

- **Assess the mandate and capacity for change.** The mandate and capacity for change must be examined and made explicit. There are political, social, economic and cultural drivers for change. These will have different weights and influences on the amount and timing of the change process. An ongoing analysis of the fluidity of these drivers will influence the design of any future model of service. The capacity for change at a systemic level and the cultural enablers / disablers of change will need to be analysed and understood.

- **Address the underlying organisational culture.** The structural changes envisaged in the reform programme will bring some improvements but they will not address some of the underlying problems identified in this paper unless there is also change in the organisational culture. The lessons from other jurisdictions that have undergone continuous structural change is that it fails to deliver the needed systems change because the cultural forces holding the system together can withstand structural change on its own. Both structural and cultural changes need to come together to change the functioning of the system. An analysis of existing organisational culture will be helped by a strong change management and organisational development approach.

- **Articulate the explicit nature of the new system.** The analysis of the capacity and mandate for change will identify whether its nature will be incremental or radical, how much is desirable and possible, and the order and sequencing of the process. The sooner this can be articulated for staff and stakeholders the better, with the accompanying clarity around what will be retained and strengthened in the new system and how these transitions will be managed.

- **Review the legislative framework that underpins the service delivery.** Children and families services have seen a big increase in primary and secondary legislation governing and increasing its statutory duties and responsibilities. These have been accompanied by regulations and national standards providing a regulatory framework for services. Procedures and guidelines have also been developed to clarify and standardise practice. A complete review of this legislative and regulatory framework is needed in terms of how it enables or disables us when meeting the above core business in the best interests of children within our available resources. Irish child care has also borrowed and transported legislative and service concepts from other jurisdictions. It is possible for specific areas to transfer productively across national boundaries, as the family group conference has illustrated, but usually some degree of fit is required with the existing values and structures; and also some adaptation to them. A review of these issues would be useful.

- **Produce an analysis of the resources available.** An analysis should commence of the resources available to the new system, including the human resource, knowledge resource, financial allocations and the resource in the voluntary, community and NGO sector. The analysis should include how these resources are being currently deployed at a micro and macro level where the service pressures exist, and how incentives are influencing practice. The analysis should highlight inequities, address value for money issues, identify areas of possible re-focusing of existing budgets and highlight areas of priority investment in line with the new service design.

- **Collect accurate and meaningful information and data.** Service design requires accurate information and data. Foundation tasks include the mapping of current service provision, information on needs linked to agreed needs indicators, and information on outcomes. Information should be aligned with population health approaches. Evaluation methodologies will be designed to measure impact of services.

- **Promote ongoing learning.** Over and above the tasks identified above there is a need to promote ongoing learning and analysis, but priority should be given to those areas which have been identified in the paper as critical for service design. The learning from current practice nationally and internationally should be captured:

  - How multi-disciplinary and inter-sectoral working can bring better outcomes.
  - Shared priorities for children and families across all sectors.
  - Universal service design with targeted services available within it that meets the totality of children's and families' needs.
  - Where consumer involvement is meaningful in the design and delivery of systems.
  - Community development models - "It takes a whole village to raise a child".
  - Shared training and development strategies or initiatives to support a better response to children and families.
  - Whole-family approaches to child protection and welfare and balancing the best interests of the child.
  - How to develop services which are culturally and gender appropriate, and socially inclusive.
  - Where the focus on quality supports safe systems as the basis for an organisational risk management approach.
  - The relationship between judicial and therapeutic systems - how they need to complement each other to best provide for the needs of children and families.
  - How models of leadership and management influence positive services.

In conclusion, while the challenges to achieving a future service of excellence for children and families may seem daunting given the scale of the reform process which is planned and the current political and public attention on the acute sector as the only focus for change and development, many positive indicators should give confidence that the task is possible. Much is known about what works for children and families; the analysis of the existing services in this paper has been validated by peers and colleagues and is given weight by national and international research. Considerable knowledge and expertise is available internally to assist with this change and reform process. Strong and committed leadership can harness this vision and energy and translate what is known into a reality.

# Appendices

APPENDIX A

# MEMBERSHIP OF THE NATIONAL FORUM FOR DIRECTORS OF CHILDREN AND FAMILY SERVICES

| | |
|---|---|
| East Coast Area Health Board | Marian Quinn |
| Eastern Regional Health Authority | Yvonne O'Neill |
| Midland Health Board | Aidan Waterstone |
| Mid Western Health Board | Ita O'Brien |
| North Eastern Health Board | Nuala Doherty (Chairperson) |
| Northern Area Health Board | Paul Harrison |
| North Western Health Board | Aisling Gillen |
| South Eastern Health Board | Peter Kieran |
| Southern Health Board* | Cathleen Callanan<br>Oliver Mawe |
| South Western Area Health Board | Michèle Clear (Secretary) |

* *The Southern Health Board was represented by a Child Care Manager on the Forum*

**The above are the members who signed off on the final draft**

APPENDIX 2

# STATUTORY RESPONSIBILITIES IN COMMUNITY CARE, CHILD CARE AND FAMILY SUPPORT SERVICES

Adapted from a document prepared by P. Kieran, South Eastern Health Board

1. The Health Act, 1970 established the health boards, and all general functions of health boards derive from that legislation (Section 6). These include, among others, services covered by the previous Health Acts, the Mental Treatment Acts, Part 1 of the Children Act, 1908, Section 2 of the Children (Amendment) Act, 1957 (dealing with 'children at nurse'), and the Adoption Acts. The Health Act, 1970 at Sections 45 and 46 sets out criteria for full and for limited Eligibility, but these are restricted to consideration of medical services and the Act is moot in relation to eligibility for personal social services. Child Health Services are dealt with in Section 66, but the wording of the Act specifies that these constitute 'a health examination and treatment service for children under the age of six years'.

2. The specific responsibilities, duties and powers of health boards in relation to child and family welfare, care and protection matters are set out in the Child Care Act, 1991, the Children Act, 2001 and regulations that follow from these statutes, as well as various Family Law Acts, (including the Domestic Violence Act), Adoption Acts, the Refugee Act, 1996 and the Immigration Act, 1999.

3. National and international conventions, standards, guidelines and framework documents set out best practice criteria that are based on policy, research evidence and other considerations, but which are not (yet) statutorily based.

4. The specific roles, tasks and responsibilities of social workers, community child care workers, community development workers and family support workers are not set out or otherwise described in legislation or regulation. References are made to the responsibilities of health boards, or of CEOs of health boards, or of 'designated' or 'authorised' officers or 'representatives', but individual disciplines are generally not named or referred to.

5. Eligibility is different to Entitlement. People can be eligible to apply for or to seek a service, but then some assessment process generally decides which applicants will actually receive the service applied for. This is not completely straightforward in social work, as many who do not themselves apply for or seek a service actually attract the service nonetheless, because of someone else's concern about a protection, care or welfare issue.

6. Entitlement means that a person has a right to receive what she/he applies for or seeks, and must receive this.

7. The various sections of the legislation and regulations provide raw criteria for eligibility for child care and family support services:

| Child Care Act, 1991 | Function/Responsibility |
|---|---|
| Section 3 | '...promote the welfare of children in its area who are not receiving adequate care and protection'. |
| | '...identify children who are not receiving adequate care and protection'. |
| | '...coordinate information from all relevant sources relating to children in its area'. |
| | '...regard the welfare of the child as the first and paramount consideration (having regard to the rights and duties of parents)'. |
| | '...give due consideration to the wishes of the child (having regard to the rights and duties of parents; and as far as is practicable, having regard to his age and understanding)'. |
| | '...have regard to the principle that it is generally in the best interests of a child to be brought up in his own family'. |
| | '...provide child care and family support services (and may provide and maintain premises and make such other provision as it considers necessary or desirable for such purposes)'. |
| Section 4 | 'Where it appears to a health board that a child in its area requires care or protection that he is unlikely to receive unless he is taken into its care, it shall be its duty to take him into its care' (but the board cannot retain the child in care against the parents' wishes/the wishes of a person acting in loco parentis). |
| | '...maintain the child in its care so long as his welfare appears to the board to require it and while he remains a child'. |
| | '... the board shall endeavour to reunite him with that parent where this appears to the board to be in his best interests'. |
| Section 5 | 'Where it appears to a health board that a child in its area is homeless...and if the board is satisfied that there is no accommodation available to him which he can reasonably occupy, then unless the child is received into the care of the board under the provisions of this Act, the board shall take such steps as are reasonable to make available suitable accommodation for him'. |
| Section 6 | 'Each health board shall provide or ensure the provision in its area of a service for the adoption of children'. |

'A health board may take a child into its care with a view to his adoption and may maintain him in such care in accordance with the provisions of this Act until he is placed for adoption'.

### Section 8

'...a health board in preparing a report under this section shall have regard to the needs of children who are not receiving adequate care and protection and, in particular –
(a) children whose parents are dead or missing,
(b) children whose parents have deserted or abandoned them,
(c) children who are in the care of the board,
(d) children who are homeless,
(e) children who are at risk of being neglected or ill-treated, and
(f) children whose parents are unable to care for them due to ill health or for any other reason'.

### Section 9

'Nothing in this section shall empower a health board to delegate to a voluntary body or any other person the duty conferred on it under section 4 to receive certain children into care or the power to apply for an order under Part III, IV or VI'.

### Section 12

Where a Garda believes that there is 'an immediate and serious risk to the health or welfare of a child', and the child is removed from that situation by the Garda, 'the child shall as soon as possible be delivered to the custody of the health board'. The health board either delivers the child to the custody of its parent or person acting in loco parentis, or it makes application to the District Court for an emergency care order hearing within three days.

### Section 13

Where the health board brings before a District Court the case of a child where 'there is a serious risk to the health or welfare of the child' that leads to the child being placed in the care of the health board; or if the removal from the health board's care would cause such a risk to the child, the District Court can grant an emergency care order. The District Justice can give directions with respect to 'the access, if any, which is to be permitted between the child and any named person and the conditions under which the access is to take place'; and can give directions with respect to 'the medical or psychiatric examination, treatment or assessment of the child'.

### Section 14

The health board has to inform the parent or the person acting in loco parentis that the child is in the board's care. It does so by showing them a copy of the emergency care order. If they have been at the District Court sitting where the emergency care order was granted, they are already informed.

### Section 16

Where a health board believes that a child in its area 'requires care or protection which he is unlikely to receive unless a court makes a care order or a supervision order in respect of him, it shall be the duty of the health board to make application for a care order or a supervision order, as it thinks fit'.

### Section 17

A District Court Justice can grant an interim care order (with directions, as at 13), if he/she is satisfied that (a) 'the child has been or is being assaulted, ill-treated, neglected or sexually abused, or (b) the child's health, development or welfare has been or is being avoidably impaired or neglected, or (c) the child's health, development or welfare is likely to be avoidably impaired or neglected'.

### Section 18

A District Court Justice can grant a care order (with directions, and for reasons similar to those at 17 above), and the health board that is granted the care order shall '(a) have the like control over the child as if it were his parent; and (b) do what is reasonable... for the purpose of safeguarding or promoting the child's health, development or welfare'.

### Section 19

A District Court Justice can grant a supervision order (with directions, and for reasons similar to those at 17 above), and this allows the health board to have the child visited in order to oversee his welfare and, if necessary, advise his parents/carers.

### Section 20

In family law cases, if a court is concerned about the safety, care, health or welfare of a child concerned in the proceedings, and wants to consider whether some form of care or supervision order should be made, it can '...of its own motion or on the application of any person, adjourn the proceedings and direct the health board for the area in which the child resides or is for the time being to undertake an investigation of the child's circumstances': and the health board must do so. The expectation is that the subsequent report back to the court will either advise that a supervision or a care order should be applied for or not, with reasons for either advice; and an indication will be given of what other services the child may need and will receive from the health board.

Section 23

As amended by Section 16 of the Children Act, 2001:

The first sections (A-N) deal with special care orders.

**23A** - If a child is in need of special care or protection that he will not receive without a special care order or an interim special care order being made, the health board will convene a Family Welfare Conference (FWC), seek the views of the Special Residential Services Board and make the appropriate application to the court.
**23B** - The court may grant a special care order 'if it is satisfied that - (a) the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare, and, (b) the child requires special care or protection which he or she is unlikely to receive unless the court makes such an order'. The order commits the child to the care of the health board, which care is to be provided in a designated special care unit.
**23C** - The court may grant an interim special care order (28 days) in similar circumstances to those at 23B.
**23D** - allows a Garda (similar to Section 12) to act immediately without having to wait for a court to be convened, if she/he has reasonable grounds for believing that the child is in the circumstances described at 23B. The Garda delivers the child to the care of the health board; and thereafter the health board proceeds as at 23A.
**23E** - The health board has the responsibility to ensure that parents are notified of a special care order / interim special care order being made.
**23F** - The court may vary or discharge the special care order.
**23G, H, I** and **J** - procedural sections.
**23K** - allows a health board to provide a special care unit, or to make arrangements with another agency to provide such a unit on its behalf, subject to the permission of the Minister.
**23L** and **M** - procedural sections.
**23N** - 'A child on being found guilty of an offence may not be ordered to be placed or detained in a special care unit'.

The next sections (O-W) refer to private foster care.

**23O** - definitions of private foster care - essentially where the child is not in the care of the health board.
**23P** - covers the responsibility of the person placing the child and the person receiving the child to notify the health board about the placement.
**23Q** - sets out what information should be given to the health board.
**23R** - sets out the responsibilities of those who arrange private foster care.
**23S** - deals with 'authorised officers' of health boards to be appointed to inspect and monitor private foster care.
**23T** - describes the powers and duties of such authorised officers.
**23U** and **V** - describe the powers and responsibilities of health boards to act in the best interests of the child where a private foster care arrangement is not properly established, notified or operated.
**23W** - sets out the offences and sanctions that arise from the above.

### Sections 25 and 26

The court may appoint a solicitor to represent the child in proceedings that concern them, and give that solicitor directions on what is expected of them. The court may also appoint a guardian ad litem for the child. In both situations the health board pays the bills. Both types of appointments can generate work for health board social workers, but the responsibilities of health boards (other than for paying the bills) in relation to a court appointed solicitor or guardian are not described in the Act.

### Section 27

In any proceedings under Part IV or VI of the Act a court can direct a named person to produce a written report 'on any question affecting the welfare of the child'; and may further direct that person to be a witness in court.

### Sections 36

This section directs health boards to provide a range of appropriate alternative care services for children in its care, including foster care, residential care, adoption, care with a relative or 'such other suitable arrangements...as the health board thinks proper' (including a school, 'hospital or any institution which provides nursing or care for children suffering from physical or mental disability').

### Section 37

The health board shall facilitate reasonable access to children in its care 'by his parents, any person acting in loco parentis, or any other person who, in the opinion of the board, has a bona fide interest in the child and such access may include allowing the child to reside temporarily with any such person'.

### Section 38, 39 40, 41 and 42

These sections allow for the Regulations that were subsequently issued in 1995 and 1996 covering residential care, foster care and placements with relatives. These sections refer to the 'supervision and visiting by a health board of children' in care. Section 42 deals with the requirement of health boards to review children in their care.

### Section 43

This section allows a health board to remove a child from a care placement.

**Section 44**

This allows a health board to continue to financially support a child who, having been in foster care with a family, is then adopted by them.

**Section 45**

This section allows a health board to provide aftercare services to a young person leaving health board care, and specifies a number of ways in which this can be done.

**Section 46**

This section deals with the steps to be undertaken in recovering a child who has been unlawfully removed from the care of a health board.

**Section 47**

'Where a child is in the care of a health board, the District Court may, of its own motion or on the application of any person, give such directions and make such order on any question affecting the welfare of the child as it thinks proper and may vary or discharge any such direction or order'.

**Section 72**

This section sets out the specific functions of the Chief Executive Officer of a health board; but it is assumed and is custom and practice that these functions are generally delegated to specified individual staff or staff groups, under the terms of Section 16 of the Health Act, 1970. It needs to be clarified whether the job description for a particular position constitutes a document that officially delegates a function of the CEO to another officer of the Board.

**Section 75**

This section allows for the committal of a child to the care of a health board in school attendance proceedings, presumably where a health board has provided evidence to the court that warrants such a decision. Children Act, 2001, Section Function/Responsibility in Section

**Section 7, 8, 9, 10, 11, 12, 13, 14 and 15**

These sections deal with family welfare conferences (FWC) directed by the Children Court to a health board to happen or convened on behalf of a health board where a special care order is being considered. The FWC makes recommendations to the health board, so it operates as an independent entity.
An officer or officers of a health board may attend an FWC.
The relevant health board provides administrative supports to the FWC.
The Coordinator of the FWC shall notify the relevant health board of any recommendations of the FWC.

The health board must act on the recommendations received; and this may involve applications to the courts for particular orders, or putting specified services in place, or reporting back to the Children Court, if that court directed that the FWC be held.

### Section 16

Amends the 1991 Act by inserting a lengthy new Section 23, A to X, that deals with children in need of special care or protection, and private foster care - see Child Care Act, 1991.

### Section 52

Deals with who can attend the Garda convened conference. This section mentions that the 'facilitator shall invite any other persons who in his or her opinion would make a positive contribution to the conference, including one or more representatives from any of the following bodies: (a) the health board for the area in which the child normally resides'.

### Section 53

Deals with the duties of Gardaí to notify the health board of a child up to 14 years of age who has come to their attention because of their (previously criminal) activities, and who has been brought home by the Gardaí, who then discovered that the child is not receiving adequate care or protection; or in certain circumstances, including 'immediate and serious risk to the health or welfare of the child', to deliver the child to the health board. The health board must then make a decision on what action, including application to a court for an order of a specific type, is required of it.

### Section 59

Deals with children in Garda custody, where the member in charge suspects that the child in custody may be in need of care or protection and notifies the health board of this, at which time the health board 'shall send a representative to the station as soon as practicable'. This health board representative may sit in on the questioning of the child in custody. The health board then decides what course of action is required of it to support and protect the child.

### Section 70

Allows the Minister to make regulations covering the detention of a child in custody at a Garda station, including the role of the health board representative in such situations.

## Section 77

Allows a judge of a Children Court to direct that a health board convene an FWC; and may make an emergency care order pending the outcome of the FWC. The health board has to carry out the recommendations of the FWC, and inform the Children Court of what these are. (These may include application for a care order, a supervision order or a special care order.)

## Section 88

Deals at length with remand in custody matters. At 88 (13) it is stated that, 'The court shall not remand a child in custody under this section if the only reason for doing so is that the child is in need of care or protection'.

## Section 96

This section sets out the principles relating to the exercise of criminal jurisdiction over children, including '(b) the principle that criminal proceedings shall not be used solely to provide any assistance or service needed to care for or protect a child'.

## Section 100 to 106

Allow the Children Court judge to seek reports other than reports from a probation and welfare officer; and to request that the author attend court as a witness.

## Section 117

Describes conditions that may be attached to a community sanction order. These may include participating in some health board service.

## Section 129

Deals with 'suitable person (care and supervision) orders'. Like the old 'fit person orders', these might be granted to health boards - this will be clarified by practice and precedent.

## Section 167

Deals with boards of management of children detention schools, one member of which shall be 'an officer of a health board nominated by the Minister for Health and Children'.

## Section 190

Deals with visiting panels to children detention schools. It is possible that officers of health boards may be invited to join such panels from time to time.

**Section 227**

Sets out the functions of the Special Residential Services Board, including to '(e) give its views on any proposal of a health board, pursuant to section 23A(2)(b) of the Act of 1991 to apply for a special care order...'

**Section 230**

Deals with the membership of the Special Residential Services Board - three members to be nominees of CEOs of health boards, and another three to be 'experts in child care' (some of whom could be health board officers).

**Section 245 to 257**

Deal with the protection of children and various offences against children. Section 254 allows a Garda officer to remove an arrested child to a place of safety, as if using section 12 of the 1991 Act.

**Section 263**

A child in certain prescribed circumstances can be detained for up to 24 hours in designated place of detention, including a Garda station.

**Section 267**

Extends the duration of an interim care order under the 1991 Act from 8 days to 28 days; and brings residential services for children with disabilities within the scope of the 1991 Act's provisions regarding registration, inspection and regulation.

**Section 268**

'While a child is in the care of a health board pursuant to any provision of this Act, the health board shall - (a) have the like control over the child as if it were his or her parent; and (b) do what is reasonable (subject to the provisions of this Act) in all the circumstances of the case for the purpose of safeguarding or promoting the child's health, development or welfare'.

| | |
|---|---|
| Family Law Act, 1995; | Education/Responsibility |

Section 47

The court in family law proceedings may make a direction that a written report is procured on any question affecting the welfare of a party to the proceedings, including children, from - '(b) such person nominated by a health board specified in the order as that board may nominate, being a person, who in the opinion of that board, is suitably qualified for the purpose...' The person who prepares the report may be required to attend to be a witness. The function conferred on a health board by this section 'shall be a function of the chief executive officer of the board'. As well as the 1995 Act, this section also applies to all other Family Law Acts (listed in the text at 47(6)), and the Family Law (Divorce) Act, 1996.

| | |
|---|---|
| Domestic Violence Act, 1996 | Education/Responsibility |

Sections 3, 4, 5 and 6

The health board is given the power to apply for certain orders, i.e. a safety order or an interim barring order or a barring order, where the aggrieved person (the alleged victim) is unwilling or unable to make such an application.

Sections 7

Where the proceedings under the Act are initiated by a party other than a health board, and where the judge becomes concerned about the safety or welfare of a child, he/she can adjourn so that the health board can undertake an investigation; and the relevant sections of the Child Care Act, 1991 then apply.

Section 11

Where the health board is the applicant and where a safety or barring order is made, the court must provide the health board with a copy of the order.

Section 13

If the health board is the original applicant, it can later apply to have the order discharged.

| | | |
|---|---|---|
| Adoption Act, 1952 | Section 34 to 38 | Function/Responsibility<br>Sets out the requirement that bodies arranging adoption placements should be registered adoption societies, and what is required of them. |
| Adoption Act, 1988 | Section 2 | Function/Responsibility<br>First reference in adoption legislation to the 'health board' - gives a health board a hearing in adoption cases under this Act, i.e. cases where there is a possibility that parents have failed in their duty of care towards a child who may then be declared eligible to be adopted, in 'exceptional cases'. |
| | Section 3 | Places responsibility on a health board to apply to the High Court on behalf of the potential adopters to have the consent of the natural parents set aside - unless the health board considers that it is not proper to make such an application. |
| | Section 5 | The health board is responsible for the costs of these High Court and, in cases of appeals, Supreme Court hearings. |
| Adoption Act, 1991 | Section 8 | Function/Responsibility<br>Places a legal duty on a health board to provide an assessment to anyone who wants to be considered suitable to adopt a child abroad; and to provide a written report of this assessment to the Adoption Board. |

| | |
|---|---|
| Adoption Act, 1991 | Function/Responsibility |
| Section 6 | Allows the Adoption Board to seek the assistance of a health board in providing post-placement consultation and counselling to the natural mother in an attempt to ascertain the identity of the natural father, where the mother and a man, not the natural father, apply to adopt the child, and where the placement has not been made by a health board or registered adoption society. |
| Refugee Act, 1996 | Function/Responsibility |
| Section 8 | (5) (a) 'Where it appears to an immigration officer that a child under the age of 18 years who has arrived at the frontiers of the State is not in the custody of any person, the immigration officer shall, as soon as practicable, so inform the health board in whose functional area the place of arrival is situated and thereupon the provisions of the Child Care Act, 1991 shall apply in relation to the child' - this may require that the child is provided with accommodation, or is taken into care, or is provided with a range of welfare and support services.<br><br>(5) (b) The health board in such a situation may need to assist the child to apply for a declaration of their status as a refugee; and under (5) (c) shall bear any costs, other than legal costs that may arise from this. |
| Immigration Act, 1999 | Function/Responsibility |
| Section 5 | (4) (c) Where a non-national child is detained on foot of a deportation order, the immigration officer or Garda concerned shall 'without delay, notify the health board for the area in which the person is being detained of the detention and of the circumstances thereof'. It is not stated in this Act what the responsibilities of a health board are to a child detained, but they may be similar to those set out in the Children Act, 2001, Section 59. |

| Child Care (Placement of Children in Foster Care) Regulations, 1995, | Function/Responsibility |
|---|---|
| Article 4 | Sets out same principles as in Section 3 of the 1991 Act. |
| Article 5 | Applicants for foster care must be assessed in a specified manner; and their suitability is adjudicated on by a properly composed and convened committee. |
| Article 6 | The circumstances of the child to be placed must be assessed. |
| Article 7 | The capacities of the foster parents must match the needs of the child to be placed. |
| Article 8 | A child's religious upbringing should be considered when placing her with foster parents, and the wishes of the natural parent must be ascertained and accommodated as much as is practicable. |
| Article 9 | A foster care placement is based on a prescribed form of contract between the health board and the foster carers (as set out in Schedule 1 of the Regulations). |
| Article 10 | A health board has to provide the foster carers with prescribed information about the child to be placed before the placement (as set out in Schedule 2 of the Regulations). |
| Article 11 | Before placing the child, the health board has to produce a written care plan. |

Article 12

A health board has to keep a register of children placed for foster care, in a prescribed manner.

Article 13

A health board has to keep case records on every child placed in foster care, in a prescribed manner.

Article 14

A health board shall pay a Foster Care Allowance to the foster carers at the rate set by the Minister.

Article 15

A health board has to provide to foster parents 'such support services, including advice, guidance and training as the board considers necessary to enable foster parents to take care of children placed with them by the board'.

Article 16 Sets out the duties of foster carers and the standard of care expected of them.

Article 17

Places responsibility on health boards to supervise and to visit children placed in foster care at prescribed intervals.

Article 18

Places responsibility on health boards to conduct reviews of cases of children placed in foster care, and especially of their care plan, at prescribed intervals.

Article 19

Allows for the conduct of special reviews (outside the time schedule of reviews to be conducted as per Article 18), at the request of a party who has a bona fide interest in the child's welfare.

Article 20 Deals with reviews for children who move often.

Article 21

Deals with the removal of a child from foster care at the request of the foster parents.

Article 22 — Deals with the termination of a foster placement by a health board.

Article 23 — Allows a health board to provide counselling for foster parents whose contract with the board has been terminated against their will.

Article 24 — Allows a health board to make arrangements with voluntary agencies and other suitable individuals/organisations to assist it in meeting its responsibilities under the Regulations.

Article 25 — Provides for the inspection of a health board's foster care service by an authorised person appointed by the Minister.

Article 26 — 'The functions of a health board under these regulations shall be functions of the chief executive officer of the board or any person acting as deputy chief executive officer in accordance with section 13 of the Health Act, 1970'.

Article 27 — Allows a child to be placed with foster parents approved by another health board.

Article 28 — Revocation of the 1983 Regulations.

**Child Care (Placement of Children with Relatives) Regulations, 1995**

**Function/Responsibility**

These Regulations are very similar to the foster care Regulations immediately above. There is really only one significant difference - this relates to the making of emergency placements with non-assessed and approved relatives - Article 6.

### Article 6

'(1) Where a health board is satisfied that the immediate placement of a child in its care with his or her relatives is in the interests of the child, the board may, notwithstanding that one or more of the provisions of Article 5 of these Regulations have not been complied with in relation to the relatives, place the child with those relatives...', having interviewed them and made whatever checks can be made in the time available. Such relatives have to be fully assessed within twelve weeks of the emergency placement being made.

## Child Care (Placement of Children in Residential Care) Regulations, 1995

### Function/Responsibility

### Article 4

Sets out the same principles as in Section 3 of the 1991 Act.

### Article 5 to 16

Set out the standards that a health board must satisfy itself are in place in a registered children's residential centre.

### Article 17

Establishes the health board's responsibility to inspect centres and to monitor standards regularly.

### Article 18

Provides for one health board being able to rely on another health board to ensure that a residential children's centre in its area is up to standard.

### Article 20

A child being placed in residential care must have a medical examination - to be arranged by the placing health board.

Article 21

A health board must keep a register of children placed in residential care, in a prescribed manner.

Article 22

A health board has to keep a case record on every child placed in residential care, in a prescribed manner.

Article 23

A health board placing a child in residential care must produce a written care plan, in a prescribed manner.

Article 24

Sets out the health board's responsibilities to supervise and visit children placed in residential care at prescribed intervals.

Article 25

Deals with the responsibility of the placing health board to conduct reviews of children in residential care regularly, including a review of the child's care plan.

Article 26

Allows for special reviews to be convened at the request of a person who has a bona fide interest in the child's welfare.

Article 27

Deals with reviews for children who move placements a lot.

Article 28

Deals with the removal of children from residential care.

Article 29

'A health board shall make available to a residential centre such support services as the board considers necessary to enable the centre to take care of children placed in the centre by the board'.

### Article 30

Allows a health board to have the assistance of a voluntary agency or another individual/body in carrying out its functions under the regulations.

### Article 31

Allows for inspections of residential children's centres by an authorised person appointed by the Minister.

### Article 32

'The functions of a health board under these regulations shall be functions of the chief executive officer of the board or any person acting as deputy chief executive officer in accordance with section 13 of the Health Act, 1970'.

The tables set out most of the statutory responsibilities, duties and powers of health boards in relation to child care and family support services. It would be logical to assume that any person whose situation is covered by any statute or Regulation outlined above would be eligible for a service from a health board, and in some cases may also be entitled to receive a service. However, it needs to be emphasised that each Act and Regulations contain the same or very similar wording in relation to the health board's responsibility, that is

'The functions of a health board shall be functions of the chief executive officer of the board or any person acting as deputy chief executive officer in accordance with section 13 of the Health Act, 1970'.

## Other relevant Primary Legislation, Policies and Strategies 1998-2004

- 1998: Strengthening Families for Life, Commission on the Family
- 1999: Children First
- 1999: National Childcare Strategy
- 2000: National Children's Strategy
- 2001: Children Act
- 2001: Report of the Working Group on Foster Care
- 2002: Family Support Agency Act
- 2002: National Standards for Residential Care
- 2003: National Standards for Foster Care
- 2003: Crisis Pregnancy Agency Strategy Document
- 2004: Ready, Steady, Play (national policy on play)
- 2004: Adoption Board Business Plan

APPENDIX 3

## PRINCIPLES THAT SHOULD UNDERPIN ANY FUTURE MODEL OF SERVICE

| National Children's Strategy Principles | National Health Strategy Principles |
|---|---|
| **Equitable**<br>All children should have equality of opportunity in relation to access to and participation in, and derive benefit from the services delivered and have the necessary levels of quality support to achieve this. A key priority in promoting a more equitable society for children is to target investment at those most at risk.<br><br>**Inclusive**<br>The diversity of children's experiences, cultures and lifestyles must be recognised and given expression. | **Equity**<br>Health inequalities are targeted and people are treated fairly according to need. |
| **Child Centred**<br>The best interests of the child shall be a primary consideration and children's wishes and feelings should be given due regard.<br><br>**Family Oriented**<br>The family generally affords the best environment for raising children and the external environment should be to support and empower families within the community. | **People Centred**<br>Identifies and responds to the needs of individuals, is planned and delivered in a co-ordinated way and helps individuals to participate in decision-making to improve their health. |
| **Action Oriented**<br>Service delivery needs to be clearly focused on achieving specified results to agreed standards in a targeted and cost effective manner.<br><br>**Integrated**<br>Measures should be taken in partnership, within and between relevant players, be it the State, the voluntary/community sector or families; services for children should be delivered in a more co-ordinated, coherent and effective manner through integrated needs analysis, policy planning and service delivery. | **Quality**<br>Evidence-based standards are set in partnership with consumers and are externally validated. Continuous improvement is valued. |
| | **Accountability**<br>Financial, professional and organisational accountability is strengthened for better quality, efficiency and effectiveness. |

# Bibliography


Barter, K. (2001). 'Building Community, A Conceptual Framework for Child Protection'. *Child Abuse Review*, 10 (4) 262.

Bell, L. (1999). 'A comparison of multi-disciplinary groups in the UK and New Jersey'. *Child Abuse Review*, 8(5), 314-324.

Best Health for Children (2002). *Investing in Parenthood to achieve best health for children: the Supporting Parents Strategy.* Dublin: National Conjoint Child Health Committee.

Brennan Commission. (2003). *Commission on Financial management and Control Systems in the Health Service. Dublin: Stationery Office.*

Buckley, H. (2003). *Child Protection Work: Beyond the Rhetoric.* London: Jessica Kingsley.

Calvert, G. (2002). Plenary Paper at launch of *Best Health for Children: Investing in Parenthood.* National Policy Report. Dublin Castle.

Chaffin, M., Bonner, B.L., Hill, R.F. (2001). 'Family preservation and family support programmes: Child maltreatment outcomes across client risk levels and program types'. *Child Abuse and Neglect*, 25, 1269-1289.

Child Care Act. (1991). Dublin: Stationery Office.

Children Act. (2001). Dublin: Stationery Office.

Clarke, A. and Clarke, A. (2003). *Human Resilience: A Fifty Year Quest.* London: Jessica Kingsley.

Cleaver, H. and Walker, S. (2004). 'From policy to practice: the implementation of a new framework for social work assessments of children and families'. *Child and Family Social Work*, February 2004, vol. 9, no. 1, pp. 81-90(10).

Cleaver, H. and Freeman, P. (1995). *Parental perspectives in cases of suspected child abuse* London:HMSO.

Cole, D.,, R., Britton, E. and Hicks, L. (2004). *Building Better Connections: Interagency work and the Connexions Service.* UK: Joseph Rowntree Foundation.

Colligan, L. and Buckley H., (2004). 'Community Based Professional Responses to child Sexual Abuse'. *Irish Journal of Family Law*, No.4, November, pp. 2-7.

Combat Poverty Agency. (2003). *Annual Report.* Combat Poverty Agency Publication.

Commission on the Family. (1998). *Strengthening Families for Life. Final Report of the Commission on the Family to the Minister for Social, Community and Family Affairs.* Dublin: Stationery Office.

Compas, B.E., Orosan, P.G. and Grant, K.E. (1993). 'Adolescent Stress and Coping: Implications for Psychopathology during Adolescence'. *Journal of Adolescence*, Vol. 16, Issue 3, pp. 331-349.

Compas, B.E., Davis, D.E., Forsythe, C.J. and Wagner, B.M. (1987). 'Assessment of Major and Daily Stressful Events During Adolescence: The Adolescent Perceived Events Scale'. *Journal of Consulting and Clinical Psychology*, 55, 534-541.

Connolly, M. (2004). *Child and Family Welfare: Statutory responses to children at risk.* Christchurch: Te Awatea Press.
Dahlberg, L., Potter, L., Lloyd, B. (2001). 'Youth Violence: Developmental Pathways and Prevention Challenges'. *American Journal of Preventative Medicine*, Volume 20, No. 1s.

Deloitte and Touche. (2001). *Audit of the Irish Health Service for Value for Money.* Dublin: Department of Health and Children.

Department of Health. (UK) (2003). *Every Child Matters*, Green paper.

Department of Health. (UK) (2000). *Framework for the Assessment of Children in Need and their Families.* Quality Protects.

Department of Health and Children. (2004). *Working for Children and Families: Exploring Good Practice.* Dublin: Stationery Office.

Department of Health and Children. (2003). B*rennan Report - Commission on Financial Management and Control Systems in the Health Service.* Dublin: Stationery Office.

Department of Health and Children. (2002). *Action Plan for People Management in the Health Services.* Dublin: Stationery Office.

Department of Health and Children. (2001). *Quality and Fairness: A Health System for You.* Dublin: Stationery Office.

Dolan, P. and Holt, S. (2002). 'What Families Want in Family Support: An Irish Case Study'. *Child Care in Practice.* Vol. 8, No. 4, 2002.

Eastern Regional Health Authority. (2004). *Youth Advocacy Programme Evaluation Report.* Internal Publication.

Elkan, R., Kendrick, D., Hewitt, M., Robinson, J.J.A., Tolley, K., Blair, M., Dewey, M., Williams, D., Brummell, K. (2000). *The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature.* HTA 4 (13).

Evans, Ford. (2001). *Review Report on Foyle Trust Child and Family Welfare Services.* Unpublished.

Farmer, E. and Owen, M. (1995). *Child Protection Practice: Private risks and public remedies - decision making, intervention and outcome in child protection work.* HMSO.

Farrington, D.P. and Welsh, B.C. (2003). *Family-based prevention of offending: A meta-analysis*, Vol.36, No.2, pp.127-151

Gardner, R. (2003). *Supporting Families: Child Protection in the Community.* NSPCC. UK: Wiley.

Ghate, D. and Hazel, N. (2002). *Parenting in Poor Environments: Stress, Support and Coping.* UK: Jessica Kingsley.

Gilbert, N. (1997). *Combating child abuse: International Perspectives and Trends.* Oxford: Oxford University Press.

Gilligan, R. (2001). *Promoting Resilience: A Resource Guide on Working with Children in the Care System.* London: British Agencies of Adoption and Fostering London.

Gomby, D.S., Culross, P.L., Behrman, R.E. (1999). 'Home Visiting: Recent program evaluations - Analysis and recommendations'. *The Future of Children*, 9, pp. 4-26.

Hardiker, P., Exton, K. and Barker, M. (1991). *Policies and Practices in Preventive Child Care.* Aldershot:Avebury.

Heenan, D. (2004). 'Learning Lessons from the Past or Re-Visiting Old Mistakes: Social Work and Community Development in Northern Ireland'. *British Journal of Social Work,* Issue 34, pp. 793 - 809.

Hetherington, R. (2002). *Learning from Difference: Comparing child welfare systems.*:Partnerships for children and families project.

Hill, M., Stafford, A. and Lister, P.G. (2002). *International Perspectives on Child Protection.* Report on seminar held on 20 March 2002. Part of the Scottish Executive Child Protection Review: Protecting Children Today and Tomorrow. Centre for the Child and Society, University of Glasgow.

Horwath, J. (ed.). (2001). *The Child's World: Assessing Children in Need and Their Families.* London: Jessica Kingsley.

Inbucon Management Consultants. (1982). *Community Care Review Report.*

Jack, G. (2004). 'Child Protection at the Community Level'. *Child Abuse Review,* Vol. 13: 368-383 (2004).

Jack, G. and Jordan, B. (1999). 'Social Capital and Child Welfare'. *Children and Society,* 13: 242-256.

Jenkins, Patricia H. and Welsh, Wayne N. (2003). 'Neighbourhood -Based Prevention/ Intervention: A Process Evaluation of a Risk-Focused Approach'. *Children and Youth Service Review,* Vol. 25, No.4, pp. 327 - 351.

Johnson, Z., Howell, F. and Molloy, B. (1993). 'Community mothers programme: randomised control trial of non-professional intervention in parenting'. *British Medical Journal,* 306, pp.1449-1452.

Kamerman, S.B. and Kahn, A.J. (2001). 'Child and family policies in an era of social policy retrenchment and restructuring'. In Vleminckz, K. and Smeeding, T.M. (eds). (2001). *Child Well-Being, Child Poverty and Child Policy in Modern Nations: What do we know?* Bristol: The Policy Press.

Khoo, E.G., Hyvonen, U. and Nygren, L. (2002). 'Child Welfare or Child Protection: Uncovering Swedish and Canadian Orientations to Social Intervention in Child Maltreatment'. *Qualitative Social Work,* Vol. 1(4) pp.451-471.

Laming, Lord. (2003). *The Victoria Climbie Inquiry Report.* UK: The Stationery Office.

Lyons, S., Collins, C. and Staines, A. (2001). *Are universally available supports for families effective and efficient?* University College Dublin for the Best Health for Children Initiative.

MacKinnon-Lewis, Carol, Kaufman, Martha C. and Fraubutt, James M. (2002). 'Juvenile Justice and Mental Health: Youth and Families in the Middle'. *Aggression and Violent Behaviour,* 7, pp. 353 - 363.

MacLeod, J. and Nelson, G. (2000). 'Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review'. *Child Abuse and Neglect,* Vol. 24, No. 9, pp. 1127-1149.

MacMillan, H.L., Macmillan, J.H., Offord, D.R., Griffith, L. and MacMillan, A. (1994). 'Primary prevention of child physical abuse: a critical review (part 1)'. *Journal of Child Psychiatry and Psychology,* 35 (5): pp. 835-56.
Marsh, P. and Crow, G. (1998). *Family Group Conferences in Child Welfare.* Oxford: Blackwell.

McAuley, C., Knapp, M., Beecham, J., McCurry, N., Slead, M. (2004). *Young Families Under Stress: Outcomes and Costs of Home-Start Support.* York: Joseph Rowntree Foundation.

McCain, M. and Mustard, J.F. (1999). *The Early Years Study.* Toronto: Children's Secretariat.

McGuinness, C. (1993). *Report of the Kilkenny Incest Investigation.* Dublin: Stationery Office.

McKeown, K. (2001). *Springboard promoting family well-being: through Family Support Services, Final Evaluation Report of Springboard January 2000 to May 2001.* Springboard Publication, Department of Health and Children. Dublin: Stationery Office.

McKeown, K. (in Paper) *Census of Family Support Services in Ireland.* A publication for the Department of Health and Children. Dublin: Stationery Office.

McKinsey and Company, Inc. (1971). *Towards Better Health Care*: Vols 1,2,3,4.

Munford, R. and Saunders, J. (2003). *Making a Difference in Families: Research That Creates Change.* Australia: Allen and Unwin.

National Children's Strategy. (2000). *The National Children's Strategy: Our Children - Their Lives.* Dublin: Stationery Office.

National Conjoint Child Health Committee (2003) Get Connected: *Developing an Adolescent Friendly Health Service.* Dublin. Best Health for Children.

National Conjoint Child Health Committee. (1999). *Best Health for Children - Developing a Partnership with Families.* National Conjoint Child Health Committee.

O'Brien, M. (2004). *Youth Advocate Programme, Evaluation Report.* Galway: Child and Family Research and Policy Unit, WHB/NUI.

O'Brien, M., Canavan, J. and Curtin, C. (2004). *Young People at Risk: A Review of the Youth Advocate Programme in the Irish Republic.* Department of Politics and Sociology, National University of Ireland, Galway. Unpublished draft paper.

O'Brien, V. (2001). *Family Group Conference Pilot Project: Evaluation Report.* East Coast Area Health Board.

O'Connor, P. (1999). *Parents Supporting Parents.* Mid-Western Health Board.

Offord, D., Chmura Kraemer, H., Kazdin, A., Jensen, P., Harrington, R. (1998). 'Lowering the burden of suffering from child psychiatric disorder: trade-offs among clinical, targeted and universal interventions'. *The Journal of the American Academy of Child and Adolescent Psychiatry.* 37 (7), pp. 686-694.

Parton, N. (1997). *'Child Protection and Family Support: Current Debates and Future Prospects' In N. Parton (ed.). Child Protection and Family Support: Tensions, Contradictions and Possibilities.* Ch. 1 pp. 1-24. UK: Routledge.

Pecora, P.J., Fraser, M., Nelson, K.E., McCroskey, J. and Meezan, W. (1997). *Evaluating Family Based Services.* New York: Aldine de Gruyter.

Pecora, P.J. (1995). 'Assessing the impact of family based services'. In B. Galaway and J. Hudson (eds). *Child Welfare in Canada: Research and policy Implications.* Toronto: CN Thompson Educational Publishers.

Phipps, S. (2001). 'Values, Policies and the well-being of young children in Canada, Norway and the United States'. In Vleminckz, K. and Smeeding, T.M. (eds). (2001). *Child Well-Being, Child Poverty and Child Policy in Modern Nations: What do we know?* Bristol: The Policy Press.

Prospectus. (2003). *Audit of Structures and Functions in the Health System.* Dublin: Stationery Office.

Reder, P., Duncan, S. and Gray, M. (1993). *Beyond Blame: Child abuse tragedies revisited.* London: Routledge.

Riordan, S. (2002). *Teen Parents Support Initiative - Final Evaluation Report.* CSER, Dublin Institute of Technology for the Department of Health and Children. Dublin: Stationery Office.

Riordan, S. (2001). *Supporting Parenting: A Study of Parents' Support Needs.* CSER, Dublin Institute of Technology for the Families Research Programme. Department of Social and Family Affairs.

Roberts, H. and MacDonald, G. (1999). 'Working with Families in the Early Years', in M. Hill (Ed.) *Effective Ways of Working with Children and their Families*, Jessica Kingsley, London.

Rogers, J. (ed.) (2003). 'New Directions in Child Welfare'. In N. Trocme, D. Knoke and C. Roy (eds). *Community collaboration and differential response:* Canadian and international research and emerging models of practice. Ottawa: Centre of Excellence for Child Welfare.

Rutter, M., Giller, H. and Hegel, A. (1998). *Anti-social Behaviour by Young People.* Cambridge: Cambridge University Press.

Schoon, I. and Bynner J. (2003). 'Risk and Resilience in the Life Course: Implication for Interventions and Social Policies'. *Journal of Youth Studies,* Vol. 6, No.1, pp. 21-31.

Scott, D. (1995). 'Child Protection: Paradoxes of publicity, policy and practice'. *Australian Journal of Social Issues.* 23(2), pp. 5-14.

Social Services Inspectorate. (2003). *Annual Report.* Dublin: Stationery Office.

Solera, C. (2001). 'Income transfers and support for mothers' employment: the link to family poverty risks'. In Vleminckz, K. and Smeeding, T.M. (eds). (2001). *Child Well-Being, Child Poverty and Child Policy in Modern Nations: What do we know?* Bristol: The Policy Press.

South, S.J. and Haynie, D. L. (2004). Friendship Networks of Mobile Adolescents, *Social Forces* Sept 2004 (1) pp. 315- 350.

Spratt, T. (2001). 'The influence of child protection orientation on child welfare practice'. *British Journal of Social Work,* 31, pp. 933-954.

Sundell, K. and Vinnerljung, B. (2004). 'Outcomes of family group conferencing in Sweden: A three year follow up'. *Child Abuse and Neglect,* 28 (2004) pp. 267-287.

Thoburn, J., Lewis, A. and Shemmings, D. (1995). *Paternalism or Partnership: Family Involvement in the Child Protection Process, Studies in Child Protection Series.* London: HMSO.

Thorpe, D. and Bilson, A. (1998). 'From protection to concern: Child protection careers without apologies'. *Children in Society,* 12(5) 373.

Tierney, J., Grossman, J. and Resch, N. (1995). *Making a Difference: An Impact Study of Big Brothers Big Sisters of America.* Philadelphia: Public Private Ventures.

Tomison, A.M. (2004). *Current issues in child protection policy and practice: Informing the NT Department of Health and Community Services child protection review.* National Child Protection Clearinghouse. Melbourne: Australian Institute of Family Studies.

Tomison, A.M. and Stanley, J. (2001). *Strategic Directions in child protection: Informing policy and practice.* Unpublished Report for the South Australian Department of Human Services.

Tracy, E.M. and Whittaker, J.K. (1990). 'The Social Network Map Assessing Social Support in Clinical Practice, Families in Society'. *The Journal of Contemporary Human Services.* 1994 pp. 481-489.

Vleminckz, K. and Smeeding, T.M. (eds) (2001). *Child Well-Being, Child Poverty and Child Policy in Modern Nations: What do we know?* Bristol: The Policy Press.

Ward, A. and McMahon, L. (1998). *Intuition is not Enough: Matching Learning with practice in therapeutic child care.* UK: Routledge.

Waterstone, A. (2003). 'Social Work in Community Care - A Management Perspective'. *Irish Social Worker.* Vol. 21 No. 1.

Weiss, H.B. (2001). 'Reinventing Evaluation to Build High-Performance Child and Family Interventions in Perspectives on Crime and Justice: 1999-2000 Lecture Series'. *National Institute of Justice,* Vol. IV (March), pp. 99-126.

Whittaker, J.K. and Maluccio, A.N. (2002). 'Rethinking 'child placement': A reflective essay'. *Social Service Review,* 76 (1) 108.

Whittaker, J. K. (1997). 'Intensive Family Preservation Work with High-risk Families: Critical Challenges for research, clinical intervention and policy'. In W.Hellinckx, M. Colton and M. Williams (eds). *International Perspectives on Family Support.* Ashgate USA, Ch.8, pp.124 - 140.

Whittaker, J. K. (1993). 'Changing Paradigms in Child and Family Services: Challenges for Practice, Policy and Research. In H. Ferguson, R. Gilligan and R.Torode (eds). *Surviving Childhood Adversity, Issues for Policy and Practice,* Dublin: Social Studies Press, Trinity College. Ch. 1 pp. 3-14.

Whittaker, J.K. and Garbarino, J. (1983). *Social Support Networks: Informal Helping in the Human Services,* New York: Aldine De Gruyter, pp. xi-xiv.

Yoshikawa, H. (1994). 'Prevention as cumulative protection: Effects of early family support and education on chronic delinquency and its risks'. *Psychological Bulletin,* 115, pp. 28-54.

Produced by Vision Design & Marketing, Dundalk, Co. Louth, Tel: 00353 42 933 0690