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Acknowledgements

This report was initiated jointly by Clarecare and the Mid-Western Health Board. Particular thanks is due to the managers in both organisations notably:

- Fiacre Henesy, Director, Clarecare
- Jacinta Swan, Social Work Team Leader, Clarecare
- Jackie Deevey, Child Care Manager, Mid-Western Health Board
- Áine Millett, Community Development Manager, Mid-Western Health Board

Detailed consultations were held with the staff teams involved in Clarecare’s family support services and the report has benefited greatly from their input. Intensive and community family support services are delivered by a team of Social Workers, Community Childcare Workers and Family Workers. The team of Social Workers comprises Catherine Cahill, Jenny Shaw, Therese Duggan, Breeda Hallissey, Gill Moses; James McMahon, who works with older people, also participated in the consultations. The team of Community Childcare Workers comprises Pauleen McAllister, Cathy McHugh, Catherine O’Hare, and Eve Brennan; Sarah Jane Lusk, who works with Travellers, and Gina Norris who works with adolescents, also participated in the consultations. The team of Family Workers comprises Ann Dunne, Jackie Bebbington, Patricia Kelly, and Anna Lynch. Support services for children in care are provided by Fiona Purcell who works with children leaving, or have left, care and by Ann Marie Regan and Chris Jenkins who are Advocacy Workers for the parents of children in care.

In preparing the report, a group discussion was held with two former Directors of Clarecare, Fr. Brian Geoghan and Fr. Ger Nash as well as with a former manager in the Mid-Western Health Board with responsibility for Clarecare, Jackie Brown. A meeting was also held with the Board of Clarecare attended by Noel Davis, Fr.Ger Nash, Angela McMahon, Eugene Ryan, Hugh Gallagher, with Maureen Quinn (Secretary) and Fiacre Hensey (General Manager) in attendance; one Board member, Michael Neylon, was unable to attend.

A group discussion was held with the Care Team for County Clare in the Mid-Western Health Board comprising: Jackie Deevey, Child Care Manager, Bill Hamill, Principal Social Worker, Maurice Ward, Senior Clinical Psychologist and Áine Millett, Community Development Manager.

In acknowledging these different contributions we also absolve them of responsibility for the contents of the report which, in the time-honoured tradition, rests with the author.
Executive Summary

Clarecare in perspective
Clarecare, formerly known as Clare Social Service Council, has been in existence since 1968 and has lived through a major expansion in Irish social services over the past 35 years. It pre-dated the introduction of Health Boards in 1971 and will outlive their abolition in 2004/5. Like other social service organisations, Clarecare emerged at a time when, by comparison with the present, there were relatively few social services in Ireland. It began by building on a spirit of volunteerism to develop a network of services across the county. In this sense, Clarecare was informed by a vision of community development which encouraged people to be actively involved in responding to needs within their local community, thereby building up a county-wide infrastructure of care and support.

The initial focus of Clarecare was on services for the elderly but this soon extended to cover the family in its broadest sense and saw the development of a range of support services including child protection, fostering and adoption placement, pre-school playgroups as well as holiday schemes for families and the elderly. Counselling services have also been provided for many years, including a dedicated residential service for those needing support in overcoming addictions. As a result of these developments, Clarecare now offers a wide spectrum of services to people in need throughout the county and continues to respond to new needs as they arise including the needs of asylum seekers as well as the more enduring needs of Travellers. Throughout its existence, there has been a cordial and mutually supportive relationship between Clarecare and the Mid-Western Health Board and there is now a formal service agreement between the two organisations. The dynamism which has characterised the work of Clarecare is also the impulse which gave rise to this review.

The Review
This review focuses on three services which are provided by Clarecare and funded by the Mid-Western Health Board. The three services are: (i) intensive family support (ii) community family support and (iii) children in care support services.

The review involved consulting with all key personnel in Clarecare and the Care Team in the Mid-Western Health Board as well as examining a number of documentary sources. This yielded valuable information and insights which, in light of further reflection from the perspective of best practice, yielded four key questions which can be raised about services in Clarecare. The four questions are:
1. Is there an adequate system for evaluating the outcome of services?
2. Is there an appropriate balance between prevention, early intervention and late intervention?\(^1\)

\(^1\) These terms - prevention, early intervention and late intervention - refer to types of services which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (late intervention, sometimes referred to as treatment).
3. Are services based on an inclusive concept of the family?

4. Do services promote community development?

Essentially the review involved addressing each of these questions not only by offering an opinion as to the answer but also working out the implications of that answer.

1. Is there an adequate system for evaluating the outcome of services?

Our answer to this question is that Clarecare is no different to most other services in Ireland – including Health Board services - in not having an adequate system for evaluating the outcomes of its services. Also, like other services, it has become increasingly aware of the need to evaluate its services in order to be more accountable to both its funders and to the families it serves. In Chapter Two of the report we describe in detail how an evaluation system could be put in place and conclude by recommending that Clarecare, in consultation with the Mid-Western Health Board, should proceed with the introduction of a system for evaluating its family support services. This will require that management and staff are fully engaged in all decisions about the evaluation system, particularly the following key issues: (i) deciding on the outcomes to be measured (ii) deciding on the instruments for measuring those outcomes (iii) setting up procedures for collecting data at baseline and follow-up (iv) collating, analysing and reporting on the data.

2. Is there an appropriate balance between prevention, early intervention and late intervention?

Our answer to this question is that the balance of services for families and children in Clarecare is probably leaning more towards late intervention rather than prevention and early intervention. This is suggested by the fact that both intensive family support and community family support are all based on referrals from the Mid-Western Health Board and involve families whose problems are known to be well developed, some to the extent of being in crisis; the same could also be said about Clarecare’s support services for children in care. In other words, the balance of services in Clarecare mirrors the pattern within Health Boards generally and is probably a direct consequence of Clarecare’s service agreement with the Mid-Western Health Board. One of the major challenges for Clarecare therefore – as for Health Boards generally - is to identify ways of tilting the balance of its services away from late intervention towards prevention and early intervention. In order to address this challenge it is necessary to take a closer look at the needs of families and children across the entire county and to examine how well the existing range of services matches those needs. In line with this we conclude our analysis by recommending that a study should be carried out to determine the needs of families and children in County Clare which would be used to both improve the match between needs and services while also contributing towards a better balance between prevention, early intervention and later intervention.

3. Are services based on an inclusive concept of the family?

Our answer to this question is that Clarecare is no different to most other services in its tendency to target family services almost exclusively at mothers and children and to overlook fathers. This is understandable given that mothers typically carry more responsibility for parenting in many two parent households and often have sole responsibility in one parent households. Nevertheless it is appropriate to ask if this approach to family support services is consistent with a proper understanding of the family system and the factors which promote family...
well-being, particularly the well-being of children. A challenge for Clarecare therefore is to develop its services around a more inclusive concept of family which is based not on households but on the set of relationships which link parents to each other and to their children, even where the parents are not living in the same household, and irrespective of their marital status. We conclude our analysis by recommending that Clarecare’s services should be informed by a more inclusive concept of the family which takes greater account of the role and needs of fathers, irrespective of their residential or marital status.

4. Do services promote community development?

Our answer to this question is less clear cut and is designed primarily to promote reflection within Clarecare and the Mid-Western Health Board on how services can promote community development. This seems an appropriate question since Clarecare has always endeavoured to develop services by recognising the interdependent links between the individual, the family and the community. The way in which community development is understood within Clarecare has probably changed over the years - just as the concept of community development has itself evolved - but there is still a clear sense within the organisation that the individual, the family and the community are part of an interdependent system and that community development is one of the key ways to supporting both individuals and families. Given that this review was not in a position to examine the community development aspect of Clarecare’s work in detail we conclude by recommending that Clarecare assesses its current and future role in community development by taking into account the principles of best practice, as summarised in Chapter Five, which now inform this work.

Concluding Comment

The questions raised by this review are challenging and invite reflection in order to bring about greater clarity and effectiveness in the work of supporting individuals, families and communities. The decision to offer a service to anyone - either a parent or a child - is a significant intervention in their lives and carries the ethical responsibility of being clear about how that service will promote their well-being. In commissioning this review therefore, both Clarecare and the Mid-Western Health Board are engaging with these questions in order to develop services based on a clearer understanding of need and finding the most appropriate match of need to services. This report is one element, but only one, in that review process.
Chapter One

Overview of Clarecare

1.1 Introduction

We begin this review with a brief historical outline of the origin and development of Clarecare, formerly known as Clare Social Service Council. This is an important starting point since Clarecare has been in existence since 1968 and has lived through a major expansion in Ireland’s social services over the past 35 years. Indeed it is worth remembering that Clarecare pre-dated the introduction of Health Boards in 1971 and will outlive them following their abolition in 2004/5. As an organisation therefore it has a history and a culture that needs to be taken into account in order to understand the range and type of services it provides. In view of this we begin by describing the context from which Clarecare emerged in 1968 (Section 1.2). One of the key influences on the development of Clarecare – as of other social service councils throughout Ireland – is its relationship with the Health Board and this is briefly analysed (Section 1.3). This relationship has been crucial in terms of the evolution of Clarecare’s services which are then described (Section 1.4). The three services which are the specific focus of this review – intensive family support, community family support and children in care support – are then described in more detail drawing on the format jointly used by Clarecare and the Mid-Western Health Board to describe these services in their Service Agreement (Sections 1.5, 1.6 and 1.7). We conclude the chapter with a brief summary (Section 1.8).

1.2 Context

Social service councils emerged throughout Ireland in the 1960s at a time when, by comparison with the present, there were relatively few services – either statutory or voluntary - to address the needs of people adversely affected by circumstances such as old age, family problems, child neglect or abuse, addiction, unemployment, emigration, and so on. The legacy of nineteenth century social policy which believed that State services should be kept to a minimum and made available to people only if they were destitute left its mark on the development of services in Ireland right up to the 1960s. This minimalist approach to services provided a major incentive to the growth of charities, particularly religious orders, who often filled significant gaps left by statutory services and have had a major influence on the development of a wide range of services. At the same time, the church-inspired conservatism of Irish social policy up to the 1960s reinforced a minimalist role for the State in the provision of social services and further created a context which facilitated the emergence of voluntary activity as exemplified by the social service councils in the 1960s. Prior to this, but also illustrating this approach to social policy, Muintir na Tire was founded in 1931 as a way of promoting local development through the volunteer efforts of local people, focusing primarily on the parish as the basic building block of society, with State involvement being seen as both unnecessary and undesirable. Against this background, it is worth remembering that the modern notions of statutory social services being friendly or accessible, or addressing problems before they reach crisis proportions, would have been unimaginable to people influenced by a more minimalist understanding of social services.
The first social service council was established in Kilkenny in 1963 and was explicitly inspired by Catholic social teaching as articulated by Bishop Peter Birch and Sr. Stanislaus Kennedy. According to the latter, the people who set up social service councils were “stepping into an Irish tradition of caring which had been carved out by churches, charities and groups with no religious affiliation, and which had made Ireland, unlike many countries in Europe, open to volunteerism” 2. Clarecare was established in 1968 and by the mid-1970s, over 40 social service councils were established throughout Ireland3.

Social service councils have tended to adopt a holistic approach to service development by responding to whatever needs presented. Almost all social service councils began with a strong focus on the elderly and Government policy in the 1960s saw this as a particular service which should be developed as a way of supporting people in their local community. In 1968, a report by a Government inter-departmental committee - entitled Care of the Aged4 – encouraged local health authorities5 to financially support the development of social service councils, particularly for the purpose of providing support services to the elderly through home visiting, meals on wheels, laundry, etc. This report pointed out that social service councils, and voluntary organisations generally, can respond more quickly, flexibly and on a more personal basis than health authorities in addressing needs within the community. It also believed, as some still do, that voluntary organisations offer a more cost effective service than local health authorities presumably because of their greater volunteer input, although the growth of professionalism and the decline in volunteerism is now making this belief less certain.

1.3 Relationships with Health Boards

In most, if not all cases, the emergence of social service councils throughout Ireland was made possible through close personal ties between the local church leader and the manager in the local health authority. In the case of Clarecare the process has been described by one researcher and a former staff of Clarecare as follows: “In May 1968, the then Clare County Manager Mr. Joseph Boland suggested there was need for a Social Service Council to co-ordinate the efforts of the various voluntary groups in the county. In his role as County Manager, Mr. Boland felt that he was dealing with a large number of such organisations and he believed that a vast reservoir of good will and enthusiasm existed among these groups. In discussions with Dr. Harty, the Bishop of Killaloe, it was agreed that a Social Service Council would be the best structure to realise the potential of the voluntary contribution in the county. … The initial meeting to set up such a Council was called by the County Manager in September 1968. Clare Social Service Council was thus inaugurated in November 1968”6

With the introduction of Health Boards in 1971 came the development of new administrative systems. As a result, the relationship between Health Boards and voluntary bodies – including social service councils – was placed on a more formal footing. Although inter-personal relations continued to have an important influence on

4 Department of Health, 1968.
5 Note that Health Boards were only introduced in April 1971 following the Health Act 1970.
the statutory-voluntary relationship, it was also influenced by a range of other factors including the bureaucratic rules governing health authorities, the amount of resources available, and the desire of voluntary bodies to expand the quality and quantity of its services. In some areas, though not in Clare, statutory-voluntary relationships were occasionally fraught. One of the reasons for this, as seen from the voluntary perspective of Kilkenny Social Services, was attributed to the fact that Health Boards inherited an unsatisfactory system for dealing with voluntary bodies: “The main weakness of the inherited system was its method of consulting and funding. Voluntary bodies were to be funded under Section 65 of the 1953 Act, according to which the ‘health authority may fund ancillary or similar services provided by voluntary bodies’. There were two problems with this kind of funding. Firstly, there was no clear definition of what ‘ancillary or similar services’ meant and secondly, the funding was permissive and not mandatory, which meant that there was no obligation on the Health Board to fund particular services”7.

Relations between Clarecare and the Mid-Western Health Board have remained consistently cordial and constructive from the beginning. According to one review of the 20 year period between 1968 and 1986, Clarecare has evolved “a productive relationship with a range of state and semi-state agencies, most notably the Mid-Western Health Board”8. It is symptomatic of the good relations between Clarecare and the Mid-Western Health Board that, throughout the 1970s, the Director of Clarecare was a member of the Health Board’s Community Care Team for County Clare9. Other Clarecare staff also served on Health Board committees and worked closely with Clare County Council on issues such as the repair of houses for the elderly and the provision of public housing generally. Indeed, the boundary between the Mid-Western Health Board and Clarecare was often blurred, even to the point where the Health Board’s statutory function of child protection was transferred to Clarecare for a period between 1997 and 2002. According to one review, the quality of relations between Clarecare and other statutory agencies in the county “offer an important Irish example of voluntary / statutory co-operation in social service provision”10.

1.4 Evolution of Services

Clarecare began as a parish-based organisation with affiliated social service organisations throughout the county. In its first year it had 23 affiliated organisations but by 1987, Clarecare was working with 49 local service groups in 44 parishes. In this sense Clarecare, like other social service councils, was informed by a vision of community development which encouraged people to be actively involved in responding to needs within their local community, thereby building up a county-wide infrastructure of care and support.

Initially the core idea was to support the work of volunteers in the different organisations and this occurred through offering training courses, some of which were provided by Kilkenny Social Services. The employment of staff began in 1969 – initially Social Workers and then Nurses – and the first Director was appointed in 1973, having previously worked with Limerick Social Services; as with other social service councils, the Directors

7 Kennedy, S., 1981:152.
8 Stuart and Cawley, 1987:176
9 Stuart and Cawley, 1987:178
10 Stuart and Cawley, 1987:185
tended to be priests, reflecting the church’s commitment to services which were based in, and had the involvement of, the community. The growth of services occurred organically as the following description of services for the elderly testifies: “Initially, services provided for the elderly took the form of social gatherings and outings where people could meet with their contemporaries and with other members of their communities. A limited home help service, administered by CSSC on behalf of the Mid-Western Health Board, commenced in 1973. Prior to 1973 a limited chiropody service was also made available to the elderly through CSSC. Holiday homes were acquired by CSSC in a number of seaside resorts during the 1970s: at Kilkee in 1973, at Lahinch in 1976 and at Spanish Point in 1978”.

The focus on the elderly was gradually extended to the broader family unit with the introduction of training in home management and household skills for young homemakers. Gradually, services expanded to include child care - including child protection as well as fostering and adoption placement - pre-school playgroups as well as holiday schemes for families and the elderly. Home help services and meals services were expanded as well as support services for Travellers. In some areas, such as Shannon and Moneypoint, specific services were provided in response to rapid economic development. Counselling services have been offered for a number of years to people with personal difficulties or more specific problems such as addiction, domestic violence or sexual offending. A residential treatment centre, Bushy Park Treatment Centre in Ennis, offers a thirty-day programme for people with addictions and a support programme for family members.

Since 2003, Clarecare has had a service agreement with the Mid-Western Health Board to provide the following services:

1. Intensive family support
2. Community family support
3. Children in care support services
4. Adoption
5. Pre-school services
6. Adult counselling services
7. Asylum seeker support.

In 2004, these services were provided by 19 employees of Clarecare, equivalent to 13.6 Whole-Time Equivalent (WTE) staff as summarised in Table 1.1. The total annual cost of these services was approximately €630,000.

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11 CSSC = Clare Social Service Council
12 Stuart and Cawley, 1987:175
As already indicated, the main focus of this report is on the first three of the services listed above. We now briefly summarise these three services drawing on the format jointly used by Clarecare and the Mid-Western Health Board in their Service Agreement. Clarecare has also prepared a more detailed description of each of these services in a document entitled ‘Descriptions of Services and Practice Protocols’ (2004).

1.5 Intensive Family Support Services

The aim of intensive family support services is to improve quality of life and promote the welfare of vulnerable children and families through the provision of a needs-led support service. The specific objective and targets of this service for 2004, as agreed between Clarecare and the Mid-Western Health Board, are summarised in Table 1.2.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>To enhance quality of life of children and families through targeting specific developmental needs of children in adversity</td>
<td>• The social work team will work intensively with a maximum of 20 families identified by the Mid-Western Health Board. The work will include parenting assessments/parenting work and identifying supports to enable vulnerable parents to care for children in their own home</td>
</tr>
<tr>
<td>To support vulnerable parents caring for their children in their own home</td>
<td>• The Family Workers will work with a maximum of 20 families in their own homes to assist them in developing child care routines and caring relationships which enhance the quality of life of children</td>
</tr>
<tr>
<td>To enable families to better access mainstream supports and participate equally in their communities</td>
<td>• Families who engage with both of these services will be enabled to avail of community supports as part of Clarecare interventions</td>
</tr>
<tr>
<td>To work with the Mid-Western Health Board Child Protection team in supporting families experiencing significant adversity and preventing reception into care where possible</td>
<td>• Five residential opportunities for respite and /or assessment to be provided for families identified by the intensive family support service</td>
</tr>
</tbody>
</table>

The three performance indicators used to monitor the output of this service are: (i) number of families worked with by the Social Work Team (ii) number of families worked with by the Family Support Workers and (iii) number of residential opportunities.
1.6 Community Family Support Services

The aim of community family support services is to provide range of community-based services which will support vulnerable children and their families within their local communities. The specific objective and targets of this service for 2004, as agreed between Clarecare and the Mid-Western Health Board, are summarised in Table 1.3.

Table 1.3 Objectives and Targets of Community Family Support Services in Clarecare, 2004

<table>
<thead>
<tr>
<th>Objectives / education support</th>
<th>Targets</th>
</tr>
</thead>
</table>
| To improve vulnerable children’s participation in education and support them to stay in school | • 1 homework club will continue to run in Kilaloe for four days a week and will cater for 10 children  
• 1 homework club will be set up in Mullagh in conjunction with the local community  
• 300 primary and secondary school students will avail of an anti-bullying programme and / or a transition to secondary school programme |

<table>
<thead>
<tr>
<th>Community participation support</th>
<th>Targets</th>
</tr>
</thead>
</table>
| To support vulnerable parents’ participation in community activities and to strengthen their interpersonal and coping skills | • 1 women’s group will continue to run in Kilrush involving 7 women  
• 1 women’s group will be set up in Mullagh  
• 3 personal development groups will be run, one in Kilaloe with a group of lone parents and one in Mullagh as a follow-on from the parenting group run last year. These groups will include a life skills course, cooking and also an input from the “Clare family learning” services  
• 2 parent and toddler groups will be facilitated  
(a) Kilaloe, this will run for three days a week in the Molua centre and parents will be encouraged to manage the sessions. The group will be open to all parents but vulnerable parents will be supported to attend by the staff involved.  
(b) Ennis, this will run one day a week. Where appropriate staff will actively promote the attendance of parents who are accessing the intensive family support service and this may involve transport to and from the group. This group will be open to all parents but will specifically target vulnerable parents who are accessing the Clarecare and Health Board services. |

<table>
<thead>
<tr>
<th>Parenting Support</th>
<th>Targets</th>
</tr>
</thead>
</table>
| To improve the quality of parenting by providing support to parents to develop their skills in caring for their children | Parenting groups, based on the “Parents Plus” model, will be delivered to groups in the following areas:  
• 4 groups in Ennis  
• 2 groups in Shannon  
• 2 groups in Kilrush  
• 1 group in Lahinch  
• 60 parents will avail of this service.  
• A monthly support group will be run in Ennis for parents who attended the parenting programmes  
• A fathers’ parenting group will be run in conjunction with the Clarecare counselling service  
• A parenting group for parents of children in care will be run |
<table>
<thead>
<tr>
<th>Support for children and young people</th>
<th>Individual work</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support vulnerable children and young people in strengthening their interpersonal and coping skills</td>
<td>• 30 children will receive individual support in relation to issues which are a cause of concern to them in relation to their relationships at home school or in their community.</td>
</tr>
<tr>
<td></td>
<td>• 5 young people who are at risk of being involved in crime or of leaving school will receive individual support in relation to these issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support for children and young people – continued</th>
<th>Group work</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide activities for vulnerable young people in local communities identified through Clarecare’s work with families and the Health Board’s child protection team</td>
<td>• 1 Crime diversion (“copping on”) programme will be run for 8 youthreach participants in Scarriff.</td>
</tr>
<tr>
<td></td>
<td>• 1 youth group will be run for 13 young women in Ennis in conjunction with Clare Youth Services.</td>
</tr>
<tr>
<td></td>
<td>• 1 young women’s activity group will be run in Kilrush involving 7 young women</td>
</tr>
<tr>
<td></td>
<td>• A weekly ‘drop-in group’ will be run for young people who are at risk of being involved in crime. This group will involve 6 young people</td>
</tr>
<tr>
<td></td>
<td>• A drug and alcohol awareness programme will be run for young people. This group will target the young people who are accessing the Clarecare aftercare and adolescent services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summer Programme</th>
<th>(a) Summer Camps</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide vulnerable children opportunities to engage in activities in their local communities which enhance their interpersonal skills and their community links</td>
<td>• 1 summercamp will be run for children in Kilaloe for 20 children</td>
</tr>
<tr>
<td></td>
<td>• 1 summercamp will be run in Kirush for teenagers involving 7 young women</td>
</tr>
<tr>
<td></td>
<td>(b) Drama / Art workshops</td>
</tr>
<tr>
<td></td>
<td>• 6 workshops will be run through out the county targeting 60 children</td>
</tr>
<tr>
<td></td>
<td>(c) Residential holiday breaks</td>
</tr>
<tr>
<td></td>
<td>• 2 three-day residential breaks will be run for Traveller children who are attending the traveller home work club and the Traveller youth club. These breaks will be facilitated by the Clarecare Traveller Support Worker in conjunction with the Clarecare social work service. These breaks will include 12 children.</td>
</tr>
</tbody>
</table>

The performance indicators used to monitor the outputs of this service focus on the number of participants in each type of service.

### 1.7 Children in Care Support Services

There are two aspects to this service. The first is an advocacy service which aims to improve the level of participation of parents in the care planning process of their children in the care of the Mid-Western Health Board and to provide support for parents in relation to their children in care. The second is an after-care service which aims to assist and support young people over 16 years who are leaving the care of the Mid-Western Health Board to achieve independent living and minimise their risk of becoming homeless.

The specific objectives and targets of the advocacy service and the after-care service are summarised in Table 1.4 and Table 1.5 respectively.
Table 1.4 Objectives and Targets of Advocacy Service in Clarecare, 2004

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Advocacy Worker will deliver a direct and dedicated service to parents of children in the care of the Health Board, where those families wish to avail of it.</td>
<td>• 23 parents of children in care will receive support</td>
</tr>
<tr>
<td>The Advocacy Worker will run a support group for parents of children in care.</td>
<td>• 14 parents will avail of the support group for children in care</td>
</tr>
</tbody>
</table>

Table 1.5 Objectives and Targets of Advocacy Service in Clarecare, 2004

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Aftercare Worker will engage with young people aged 17 and over who are preparing to leave care. The Mid Western Health Board will refer these young people.</td>
<td>• 18 young people will receive individual support with their transition from the care system</td>
</tr>
<tr>
<td>The Aftercare Worker will support young people who are living independently and liaise with other agencies who provide essential support services. Such liaison will take particular account of meeting their ongoing needs e.g. accommodation, education, physical and mental health, personal relationships.</td>
<td></td>
</tr>
</tbody>
</table>

The performance indicators used to monitor the outputs of these services are based on the number of parents, children and young people involved.

1.8 Summary

Clarecare has been in existence since 1968 and has lived through a major expansion in social services over the past 35 years. It pre-dated the introduction of Health Boards in 1971 and will outlive their abolition in 2004/5. Like other social service organisations, Clarecare emerged at a time when, by comparison with the present, there were relatively few social services in Ireland. It began by building on a spirit of volunteerism to develop a network of services across the county. In this sense, Clarecare was informed by a vision of community development which encouraged people to be actively involved in responding to needs within their local community, thereby building up a county-wide infrastructure of care and support. The initial focus of Clarecare was on services for the elderly but this soon extended to cover the family in its broadest sense and saw the development of a range of support services including child protection, fostering and adoption placement, pre-school playgroups as well as holiday schemes for families and the elderly. Counselling services have also been provided for many years, including a dedicated residential service for those needing support in overcoming addictions. As a result of these developments, Clarecare offers a wide spectrum of services to people in need throughout the county and continues to respond to new needs as they arise including the needs of asylum seekers as well as the more enduring needs of Travellers. Throughout its existence, there has been a cordial and mutually supportive relationship between Clarecare and the Mid-Western Health Board and there is now a formal service agreement between the two organisations. The dynamism which has characterised the work of Clarecare is also the impulse which gave rise to this review, particularly the commitment to developing a
system for evaluating the impact of its services which is evidence of a willingness to remain accountable to both its funders and the people it serves.

We now proceed to the review proper which involves asking four key questions about family support services in Clarecare. The four questions, which are addressed in Chapters Two, Three, Four and Five respectively, are:

1. Is there an adequate system for evaluating the outcome of services?
2. Is there an appropriate balance between prevention, early intervention and late intervention?\(^{13}\)
3. Are services based on an inclusive concept of the family?
4. Do services promote community development?

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\(^{13}\) These terms - prevention, early intervention and late intervention - refer to types of services which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (late intervention, sometimes referred to as treatment).
Chapter Two

Is there an adequate system for evaluating service outcomes?

2.1 Introduction

Clarecare is no different to most other services in Ireland in not having an adequate system for evaluating the outcomes of its services. Also, like other services, it has become increasingly aware of the need to evaluate its services in order to be more accountable to both its funders and to the families it serves. For this reason, it is important to explore in more detail how such a system could be put in place and the implications of doing so. That is the purpose of this chapter. We begin by summarising the rationale for monitoring and evaluation (Section 2.2) and then outline the core concepts involved (Section 2.3). We then outline the four stages involved in setting up an evaluation system which are: deciding on the outcomes to be measured (Section 2.4), deciding on the instruments for measuring those outcomes (Section 2.5), setting up procedures for collecting data at baseline and follow-up (Section 2.6), and finally collating, analysing and reporting on the data (Section 2.7). We conclude by recommending that Clarecare proceed to set up a system for evaluating the outcomes of its services (Section 2.8).

2.2 Rationale for monitoring and evaluation

The overall policy context for monitoring and evaluation is set by the Government’s health strategy which states that “monitoring and evaluation must become intrinsic to the approach taken by people at all levels of the health services”\(^{14}\). Similarly, the National Children’s Strategy makes a commitment “to improve evaluation and monitoring of children’s services”\(^{15}\).

A key reason why monitoring and evaluation are important is that services are a means to an end, not an end in themselves. Services are a means to achieve better outcomes for families and children through improving their well-being. Whether a service achieves its desired outcome is a matter to be determined, not assumed, and this requires some form of monitoring and evaluation based on agreed performance indicators. This also implies an approach to service delivery among professionals which is ‘outcome-focused’ because it continuously checks if the expected outcomes of the intervention are being achieved.

Evaluation is also a key to learning, both individually and organisationally. The learning rationale for evaluation has been articulated aphoristically by an unknown commentator in the following terms:

“What gets measured gets done.
Without measuring results, you can’t tell achievement from failure.
If you can’t see achievement, you can’t reward it.”

\(^{14}\) Department of Health and Children, 2001:179
If you can’t encourage achievement, you may be encouraging failure.
If you can’t see achievement, you can’t learn from it.
If you can’t recognise failure, you can’t address it.
If you can demonstrate achievement, you can win public support”.

2.3 Core concepts of monitoring and evaluation

The core concepts at the heart of all monitoring and evaluation are summarised in Figure 2.1. These concepts – notably objectives, inputs, outputs and outcomes - are widely used. The basic idea is that every intervention has – or should have - a set of objectives and these typically involve aiming to improve some aspect of family well-being; for example, the objective may be to improve the psychological well-being of parents and children or improve the relationship between parents and children. In order to achieve these objectives, inputs are required in the form of skilled staff and suitable premises as well as programmes and techniques which are known to be effective. The outputs refer to the quantity of services produced and is usually described in terms of the amount of activity created such as number of clients seen, number of individual and group sessions held, number of case conference and other meetings, etc. Finally, the outcome refers to the impact of the service in achieving its objectives. Many services typically measure outcome by describing qualitatively how selected parents and children have improved as a result of the service. This anecdotal approach can give valuable insights into outcomes but it can also be very selective. In addition, there is usually no way of assessing these outcomes in a standardised way for all service users since each anecdotal account will tend to be unique and not capable of any systematic comparison.

The term ‘performance indicator’ is used to denote the criteria used for monitoring and evaluating a service. Based on the concepts in Figure 2.1, three types of performance indicator are normally used for this purpose:

1. Input indicators, which measure the financial and human resources used to produce a particular service.
2. Output indicators, which measure the quantum of service produced usually by reference to the throughput of persons using a service over a period of time such as the number of childcare places, number of persons attending a parenting course, number of participants achieving certification at the end of a programme, etc.
3. Outcome indicators, which measure the impacts of a programme on the well-being of clients such as improvements in the psychological well-being of parents and children, improvements in the parent-child relationship, etc.

In Ireland, as elsewhere, organisations tend to place greater importance on performance indicators which measure inputs and outputs and less importance on outcome indicators essentially because the latter are more difficult to measure although they are also a more important test of a programme’s true worth. For this reason, there is a tendency for performance indicators to focus predominantly, if not exclusively, on input and outputs and to neglect outcomes. This can be seen in the performance indicators used in the 2003 Service Agreement between the Mid-Western Health Board and Clarecare which typically refer to the outputs rather than their

15 National Children’s Strategy, 2000:398
16 See McKeown, 1999
outcomes. However, and in recognition of this, the Service Agreement also makes a commitment “to develop a system to record service activity in order to evaluate the qualitative and quantitative impact of services for clients”.

The framework in Figure 2.1 also draws attention to the type of evaluation questions which need to be addressed in assessing services for families and children. These questions include:

- Is the service effective in achieving its goals? This involves comparing the objectives and outcomes of that service.
- Is the service efficient in achieving its goals? This involves comparing inputs, outputs and outcomes in similar services.
- Do the outcomes represent significant improvements in the well-being of families? This involves comparing the well-being of families before and after the intervention.
- Are the outcomes sustainable? This involves comparing the well-being of families at the end of an intervention and some time later (perhaps 1-5 years) to determine if the improvement was sustained after the intervention ceased.
- Would the outcomes have occurred without the intervention? This involves comparing the well-being of families who have received the intervention with those who have not.

The implications of these considerations for the evaluation of services in Clarecare will now be examined. We do this by analysing the different stages involved in setting up an evaluation system. Four stages are involved as follows:

1. Deciding on the outcomes to be measured
2. Deciding on the instruments for measuring those outcomes
3. Setting up procedures for collecting data at baseline and follow-up
4. Collating, analysing and reporting on the data

2.4 Deciding on the outcomes to be measured

The outcomes to be measured should be informed by the objectives which the service aims to achieve. These outcomes should be formulated in the broadest possible terms so that they are an appropriate measure of what all services for families and children in Clarecare are trying to achieve. For this reason we suggest that the broad outcome of family support services in Clarecare – both intensive and community as well as support services for children in care – might be stated as improving the well-being of parents and children. This raises the challenge of how to define well-being.

Elsewhere\textsuperscript{17}, we have defined the well-being of parents as having four conceptually distinct dimensions as follows:

(i) physical well-being
(ii) psychological well-being, including depression
(iii) quality of parent-child relationship
(iv) quality of couple relationship, in the case of two parent households.

Similarly the well-being of children has a number of conceptually distinct dimensions as follows:

(i) physical well-being
(ii) psychological well-being
(iii) quality of child-parent relationship
(iv) school performance and out-of-school activities.

It is not necessary for an evaluation system to measure all of these dimensions although it is desirable to measure as many as possible. The decision on what to measure depends on the relative importance attached to these different aspects of well-being as well as the more practical consideration of what information can reasonably be collected from parents and children who are in receipt of Clarecare’s services. A key consideration influencing all decisions about an evaluation system is that it should not harm the client’s relationship with the service and, if possible, should help to improve it. In practice, decisions about what to measure are often influenced more by the type of instruments available rather than the underlying concepts. For that reason we now examine how these dimensions of well-being could be measured.

2.5 Deciding on the instruments for measuring those outcomes

The decision about what instruments to use for measuring well-being among parents and children is shaped by two main considerations. The first is that the instrument has been tried and tested to make sure that it is a valid and reliable way of measuring the underlying concept. Numerous instruments are available for measuring the different dimensions of well-being which meet this criterion. The second is that the instrument must be suitable

\textsuperscript{17} See McKeown, Pratschke and Haase, 2003
for Irish conditions. Most instruments have been developed in the US or the UK and sometimes they may use language which reflects different cultural expressions or values to those prevailing in Ireland. Decisions about suitability often have an intuitive aspect and involve a judgement about how the instrument would be received by a typical Irish parent or child. Against this background we propose a range of already-validated instruments for measuring well-being which have been used in Ireland – notably in the evaluation of Springboard\(^\text{18}\) and in a national study of family well-being\(^\text{19}\) - and were found to be acceptable with Irish parents and children.

The instruments which we propose to measure the well-being of parents are summarised in Table 2.1. These instruments are laid out in the form of a questionnaire in the Technical Appendix, Appendix One.

<table>
<thead>
<tr>
<th>Table 2.1 Well-Being of Parents</th>
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<tbody>
<tr>
<td><strong>Type of Well-Being</strong></td>
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<tr>
<td>Physical Well-Being</td>
</tr>
<tr>
<td>Psychological Well-Being</td>
</tr>
<tr>
<td>Quality of Couple Relationship</td>
</tr>
<tr>
<td>Areas of Conflict</td>
</tr>
<tr>
<td>Ways of Resolving Conflict</td>
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<td>Ability to Resolve Conflicts</td>
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<tr>
<td>Forms of Conflict</td>
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<tr>
<td>Conflicts with Children</td>
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<tr>
<td>Quality of Parent-Child Relationship</td>
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Similarly, the instruments which we propose to measure the well-being of children are summarised in Table 2.2 and these are laid out in the form of a questionnaire in the Technical Appendix, Appendix Two.

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\(^{18}\) McKeown, Haase and Pratschke, 2001

\(^{19}\) McKeown, Pratschke and Haase, 2003

\(^{20}\) Adapted from Derogatis, 1992.

\(^{21}\) Adapted from Ryff, 2001.

\(^{22}\) Adapted from Rusbult, Martz, and Agnew, 1998.

\(^{23}\) Adapted from Miller and Lefcourt, 1982.

\(^{24}\) Kurdek, 1994.

\(^{25}\) Ibid.

\(^{26}\) Strauss, Hamby, Boney-McCoy and Sugarman, 1996.

\(^{27}\) Strauss, Hamby, Finkelhor and Runyan, 1995.

\(^{28}\) All PCRI scales adapted from Gerard, 1994.

\(^{29}\) Strauss, Hamby, Finkelhor and Runyan, 1995.
Table 2.2 Well-Being of Children

<table>
<thead>
<tr>
<th>Type of Well-Being</th>
<th>Scale for Measuring Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Well-Being</td>
<td>Health and Daily Living Scales$^{30}$</td>
</tr>
<tr>
<td>Psychological Well-Being</td>
<td>Beck Youth Inventories of Emotional and Social Impairment: Self-Concept, Anxiety, Depression, Anger and Disruptive Behaviour$^{31}$, Multidimensional Students’ Life Satisfaction Scale$^{32}$, Strengths and Difficulties Questionnaire (SDQ)$^{33}$</td>
</tr>
<tr>
<td>Child-Parent Relationship</td>
<td>Index of Parenting Style$^{34}$, Parenting Style Scale$^{35}$</td>
</tr>
<tr>
<td>School</td>
<td>No. subjects passed / failed in Junior Certificate, Relationship with teacher and peers</td>
</tr>
</tbody>
</table>

These instruments need to be carefully examined by management and staff in Clarecare, and by the Care Team in the Mid-Western Health Board, for the purpose of assessing their intuitive acceptability and deciding on their appropriateness with the clients. In making this assessment, it is important to remember that instruments which have been tried and tested cannot be altered except in minor ways since this could affect their validity and reliability; indeed even minor adjustments are sometimes not allowed on certain instruments.

2.6 Setting up procedures for collecting baseline and follow-up data

A core principle in evaluating the impact of any service is that there must be a comparison between the well-being of clients before they receive a service and their well-being after receiving the service. This ‘before-and-after’ comparison provides a measure of impact. However one can only be sure that an impact is attributable to the service if the ‘before-and-after’ comparison is made with two matched groups: an ‘experimental group’ who receives the service and a ‘control group’ who does not. This form of ‘experimental design’ is usually difficult and expensive to undertake and for this reason, most evaluations in Ireland involve a ‘quasi-experimental design’ which relies on ‘before-and-after’ comparisons with the experimental group only; some would not accept this quasi-experimental design as a ‘proper’ evaluation.

The practical implication of these considerations is that baseline data must be collected as soon as possible before the service begins. However this principle needs to be applied sensitively and should not interfere with the professional requirement of building a strong therapeutic relationship with the client. As a rule of thumb, it should be possible to collect baseline data within the first four meetings. A recommended strategy is to use the questionnaire as part of an initial needs assessment with the client and to present it as such, including offering feedback on the results and indicating how the client compares with the results from elsewhere. A number of

$^{30}$ Adapted from Moos, Cronkite, Billings, and Finney, 1986.
$^{31}$ Adapted from Beck, Beck & Jolly, 2002.
$^{32}$ Adapted from Huebner, 2001.
$^{34}$ Lamborn, Mounts, Steinberg and Dornbusch, 1991
services – for example some Springboard projects – have managed to integrate evaluation and needs assessment in this way.

Equally, the same questionnaire must be administered ‘at follow-up’ either when the case is closed or after an agreed period of, say, one or two years. The decision on when the follow-up data should be collected may be influenced by the Service Agreement between the Mid-Western Health Board and Clarecare and the requirement to provide an annual report on the impact of services; however the over-riding consideration should be to ensure that the evaluation system complements rather than interferes with the therapeutic relationship between professional as client. As with the baseline, the follow-up data can also be used to give feedback to clients on how they have progressed over the course of the intervention. This would add transparency and accountability to the relationship between staff and client and could have a positive effect on both. Again, the basic principle is that any assessment of impact requires data at both baseline and follow-up; missing data for any question essentially means that no assessment of impact can be made for that question.

The way in which evaluation is integrated into the process of service delivery is heavily dependent on each staff being familiar with the questionnaire, confident in asking the questions, and assured in how to interpret the answers. This will require an induction period during which staff are given an opportunity to become familiar with the questionnaire, undertake pilot exercises with parents and children, and learning the scoring procedure so that they are in a position to offer feedback to the client. It is clear from this therefore that the introduction of an evaluation system will not be without its own impact on the way in which staff interact with their clients and, if properly managed, this could have a positive effect for both staff and client.

In addition to the collection of baseline and follow-up data, an evaluation system will also require staff to collect data on family and household characteristics, possibly including data on personality traits and lifestyle habits such as drinking and smoking. Staff will also need to keep a detailed account of the amount of time spent on each client. This could also involve collecting details on how the time was spent with each client, using categories such as the following: (i) individual work (ii) family work (iii) group work (iv) advocacy (v) administration, including inter-agency work. The reason why this information is important is that it allows one to subsequently analyse if there is any association between impact and the amount or type of staff input; this in turn could help to develop guidelines on the length of time which parents or children typically require to show significant improvements in their well-being.

2.7 Collating, analysing and reporting on the data

The key benefit of an evaluation system is that it allows the impact of a service to be aggregated across a number of individuals in a way that is not possible with the more qualitative approach referred to above. The approach proposed here is also qualitative in that it involves measuring quality of life and well-being but does so in ways which allow the results to be quantified and analysed statistically. For this reason, a good evaluation
system is one which both captures the qualitative dimensions of the service but does so in a quantitative manner thereby allowing impacts to be summarised across individuals and compared across projects and services.

One of the consequences of introducing an evaluation system is that it requires provision to be made for collating, analysing and reporting the data. This work involves a number of tasks including: (i) storing the data (ii) computerising the data (iii) analysing the results and (iv) writing up the results. These skills may be available, or developed, within Clarecare or contracted to an outside agency with the appropriate research skills such as a university.

The type of statistical analysis which is possible will depend on the number of parents and children in the evaluation system. In a system which has data on less than 100 clients, the main form of analysis will involve calculating the mean scores on each dimension of well-being at baseline and follow-up as well as estimating the proportion of clients who have improved. Data from other projects and services can provide useful benchmarks for comparison while data on dimensions of well-being for Ireland as a whole can provide an indication of distance or proximity to general population norms. An example of the type of analysis that is possible, based on an evaluation of Springboard projects, is presented in the Technical Appendix, Appendix Three. This gives an indication of the types of results that are possible from the evaluation system being proposed here.

More sophisticated statistical analysis will be possible when the number of cases exceeds 100 and this is likely to happen in Clarecare as the data base builds up over the years. With larger numbers, regression analysis becomes possible and this provides a more reliable basis for assessing how various factors – including staff time – influences changes in the well-being of parents and children. This type of analysis – which could draw upon cases from a large number of agencies, provided they all used the same evaluation system and fell within the ambit of the Mid-Western Health Board – could provide much greater insights than is available at present into the factors associated with families whose well-being is vulnerable as well insights into the relative effectiveness of different types of services. As suggested above, it could also help in developing norms about the length and type of inputs typically required to bring about improvements in well-being and could help to develop services which are less ‘trial and error’ and more ‘tried and tested’.

2.8 Recommendation

We conclude with the recommendation that Clarecare, in consultation with the Mid-Western Health Board, should proceed with the introduction of a system for monitoring and evaluating its family support services. Both management and staff need to be fully engaged in all decisions about the evaluation system, particularly the following key issues: (i) deciding on the outcomes to be measured (ii) deciding on the instruments for measuring those outcomes (iii) setting up procedures for collecting data at baseline and follow-up (iv) collating, analysing and reporting on the data.
Chapter Three

Is there a balance of prevention, early intervention and late intervention?

3.1 Introduction

Health and social services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed and address the consequences which have evolved (late intervention, sometimes referred to as treatment). The practical application of these concepts can be illustrated using the example of interventions to promote the well-being of children; for example, prevention could take the form of ensuring that pregnant mothers are healthy and have healthy lifestyles; early intervention could involve regular screening of children in terms of developmental milestones or supporting mothers who may show early signs of post-natal depression; late intervention would involve addressing emotional, behavioural or intellectual difficulties which are displayed when the child goes to school or when there are serious difficulties in the parent-child relationship.

The classification of services according to when they intervene in the life of a problem is sometimes referred to as primary prevention, secondary prevention and tertiary prevention 36 which have a similar meaning to the terms prevention, early intervention and late intervention 37. Whichever terminology is used, policy makers are increasingly aware of the need to have balance across the continuum of services involving prevention, early intervention and late intervention. This awareness comes from a growing realisation that many services, including services for families and children, are more weighted towards late intervention than prevention and early intervention. Our purpose in this chapter is to examine the balance of services within Clarecare. We begin by setting the context in terms of the balance of services within Health Boards (Section 3.2) and then examine the balance within Clarecare (Section 3.3). We outline a needs-led approach to service provision which offers a way of re-balancing services (Section 3.4) and describe in some detail how the needs of families could be measured (Section 3.5). We conclude by recommending that a study should be carried out to determine the needs of families in County Clare (Section 3.6).

36 Hall and Elliman, 2003 distinguish between primary prevention (aimed at reducing the incidence of problems in the population), secondary prevention (aimed at reducing the prevalence of problems by shortening their duration or diminishing their impact through early detection and prompt intervention) and tertiary prevention (aimed at reducing impairments and disabilities).

37 Little and Mount, 1999 use the terms prevention, early intervention and “intervention or treatment” (p.20).
3.2 The balance of services in Health Boards

Within Health Boards, the three main services for families and children are child protection, children in care and family support. It is well recognised that child protection and children in care are late interventions in the sense that they tend to come relatively late in the life of the problem which they seek to address. In addition, these two categories of service absorb most of the resources in most Health Boards. For example, in 2003, the Mid-Western Health Board allocated 63% of its child and family budget to children in care, 15% to child protection and 22% to family support. This pattern of expenditure, which is similar to that found in other Health Boards, suggests that services for families and children may not have the right balance between prevention, early intervention and late intervention. In its 2002 Review of Child Care and Family Support Services, the Mid-Western Health Board identified one of the “key inadequacies” as “the need to provide additional early intervention / preventative programmes for vulnerable families”. At national level, the Government’s health strategy - Quality and Fairness: A Health System for You - acknowledges that there is a problem with the existing balance between prevention, early intervention and late intervention: “A specialised infrastructure was put in place from the early 1990s where the dominant focus was on child protection and on fulfilling statutory responsibilities to identify children at risk. While these services were both necessary and important, awareness has grown in recent years of the need to target preventative approaches and in particular to develop and expand family support services”.

It is significant that family support services tend to be regarded as forms of prevention and early intervention. Many of them are, particularly those involving pre-school services and nurseries as well as parent and toddler groups. However these services tend to be relatively inexpensive when compared to those family support interventions which occur much later in the life of family problems such as Springboard Projects, Family Welfare Conferences, Neighbourhood Youth Projects, Youth Advocacy Projects, etc. This suggests that expenditure on family support services may also lean more towards late intervention rather than prevention and early intervention. Indeed a recent census of family support services funded by Health Boards found that most resources within this category were spent on late intervention rather than on prevention and early intervention.

3.3 The balance of services in Clarecare

These considerations are relevant to the work of Clarecare since the balance of its services also leans heavily towards late intervention rather than prevention and early intervention. This is clear from the fact that both intensive family support and community family support are all based on referrals from the Mid-Western Health Board and involve families whose problems are known to be well developed, some to the extent of being in crisis. In other words, the balance of services in Clarecare mirrors the pattern within Health Boards generally.

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38 McKeown, Clarke and Little, 2004, Chapter Four.
39 Mid-Western Health Board, 2002:22
40 Department of Health and Children, 2001
41 Department of Health and Children, 2001:139
42 McKeown and Haase, 2004
and is a direct consequence of Clarecare’s service agreement with the Mid-Western Health Board, given that the latter is its major funder. One of the major challenges for Clarecare therefore – as for every Health Board - is to identify ways of tilting the balance of its services away from late intervention towards prevention and early intervention. In order to address this challenge it is necessary to take a closer look at the needs of families and children across the entire county and to examine how well the existing range of services matches those needs.

The reality is that services, particularly in Health Boards but sometimes in voluntary bodies like Clarecare, typically evolve in a piecemeal fashion through referrals and self-referrals of people with particular needs, particularly needs in the area of child protection. In general, no one knows if those who present for services constitute the total population of those in need or are representative of a certain proportion of them. Indeed, there is generally no way of knowing if the needs being presented are the most acute needs, although many are likely to be. Equally however not all families with acute needs will present for services. Given that services only address the needs of those who present – and who present in a particular way which fits within the statutory obligations of Health Boards - it can be difficult to have confidence that there is a genuine match between needs and services. Similarly, most services tend to be planned on the basis of professional perceptions of need rather than on the basis of larger epidemiological studies using samples drawn from the general population (‘a community sample’) and from those already using services (‘a clinical sample’).

These considerations suggest that services for families and children are often planned, developed and delivered in an environment which is not rich in information about the nature, extent and patterns of need. This makes it difficult to match needs to services and essentially results in a ‘service-led’ rather than a ‘needs-led’ approach to service provision. Almost by default, it also results in services tending to focus on problems which have reached crisis proportions with the result that the balance of resources tends to slide towards late intervention rather than prevention and early intervention.

3.4 Developing a needs-led approach to service provision

In order to address the issue of balance within services therefore it is necessary to address the prior question as to the extent and level of need in the community. Without a clearer picture of the needs of families and children it is difficult to assess if existing services are appropriate or if the overall balance of services is justified given the resources available. At present, there is a widespread perception among those involved in managing and delivering services that a better balance is required in the services for families and children.

One of the immediate challenges facing service development in the area of families and children therefore is to develop a better and more empirically based understanding of needs. The Government’s health strategy identified this as a particular problem facing the development of services for children: “An underlying issue contributing to problems in service provision is the lack of good-quality information about the needs of children and the existing capacity of the system to deliver good outcomes”43. The National Children’s Strategy also observed that, “despite … the considerable resources being committed by the Government to children, there

43 Department of Health and Children, 2001:140
continues to be limited empirical data and research-based understanding of their lives”

Prior to this, the Commission on the Family reached a similar conclusion: “The Commission’s examination of the effects of policy programmes and services on families has highlighted the dearth of research into families, family members and how children from different backgrounds fare in the longer term”.

As the term is generally understood, need refers to a deficit between a normally acceptable level of well-being and an actually experienced level of well-being. This concept implies a shared understanding of the minimum threshold of well-being so that families and children who fall below it are said to be in need. According to one definition of need: “A child is in need if his or her health or development is actually impaired or likely to become so in the absence of remedial services. Statements of needs for healthy development are a snapshot of risk and protective factors operating in the child’s life.” One of the big challenges therefore is to identify thresholds of well-being so that the scale of need and the corresponding requirement for services can be established. This would allow service priorities to be established but would also offer guidelines against which the effectiveness of services could be assessed.

3.5 Measuring the needs of children and families

In order to assess the needs of families therefore it is necessary to measure the well-being of parents and children along a number of key dimensions using measurement instruments that have been tried and tested in other research settings. As we have already seen in Chapter Two, the well-being of parents has a number of key dimensions as follows: (i) physical well-being (ii) psychological well-being, including depression (iii) quality of parent-child relationship and (iv) quality of couple relationship, in the case of two parent households. Similarly for children, the key dimensions of well-being include: (i) physical well-being (ii) psychological well-being (iii) quality of child-parent relationship (iv) school performance and out-of-school activities. Each of these dimensions is capable of being measured in valid and reliable ways using tried and tested research instruments.

In addition to measuring well-being, a study should also examine how family well-being may be influenced by factors such as demographic and socio-economic characteristics, personality traits, skills in resolving family conflicts, support networks, life events, etc. One study has already piloted this approach to the measurement of family well-being, based on a nationally representative sample of 250 parents and children, with valuable results. A list of the measurements used in that study is contained in the Technical Appendix, Appendix Four.

These considerations point to the need for a comprehensive study of family well-being in County Clare whose objective would be to address three key questions:

1. What proportion of parents and children in the community have similar levels of well-being to those who are already in receipt of services from either Clarecare or the Mid-Western Health Board?

44 National Children’s Strategy, 2000:38
45 Commission on the Family, 1998:504
46 See www.dartington-i.org /commonlang
47 See McKeown, Pratschke and Haase, 2003
48 This study could equally be carried out in the entire Mid-Western Health Board region, should this be deemed appropriate.
2. What factors are most strongly associated with well-being among parents and children, particularly those whose well-being falls below an acceptable threshold?

3. Is it possible to identify particular groups of families whose well-being is vulnerable whether by virtue of where they live (such as local authority housing estates, isolated rural areas), their household characteristics (such as young single mothers living in rented accommodation) or their ethnic status (such as Travellers or refugees)?

The answer to the first of these questions will help to identify the scale of need in County Clare by using those already in receipt of services (‘the clinical sample’) as a proxy indicator of parents and children whose well-being is already acknowledged to be below an acceptable threshold. By extrapolation, parents and children in the community (‘the community sample’) who are at, or below, this ‘clinical’ threshold could be taken as having a similar level of need to those already in receipt of services.

The answer to the second question will throw light on the dynamics of family well-being and help to identify the factors which services need to address in order to improve their impact on well-being. This information could have a significant influence on all services for families and children whether categorised as prevention, early intervention or late intervention.

The answer to the third question will help to throw light on how a strategy of prevention and early intervention might be targeted. By its nature prevention is always targeted at a population which is deemed to be vulnerable, unlike early and late intervention which is usually targeted at the family or the individual. Thus a finding that certain categories of families and children are particularly vulnerable could be of considerable value in helping to target prevention and early intervention services.

The precise details of the proposed study would need to be worked out through more detailed consultations with both Clarecare and the Mid-Western Health Board. However the board parameters could involve the following sub-samples of families, where family is defined as any household with at least one child under the age of 18.

The proposed sub-samples could be:

- a sample of 300 families drawn at random within the county to reflect the known characteristics of families in terms of social class, family type, age of parent, number of children and rural / urban distribution.
- a sample of 100 families who have been identified by the Health Board or Clarecare as needing services and may currently be in receipt of them.
- a sample of 100 families from a small number of geographical areas (such as local authority housing estates) which generate a high proportion of referrals to the Health Board or Clarecare.

Interviews would be held with one or both parents, depending on family type, and with one child in the 11-16 age category. Analysis of the results would focus on the key determinants of well-being among parents and children.

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49 The four main family types where at least one child is under the age of 18 are likely to be: (i) both parents married for first time (ii) both parents single and cohabiting (iii) one parent single (iv) one parent separated.
children and would estimate the proportion of the population whose levels of well-being is similar to those already in receipt of services. In this way the study will offer a more global picture of family needs than is currently available and will offer guidance on how services could be designed to be as effective as possible in promoting the well-being of families.

3.6 Recommendation

Our recommendation is that a study should be carried out to determine the needs of families and children in County Clare and would be used to both improve the match between needs and services contribute towards creating a better balance between prevention, early intervention and later intervention.
Chapter Four

Are services based on an inclusive concept of the family?

4.1 Introduction

Clarecare is no different to other social services in its tendency to target family services almost exclusively at mothers and children. This is understandable given that mothers typically carry more responsibility for parenting in many two parent households and often sole responsibility in one parent households. Nevertheless it is appropriate to ask if this approach to family support services is consistent with a proper understanding of the family system and the factors which promote family well-being, particularly the well-being of children. For example, a recent study of families in Ireland found that all fathers, including non-resident fathers, exercise a significant influence on the well-being of their children. The same study also found that grandparents exercised a significant influence on the well-being of children. Both of these findings indicate that the concept of a family is broader and richer than the concept of household. Most people, including policy makers and family practitioners, tend to treat the family and the household as the same although the reality of family life in Ireland today, as elsewhere, indicates that this assumption is not always justified. Among the families in receipt of services from Clarecare, it is probably even less justified, given the substantial proportion of one parent households. A challenge for Clarecare therefore is to develop its services around a more inclusive concept of family which is based on the set of relationships which link parents to each other and to their children, even where the parents are not living in the same household, and irrespective of their marital status.

Our purpose in this chapter is to raise awareness of the underlying concept of family which informs social services and its tendency to ignore or exclude fathers. We begin by reviewing some recent research on this topic (Section 4.2) and then outline some of the challenges which services face in promoting greater involvement by fathers (Section 4.3). We suggest a way in which services could carry out an audit to determine their accessibility to fathers (Section 4.4) and conclude by recommending that Clarecare’s services could be informed by a more inclusive concept of the family which takes greater account of the role and needs of fathers, irrespective of their residential or marital status (Section 4.5). In making this recommendation, we are also aware that Clarecare is responding to one aspect of this issue through planning a parenting group for fathers in 2005 while the Mid-Western Health Board has identified the absence of appropriate services for fathers as one of the “key inadequacies” in its child care and family support services.

50 See McKeown, Pratschke and Haase, 2003
51 Mid-Western Health Board, 2002:22
4.2 Research on services for fathers

There is a good deal of research and practice to suggest that fathers tend to be avoided by professionals – and possibly vice versa – and there is great uncertainty among professionals about how to approach fathers and work with them\textsuperscript{52}. In social work as in family support, parenting is often treated as synonymous with mothering and tends to “filter out fathers”\textsuperscript{53}. The reality, as many commentators have noted, is that there are virtually no strategies and interventions to involve and support fathers\textsuperscript{54}. As a result, “The absence of men from family support services and the need to make services more accessible and acceptable to fathers has become an area of growing concern for policy makers and practitioners alike”\textsuperscript{55}. In addition, as other commentators have observed, “Fathers and families need new images of what a father can be, images that go beyond the idea of father as outsider, father as provider, or father as intruder in the home. There is a need for images that acknowledge father as a potent nurturant force within the family as well as a creative liaison with the world outside the family”\textsuperscript{56}.

The way in which services are organised around families and the predominant focus on mothers is itself a reflection of the traditional division of labour in families where mothers were and still are the main carers of children; but they are not the only carers and fathers increasingly expect and are expected to become involved in the care of their children. However services are often slow to adapt to the changing realities of family life and even slower to take an active role in promoting change. Typically, women seem to be more willing than men to ask for help when family problems arise, irrespective of whether the problems are with their partner or with their child\textsuperscript{57}; at the same time, services often accept the lack of involvement of men without question. The low uptake of family services by men may be due as much to the way those services are designed and delivered as to any inherent reluctance on the part of men to use services generally. As one review of the research concluded: “reluctance among men to discuss problems in their parenting or relationships are compounded by the fact that the services on offer in family centres are often aimed at mothers to the exclusion of fathers”\textsuperscript{58}.

4.3 Challenges to developing services for fathers

The development of services for fathers faces a number of specific challenges including:

- Finding out the needs of fathers, particularly the needs of different types of vulnerable fathers, and the most appropriate types of service response; it is worth reflecting that the low uptake of existing services by fathers may itself be an indication that many of these services are inappropriate.

\textsuperscript{52} see McKeown, 2001; McKeown, Ferguson and Rooney, 1998, Chapter Seven
\textsuperscript{53} Buckley, 1998.
\textsuperscript{54} See for example, French, 1998:187-188; see also Rylands, 1995; Murphy, 1996:95.
\textsuperscript{55} Ghate, Shaw and Hazel, 2000:2.
\textsuperscript{56} Colman and Colman, 1988
\textsuperscript{57} See, for example, McKeown, Lehane, Rock, Haase and Pratschke, 2002; McKeown, Haase and Pratschke, 2004 which showed that women were much more likely than men to initiate counselling.
\textsuperscript{58} Lewis, 2000:6.
• Adopting and promoting a strengths-based perspective to work with fathers as with families generally; too often, it would appear, fathers are seen by professionals from a negative, deficit perspective rather than as persons with needs and capabilities.

• Training professionals to see fathers as part of the family even where they are not living in the same household as the mother and child; it is no longer valid to assume that the household and the family are the same thing given the extent of marital breakdown and of births outside marriage / cohabitation.

• Recruiting more men into the caring professions so that services to families are seen as the business of men as much as women; this does not imply that only men can only work with men but it does suggest that the work of caring, both inside and outside the family, is an appropriate calling for both men and women and this is not reflected in the current gender-imbalance in the caring professions.

• Promoting awareness of family services in a way which is seen as supportive of men and fathers at every stage of the life cycle from child birth to old age; many of the existing images of family services focus primarily on the mother and child.

The practicalities of making family services more inclusive of fathers is a major challenge. Research on best practice in this area suggests that two key stages are involved 59. The first involves an audit of existing attitudes among management, staff and parents within the service to the involvement of fathers by asking at least two key questions: (1) are you in favour of involving fathers in the service? and (2) what would the service look like if it was more inclusive of fathers? The second stage involves developing a concrete strategy for father involvement which involves the following key steps: (1) creating a father-friendly environment within the service by encouraging fathers to become involved, finding out what they want, recognising and addressing the fears of fathers as well as mothers and staff, displaying positive images of fatherhood in the centre, etc; (2) recruiting men to work in the service, both as staff and volunteers; (3) designing and delivering programmes of shared and separate activities for fathers, mothers and children as appropriate; (4) sustain fathers’ involvement through positive feedback, regular reviews of progress, cultivating leadership and building networks. Ideally, all of these activities should be informed by an attitude of tailoring the service to meet the needs of fathers and families generally rather than the reverse.

4.4 Auditing the accessibility of services to fathers

A useful checklist by which a service can audit its accessibility to men and fathers is contained in Table 4.1. This audit is a valuable exercise for all services but particularly those involved in family support services.

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59 See Levine, Murphy, and Wilson, 1998; Levine and Pitt, 1995; Burgess and Ruxton, 1996.
Table 4.1 Checklist for Auditing the Accessibility of a Service to Men and Fathers

Walls and Notice Boards
- Are images of men displayed?
- Are there leaflets, posters and other materials relevant to men available?

Leaflets, Posters and Brochures
- Do the images and text say men are welcome here?
- Are letters addressed to both parents where the service involves children?

Assessing Men’s Involvement
- Are men involved as clients in groups or sessions you facilitate?
- Are men actively and continually encouraged to participate?

Staff Attitudes
- Do you relate differently to men and women clients?
- Do you feel more comfortable approaching women than men?
- Do you assume men positively want to be involved?
- Do you expect men will be interested in their children’s health?
- If a mother and father are present with a child, do you listen and talk to both of them?
- Do you value his contribution?
- Do you schedule your visits or appointments to suit both parents?

Recruiting Men
- Do you want men to be involved?
- Are you prepared to make the first contact?
- Can you enlist other local health or community professionals to help with recruitment?
- Can women clients be encouraged to help recruit men?
- Can you ask male clients known to you to approach other men?
- Is providing help specifically for men possible in your work context?
- Can you tap into work, trade union, sports, fitness or leisure networks?

4.5 Recommendation

We conclude by recommending that Clarecare’s services should be informed by a more inclusive concept of the family which takes greater account of the role and needs of fathers, irrespective of their residential or marital status.

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60 Robertson and Williams, 1998:288.
Chapter Five
Do services promote community development?

5.1 Introduction

Since its establishment in 1968, Clarecare has endeavoured to develop services which recognise the interdependent links between the individual, the family and the community. This vision is reflected in its family support services which offer a range of interventions for families as well as promoting group activities which support family life in the community. Examples of these interventions include one-to-one work with parents and children, running group-based programmes for parents and young people as well as encouraging the formation of self-sustaining women’s groups in the community. Traditionally, Clarecare has placed great emphasis on supporting the volunteer efforts of people committed to addressing needs in the community and the concept of community remains an important part of its overall vision. However there may be a risk that the greater priority given to ‘case work’ over ‘community work’ in some of Clarecare’s services may be distancing it from its community development role and overshadowing its public visibility within the county.

Our purpose in this chapter is to discuss the nature of community development so that the role of Clarecare’s activities can be reviewed from that perspective. We begin by outlining how the concept of community development has evolved in recent years (Section 5.2). We also summarise some of the key principles which now inform best practice in this type of work (Section 5.3) and conclude by recommending that Clarecare assesses its role in community development in the light of these principles of best practice (Section 5.4).

5.2 Evolution of Community Development

Community development has a long history in Ireland. Traditionally a key focus has been on the economic regeneration of disadvantaged areas through various forms of community enterprise, a term which covers a variety of local employment initiatives from self-employment to community co-operatives and workers’ co-operatives. Some forms of community enterprise have focused primarily on commercial viability but others have included a strong focus on community development and community services. Central to all of them is their location within the community and their support by the community.61

A key influence on community development in Ireland has been the Combat Poverty Agency which was established in 1986. This agency has actively promoted and resourced community development as a strategy to respond to poverty and social exclusion. In 1990, the Department of Social and Family Affairs introduced the Community Development Programme and in the 12 years to 2002, some 130 projects have received funding

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Community development is now seen by the Government as a key instrument in addressing social exclusion and is specifically cited as part of the National Anti-Poverty Strategy. For example, the strategies for tackling both urban poverty and rural disadvantage include specific reference to the community dimension as follows:

“Urban Poverty: The overall objective is to tackle social exclusion in urban areas in a comprehensive and sustained manner by ensuring the provision of adequate income and by building viable and sustainable communities, through improving the lives of people living in disadvantaged urban areas and building social capital and community ownership of strategies. ….

Rural Disadvantage: The overall objective is to tackle social exclusion in rural areas in a comprehensive and sustained manner by ensuring the provision of an adequate income, through employment and income support, access to adequate services and infrastructure on a timely basis, and co-ordination of responses and empowerment of local people and communities.”

Overall, the community and voluntary sector has grown significantly in size and status over recent decades and is now recognised as a full social partner by the Government, in part due to the acknowledged importance of community development. This is reflected in the publication of the Green Paper\(^{64}\) and the White Paper\(^{65}\) on the community and voluntary sector as well as official representation of the sector in negotiations on national partnership agreements and on bodies such as the National Economic and Social Council and the National Economic and Social Forum.

### 5.3 Principles of Community Development

Community development is not easy to define but one definition which is widely used proposes the following:

“Community development is underpinned by a set of principles. It is:

- Participative of the groups and communities that are the target of the strategy or action;
- Collective in the analysis, in the development of strategy, and in the implementation of its actions;
- Empowering of the communities with whom it engages;
- Focused on social justice and equality as an outcome;
- Committed to devising strategies to combat discrimination.”\(^{66}\)

The range of actions which fall within the ambit of community development are considerable. The following is an indicative list of community development activities:

\(^{62}\) Nexus Research, 2002.
\(^{63}\) Department of Social, Community and Family Affairs, 2002a:18-19; see also Department of Social, Community and Family Affairs, 2002b.
\(^{64}\) Department of Social Welfare, 1997.
• Engagement in pre-development work with severely disadvantaged groups to resource their access, participation and involvement in development opportunities;

• Development of community groups and building independent and new forms of local organisation to vitalise and strengthen the local community infrastructure in the areas of greatest need;

• The promotion of linkages and joint working between the community sector and other sectors involved in local development;

• The provision of structures and organisation which facilitate the community sector to develop and implement a policy-focused, agenda-setting role and to enhance its capacity to impact on policy formation at local, regional and national level;

• Support for target communities to assert and articulate expectations of statutory bodies and local authorities regarding policies and services;

• Encouragement and facilitation of participation in planning and decision-making fora;

• Promotion of the concept and practice of participation to strengthen the development of active citizenship and enhance the effectiveness of community participation in local social partnership;

• Promotion of participatory and strategic planning in relation to social, economic, physical and community sector infrastructure required to sustain communities experiencing severe economic marginalisation and social exclusion in relation to areas such as rural regeneration, community childcare, transport, social economy, etc;

• Support for small-scale improvements to the local environment and community infrastructure in the most severely disadvantaged communities;

• Strengthening and building stronger equality dimension into all programmes, processes and activities;

• Utilisation of community development methods and principles in other areas of local development such as employment-related activity, vocational training and education, and youth initiatives”67.

5.4 Recommendation

Our review of services in Clarecare indicated that its work has always been informed by a community development perspective. The way in which this is understood within Clarecare has probably changed over the years - just as the concept of community development has itself evolved - but there is still a clear sense within the organisation that the individual, the family and the community are part of an interdependent system and that community development is one of the key ways to supporting both individuals and families. However this review was not in a position to examine the community development aspect of Clarecare’s work in detail. Our recommendation therefore is that Clarecare assesses its current and future role in community development by taking into account the principles of best practice which now inform this work as outlined in the definition above.

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