Respond! Housing Association

Better Being Strategy and Implementation Plan

Promoting Improved Mental Health for Families

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Respond Housing Association

Respond! Strategy to Promote Better Being and Improved Mental Health for Families

Respond! Implementation Plan 2011-2014

Respond! Pilot Implementation Plan for Better Being in Chosen Communities

This Implementation Plan sets out the steps which Respond! will take to fulfil its strategy for the promotion of improved mental health among vulnerable families and Older Persons in its estates, mainly in the South East. The plan will follow closely the process set out in the main study by Dr Kieran McKeown (page 24).

The contents of the Implementation Plan includes the following:

1. What is 'Better Being?'
2. About Respond!
3. The Context
4. Slán 2007: Mental Health and Social Well-being Report
5. The Approach
6. Implementation
7. Staffing and Locations
8. Projected Costs
9. Outcomes Envisaged
10. Partnership Opportunities
11. Ongoing Staff Training
12. Advocacy
13. Conclusion

1. What is 'Better Being'?

Most of us will be aware of the word 'well-being' which is about the enjoyment of life. It is a way of describing the quality of life and happiness of individuals, families, communities and society itself (McKeown - refer to main study). Well-being, in various degrees, can come and go in our lives. Respond! is concerned about those local communities where the absence of well-being can be all too evident for many families. We have set ourselves the task of improving the well-being of these families and we have coined the phrase, BETTER BEING, to headline our strategy. BETTER BEING is our plan to implement the strategy of promoting improved mental health among vulnerable families in our communities.

Our plan will involve our own deputed and trained Resident Support staff working with a professional mental health team. They will seek to identify families who may be at risk and liaise with them so that they may be open to working with a professional mental health team. That assistance will be available to them, in the first instance during this pilot phase, directly through Respond!'s own Clinical Psychologists and other professional trained staff. Later on we are hopeful that assistance can be made more accessible to our communities through referral to State services located contingent to these communities. This corresponds to the aspirations of the Department of Health and Children set out in the national mental health policy document "A Vision for Change" (2006) and the Slán Report (2008).

2. About Respond!

Respond! is one of Ireland's leading not for profit Housing Associations. We seek to create a positive future for people by alleviating poverty and creating vibrant, socially integrated communities. We do this by providing access to education, childcare, community development programmes, housing and other supports.
Respond! was established in 1982 as a Company limited by guarantee, with charitable status, and in 1984 we were approved by the Department of Environment, Community and Local Government as a Housing Association. We have built more than 5,300 homes nationwide and have provided homes for families, older persons, the homeless and disabled people.

Our aims:
Respond! aims to:

- Establish and maintain vibrant, socially integrated communities rather than simply provide just shelter or accommodation
- Advance education among residents of our estates
- Promote other charitable purposes beneficial to the community
- Prevent and relieve hardship and distress amongst those who are homeless and amongst those in need who are living in adverse housing conditions

Respond! believes in providing housing for social investment rather than financial profit. Therefore, we provide housing for some of the most vulnerable groups in society including those who have lived for long periods in hostels, temporary and insecure accommodation.

3. The Context

Respond! Housing Association identified the need for a therapeutic response to the mental health difficulties of some families living in our estates through a two stage study which involved: first, surveying a representative sample of Respond! households to determine the level of wellbeing among mothers and children (McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008); and second, an in-depth assessment by a clinical psychologist, in association with other Respond! Staff, to identify exactly the number of households where there was clear evidence that mothers and / or children have mental health difficulties (Amm, 2009). This revealed that upwards of 30% of mothers living on Respond! housing estates have some mental health problems and this was well above the national average. It also revealed the proportion of these mothers using sedatives, tranquilisers and anti-depressants numbered ten per cent. This is twice the national average (5%). The study also found that a quarter (25%) of mothers have a self-reported disability or chronic illness, nearly three times higher than the estimated national average for females, and these mothers were also more likely to show symptoms of depression. Turning to the children who live in Respond! estates, the study revealed that 14% to 21% have serious mental health problems, somewhat higher than in other population-based studies which are around 10% for the entire population, rising to 20% in disadvantaged areas.

In developing this Pilot Implementation Plan, Respond! recognises that resources within the statutory agencies are scarce but this shortage of funding only serves to underline the importance of all agencies, both statutory and non-statutory working together to deliver services to improve mental health in the community.

Much criticism has been made of the previous Governments' failure to address the delivery of Community Services in the area of health and mental health. When, resources were more readily available. In particular, the failure to implement the recommendations as laid out in "A Vision for Change" has created a sense of frustration within the sector. At the AGM, last year of the Irish Medical Organisation, psychiatrists claimed that this policy document had now become "a work of fiction" and was a "vision going backwards".

4. Slán: Mental Health and Social Well-Being Report (2008)

In developing this Implementation Plan, we are informed by the main conclusions and policy implications contained in the Slán Report (Department of Health and Children, 2008). The Slán report confirmed our own understanding that women in the poorest social class who are aged between 18 and 29 are the most prone to major depression and anxiety attacks. These women are most likely to be living in social housing estates. In her report on mixed tenure housing estates, Norris (2005), indicated that in Dublin City Council in 2001, 22.4% of the tenant households were single parent households compared to 10.9% nationally. The report also agreed with generally accepted research findings that *"low income areas are also associated with poorer standards of social and community services."*

More recently, the National Mental Health Programme Plan Consultation document which is clear in its aim to develop a programme plan which would reconfigure the mental health services in Ireland in line with "A Vision for Change" has outlined 4 fundamental aims for the new service delivery; *"a preventative and early detection approach towards mental disorders, the management of disorders within an evidence based framework, a broad focus on outcomes which extends to the promotion of recovery and participation in the community and the development of interventional partnerships with voluntary and community sectors to ensure that outcomes are successful and relevant to the needs and aspirations of individuals"* (National Mental Health Programme Plan, page 5).

It goes on to articulate the evidence based rationale for provision of mental health care on a partnership basis. We agree that we can indeed compliment the skills of the statutory sector. We are in a unique position to add value to statutory services by the relationships we have with our residents. We are an organisation that offers services and practical help to those who are sometimes difficult to engage with or are hard to reach. And again, we are in agreement with the document where it highlights that there may be higher levels of trust in voluntary organisations where service users are more involved in the services that they receive.

The document is clear in its understanding that including and recognising the contribution of the community and voluntary sector is critical to the *"success of a mental health service that seeks to broaden its goals and outcomes to include the restoration of personal and social functioning"* (National Mental Health Programme Plan, page 12).

The following key areas are highlighted as core elements of any strategy that seeks to enhance positive mental health at a community level.

- This plan will provide accessible community based mental health supports for people living in disadvantaged communities
- This plan will provide a multidisciplinary approach to evidence-based treatment, with links to local community resources relevant to the service users' needs

- This plan will seek to tackle the inequalities which exist in relation to social well-being. It will do this by providing community based interventions in an overall framework of promoting community involvement and social participation

The unique added value that Respond! as a housing association brings to this project is in accordance with the recommendations of the Slán report and the understanding of the National Mental Health Programme Plan of the contribution that the community and voluntary section have given. Respond! has always had at its core, the involvement of residents in the creation of positive sustainable communities. The array of residents services that Respond! provides is unique. Respond! engages in on-going community development initiatives, family resource and childcare services and education programmes on its estates. This affords us a unique relationship with residents; we are far more than just a landlord. The Slán report outlines the need for a more integrated strategic policy approach and for more intersectoral initiatives. It highlights the fact that health services in their own right cannot alone create the conditions for positive mental health; social and economic factors play a pivotal role. Models of mental health promotion that have an intersectoral approach that intervene at a level of strengthening families, communities and can look at challenging structural inequalities need to be developed.

We are advocating that the Health Service Executive look at our unique position as a housing association with a community development ethos that has a clear commitment to our residents, in particular to those with mental health issues as an opportunity to develop such a partnership model which reflects the integration of housing, community development and mental health promotion.

5. The Approach

The implementation of this Plan will be overseen by a Clinical Psychologist. In essence, effective implementation will involve identifying any parent or child who may be showing signs of distress and offering them one to one support. This falls into the "compensatory " family support model which aims to make recompense for the disabling effects of problems which impact on the individual or family such as poverty, mental health difficulties, addiction, physical illness and family breakdown etc. This approach takes the form of specialised interventions which are delivered on a one to one basis to address the actions which threaten the well-being of children and parents in order to increase the family's capacity to be a nurturing safe place.

6. Implementation

The implementation will involve the following process:

a) **Identification of families or children exhibiting mental health issues** – this initial identification may come through an assessments process, a pre tenancy induction programme or through the work of the Residents Support Worker or childcare workers on Respond! estates. We note here that Respond! has two main types of estate based workers; Residents Support Workers (RSWs) who are engaged on estate management and community development programmes within deputed estates; and Family Resource Workers (FRWs) who concentrate on specific programmes that build up family systems and supports for our residents - which programmes may involve trained child-care workers for pre-schooling, after-schooling and youth programmes.

b) **Befriending** – the development of a one to one relationship with a family or individual in distress is imperative. This work will be done by the Family Resource Worker who will offer help in the "professional" sense, as it is support offered outside of the families own informal networks. This help will seek to focus on the strengths, resources and resilience which people use to cope with and overcome problems. The Family Resource worker will become the family's key worker, interacting with agencies on behalf of the family and adopting at all times a holistic family centered approach.

c) **Identifying Need and Existing Supports** – the FRW will be required to identify need and existing supports to establish the mental health difficulties being presented by the parent or child. Where mental health issues are known, or suspected, the involvement of the Clinical Psychologist will be important at this stage so that her expertise is obtained and the response strengthened through a collaborative, team approach. It may well be necessary to consider the possibility of a mental state examination to better inform the next steps of the process. Using existing supports within the community will always be considered before an individualised care plan is fully developed.

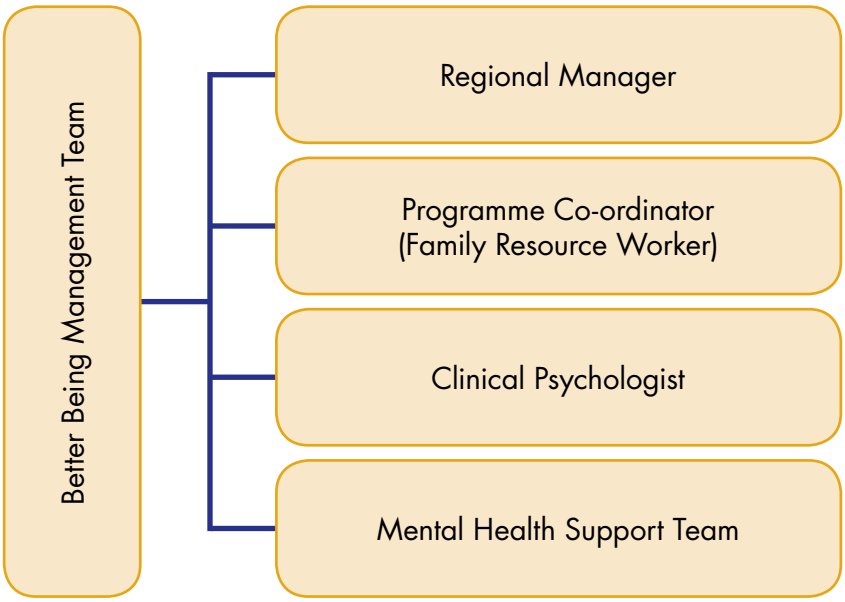
d) **Co-Ordinated Plan** – the assessment of need and mental state examination will lay the basis of the preparation of a co-ordinated plan which will be drawn up by the FRW, working closely with the family and linking in with other services that may be involved including Respond's Clinical Psychologist. The care plan lays the foundation for consideration of the specific, highly individual needs and responses to therapy of the index client and is central to good practice.

e) **Establishing a case management system** – this will be set up by the Better Being Team to record the information about the family and to ensure that commitments are upheld, work is not duplicated and gaps avoided. This will be updated as often as required through case conferences, staff reviews and client input.

7. Staffing and Locations

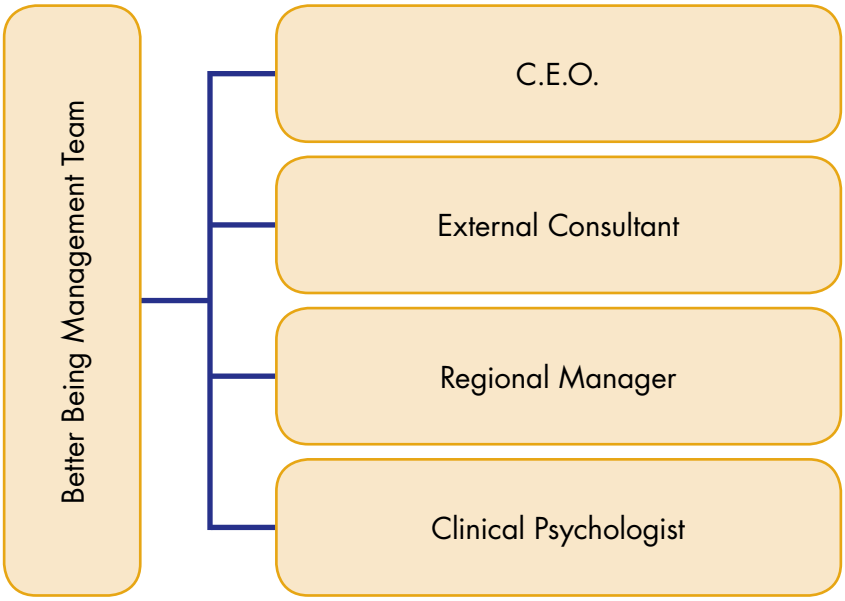
Initially, we plan to implement the programme on a pilot basis. The implementation will focus on seven estates in Year 1. This will be extended in Years 2 and 3 to 11 other estates. This service will be offered to over 558 households by the end of Year 3. This goal is very much dependent on the interaction between the service we hope to develop and the HSE's willingness to support our direct work with their statutory obligations as laid out in the Mental Health Strategy "A Vision for Change".

The implementation of the Programme will be managed by a Team consisting of the following:



In addition, this Implementation Team will report to a Management Team. The Management Team will be responsible for ensuring that the Programme is adhering to the approach set out in the strategy document. It will involve itself in directing and supporting the activities of the Better Being Implementation Team by ensuring that effective management practices and professional standards are in place. It will ensure quality reporting practices, ongoing evaluation and value for money practices are in place. It will ensure that the programme is delivering on the aims & objectives for which it was established. It will support the Better Being Staff team to deal with challenges and issues as they arise in the project roll out. It will also act as an advocate for the service with external organisations and the Respond! Board of Directors. Initially, this Team will consist of the following members:

Year 1 – Implementation of Better Being Strategy

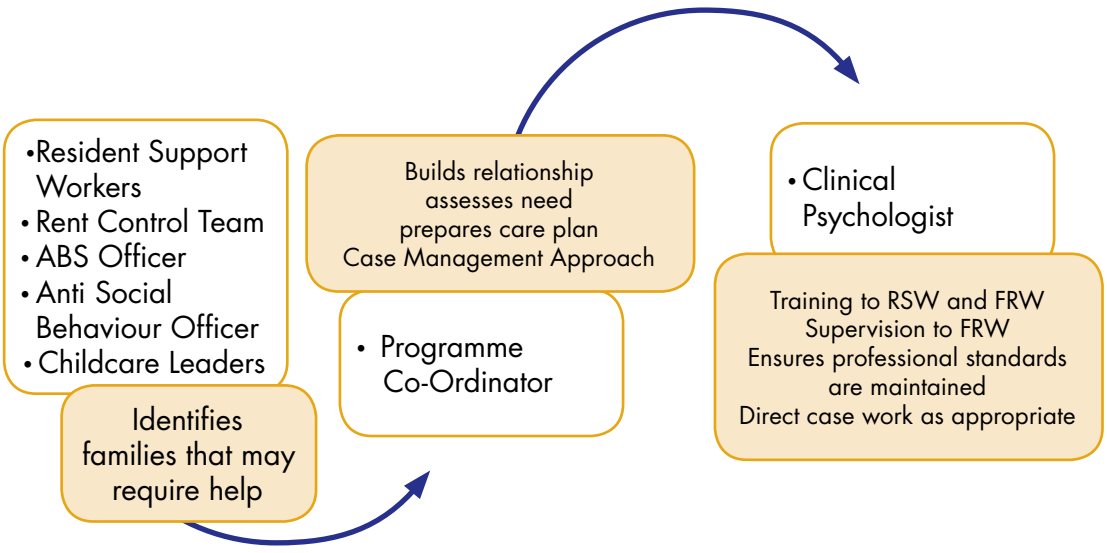


The Programme will be implemented across 7 housing estates in County Waterford comprising of some

221 HOUSEHOLDS

Within these 7 estates, there are 4 community buildings, offering a range of family support services from parent and toddler groups, pre and after schools and youth services. It is our intention that the Programme will extend to users of these Family Support Services.

The flow chart below illustrates the implementation process. The multi-faceted Resident Support Team identify the families as outlined in 5 a). The Programme Co-Ordinator will undertake the steps outlined in 5 b) to e), which includes where appropriate referral to our clinical psychologist.



Year 2 – Implementation of better being strategy

The Second Year of the Programme will continue to be implemented across 7 estates in County Waterford comprising

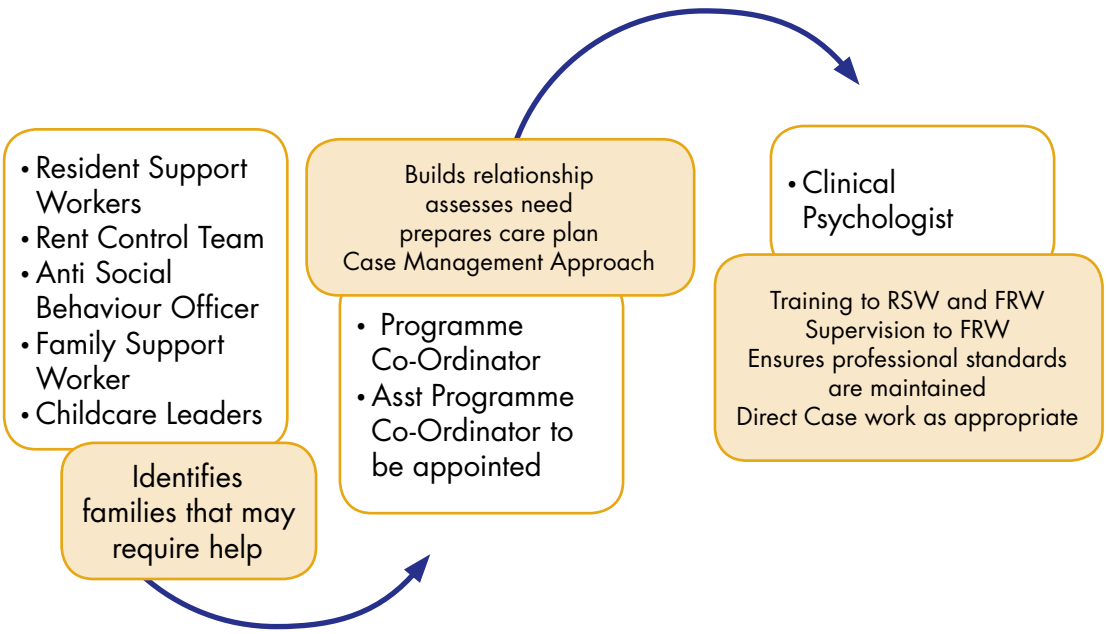
221 HOUSEHOLDS

In addition, we intend to roll out the Programme on 5 more estates in County Wexford / Wicklow comprising of some

171 HOUSEHOLDS

Within these five estates, there are four Community Buildings offering a range of Family Support services from pre and after school to youth services. It is our intention that the Programme will extend to users of these family support services.

At the end of Year Two a total of 392 Households will have access to the Programme.

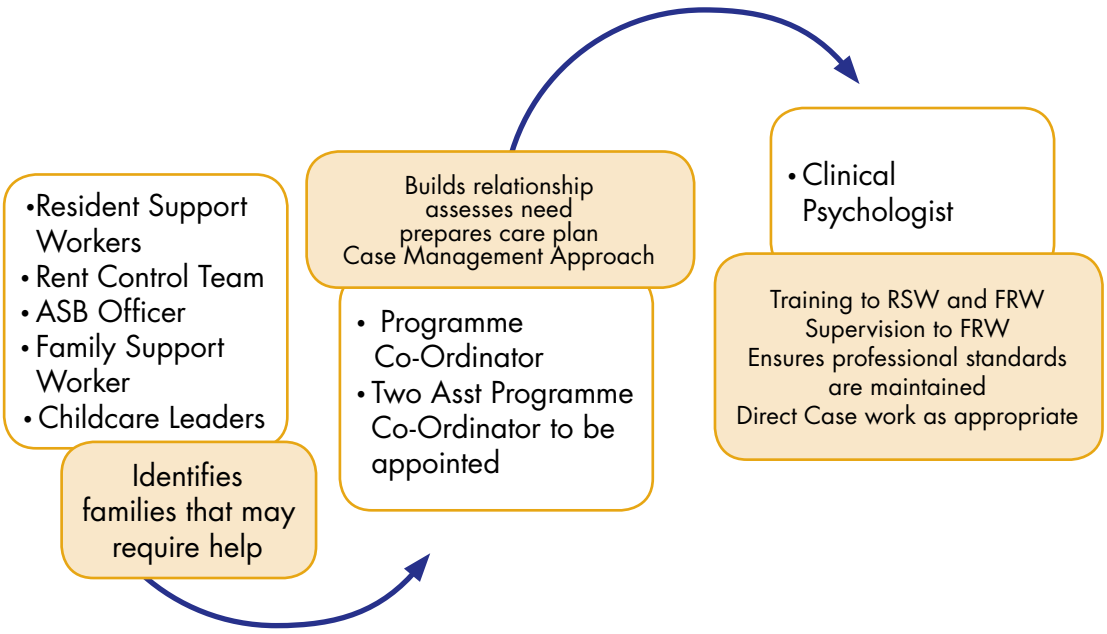


Year 3 – Implementation of Better Being Strategy

The Third Year of the Programme will continue to be implemented across 12 estates in Counties Waterford , Wexford and Wicklow, comprising 392 households and users of family support services from eight Community Centres within these estates.

It is our intention to add a further six estates from Counties Carlow / Kilkenny comprising of 166 households.
Within these estates, there are four Community Buildings offering a range of Family Support services after school to youth services. It is our intention that the Programme will extend to users of these family support services.

At the end of year three (Sept 2014), it is our intention to have 18 family estates comprising of 558 households within the Programme. In addition, we will have the service users from twelve Community Centres, which offer Family Support services within these.



8. Cost Plan

DESCRIPTION	2008-2010	2011-2012	2012-2013	2013-2014
RESEARCH to Date	€125,000			
STAFF COSTS (Clinical Psychologist, Family Resource Worker, Resident Support Workers)	€220,000	€112,000	€155,000	€203,000
EMPLOYER ON COSTS@15% (PRSI, INSURANCES, LEGAL)	€33,000	€16,800	€23,250	€30,450
TRAINING / TRAVEL	€30,000	€20,000	€30,000	€40,000
OFFICE COSTS	€10,000	€10,000	€10,000	€10,000
TOTAL	**€418,000**	**€158,000**	**€218,250**	**€283,450**

As illustrated in the above table, Respond! has already spent €418,000 in researching and developing a strategy to tackle this problem. In addition, Respond! is prepared to subvent, from its own funds the total cost of the first year of operation. Thereafter, we are calling on the HSE and other stakeholders to fund the programme in Years 2012 – 2013 and 2013 – 2014.

In the current year, we call upon the HSE to initially support this innovative programme by nominating key personnel to participate in the management group which will oversee its implementation. This participation will be extremely helpful in validating the work of the programme and act as a link between Respond! and the statutory agencies. It will build on one of the key findings of the Slán report which recommended multi-sectoral approaches to mental health provision in the community.

9. Outcomes Envisaged

- Identification of parents, children and families in particular need (particularly those whose needs are not already been met).
- Model enabling early intervention for families at high risk; thereby achieving timely interventions, supports, networks, and reducing the suffering of the children, parents and families alike.
- Model addressing secondary or tertiary level intervention supports for families/ individual needs where needs have been long undetected or unaddressed.
- Needs of families/individuals to be identified, assessed, and a personalised care plan to be put in place, with quarterly follow-up and review by clinical psychologist (family support worker to follow-up weekly with individual families and their progress/commitment to the plan).
- Enhance inter-agency working and multi-disciplinary team work at community level.

10. Partnership Opportunities

- Co funding of pilot project.
- Development of intersectoral initiative as prescribed by the Slán Report.
- Target group are significantly economically disadvantaged and are completely reliant on state services and supports.
- Development of innovative access routes to existing mental health services.
- Co-ordination and designated and shared responsibility in relation to outcomes for adults who engage with the service.
- Development of Community Based Mental Health supports as advocated in the Primary Health Care Strategy and the Vision for Change.

Opportunity to look at co-ordinated and targeted preventative or early warning programmes for those at risk or vulnerable to having significant mental health issues.

11. Ongoing Staff Training

Central to the implementation and running of the pilot scheme will be on-going training and capacity building of all staff involved, directly and indirectly, with the programme. The model in this regard will be that of "A Training of Trainers" whereby everyone becomes a student and a teacher concurrently; this fosters a culture of healthy curiosity, genuine learning, constant updating and passing on relevant skills.

In this way and the tool-kit for Better Being is generously shared, greatly enlarged and put into service in formal and informal ways and across many settings . An added and important bonus of such a climate is the extent to which appropriate knowledge fosters understanding and thus stigma is reduced.

The clients too will be helped within a model of care that sees each one as teacher and student; they are the experts of their own mental lives and students- at first- in the management of the problems they are coping with. A life-learning model is empowering for them and enables an understanding where shame and blame play no part. Being involved in their own self-healing is certainly Better Being in reality!

Teaching, learning, training, re-learning, mentoring, searching and sharing will be central activities in the whole programme; for both staff and clients this turns serious and challenging life issues into opportunities to understand more, help oneself, prevent relapse and be healers of others.

12. Advocacy

Respond! studies have shown that there is a substantial and worrying level of mental health vulnerability among our residents. This may be as high as 25% to 30% among the adult female residents and some 20% of their children. These findings, as we have set out previously, correspond to the general findings from studies conducted by the State itself, principally in its Slán Report of 2007. This study confirmed that women who have low income, low educational achievement and who are dependent on state services and supports are more likely to suffer from debilitating mental health problems than other women of different social background than the population generally.

We can say that one is more likely to find populations of women and children dependent on state support in social housing estates than in other centres of population. They form the majority of the population of Respond! family estates where some 60% to 70% of residents may be female lone parents. This in turn effects a child-density ratio with the very likely prospective negative impact upon the social cohesion and health of estates.

It would not be correct simply to extrapolate from the Respond! or the Slán study to apply these findings to all female residents and their children across social housing estates generally. Currently, there are some 150,000 households in social housing estates; over 125,000 in local authority estates and some 25,000 in housing association estates. However, the indications are that social housing providers and managers/carers need to be vigilant to ensure that we are not creating areas of cumulative deprivation and a concentration of vulnerability. and consequent disaffection among our residents. If our figures are correct, and we have no reason to suppose the contrary, then we need to worry about the incidence of family and social well-being in our estates.

Accordingly, Respond! has taken on the following considerations for its Advocacy Agenda:

- Continue to advance identification of and therapeutic response to residents and their children within our Respond! estates who may be suffering from significant mental health/wellbeing issues;

- Invite the formal Mental Health Services of the HSE to collaborate with Respond! in this regard, through a pilot programme over a three-year period;
- Invite the Department of the Environment, Community and Local Government to urge selected local authorities to conduct wellbeing surveys on some of their estates, equivalent to those conducted by Respond! and its consultants;
- Invite the Department of Health and the Department of Children and Youth Affairs to support the project, particularly in its remit to support the welfare of children. An investment in such community based mental health projects would be an investment in the present and real future of vulnerable children.
- Promote the location of mental health services contingent to clusters of social housing estates and more readily accessible to low-income families than heretofore.

13. Conclusion

This Pilot Programme is a unique attempt to address the mental health needs of our residents and users of our services. Respond! is committed to funding the Programme from its own resources for the first year. We invite the HSE and other stakeholders to partner Respond! for the benefit of children, adolescents and families whose needs are currently largely or completely unmet. The proposal fits well with stated government policy, best practice, and the 'Well-being Test' NESC (2009). It seeks to build a sustainable model of targeted family support and positive mental health to act as a counter-balance to the multiple risk factors and incidence of mental ill-health experienced by many children and families in disadvantaged communities.

- This Plan will provide a multidisciplinary approach to evidence-based treatment, with links to local community resources relevant to the service user's needs.
- This Plan will provide accessible community-based mental health supports for people living in disadvantaged communities.
- This Plan will seek to tackle the inequalities which exist in relation to social well-being. It will do this by providing Community based interventions in an overall framework of promoting community involvement and social participation.

In addition, the study by McKeown et al only related to families living in Respond! estates. We would urge the HSE and other stakeholders to commission similar research in local authority estates. Sadly, we believe that the findings by McKeown et al Well Being study 2008 will be replicated across all social housing estates. Consequently, the need to address these largely unmet needs is of great importance. We believe this Pilot Programme can deliver on the outputs outlined on page 15. We are confident that if it receives the support of the HSE and other stakeholders, it has the potential to become a mainstream programme which will deliver significant improvements to the mental health and Better Being of families.

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Respond! Strategy to Promote Better Being and Improved Mental Health for Families

Main Report

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1. Introduction

Respond! Housing Association was established nearly 30 years ago, in 1982, in order to provide housing for those unable to afford it, and to create communities where individuals and families are supported to flourish and live life to the full. It has a portfolio of over 4,000 houses and currently manages a larger and more geographically dispersed housing stock than any local authority in Ireland, barring those in the Greater Dublin Area and Cork.

This strategy has been prepared as part of Respond's vision to support families and in recognition of the fact that the need for social housing usually co-exists with many other needs. The particular focus of this strategy is to support an identifiable minority of parents and children who, from time to time, may experience mental health difficulties.

The strategy is aligned with the Government's mental health strategy which envisages 'a mental health system where informal supports and local community groups have a recognised role, where primary care is closely linked to specialist mental health services, and where mental health services across the lifespan are integrated and coordinated' [1]. The strategy is also informed by national policy on the importance of addressing needs at different stages of the lifecycle, first articulated by NESC in the Developmental Welfare State[2] and later adopted as part of the national partnership agreement, Towards 2016[3]. The strategy takes account of the national priority to improve outcomes for children as articulated in the National Children's Strategy[4] and the Agenda for Children's Services[5]. These considerations also bring the strategy into line with the HSE's priorities in its 2011 Service Plan which commits to: 'Maintaining and developing family support services and ensuring the provision of aftercare services are strengthened'[6].

Given that protecting 'the health and wellbeing of children and families' is a core statutory function of the HSE, this strategy can only be implemented with its active support and involvement. For that reason, Respond! seeks to work collaboratively with the HSE in implementing this strategy in order to strengthen supports for children and their parents. Respond! is in daily contact with some of Ireland's more vulnerable parents and children, and its relationship of trust puts it in an ideal position to support the mental health of these families, in collaboration with the HSE.

The overall objective of the strategy is to improve the well-being of an identifiable minority of parents and children who, from time to time, experience mental health difficulties. As a result of extensive research commissioned by Respond!, there is clear evidence that about 30% of mothers and 14% of children on its estates – amounting to

1 Expert Group on Mental Health Policy, 2006:59.
2 National Economic and Social Council, 2005.
3 Towards 2016, 2006:40; see also National Development Plan 2007-2013, 2007).
4 Department of Health and Children, 2000.
5 Department of Health and Children, 2007.
6 HSE, 2010:32.

around 900 households - have some mental health difficulties, well above the national average[7]. The changes in Ireland since 2008, particularly the dramatic decline in employment and economic growth, is likely to have resulted in additional stress and indebtedness for many families, including those living on Respond! estates. The strategy is designed to address the needs of these parents and children.

In its implementation, the strategy will involve identifying any parent or child on Respond! estates who may be showing signs of mental health difficulties and offering a one-to-one response.

Respond! Family Resource Workers are key to this work and will support identified parents and / or children to draw up wellness plans covering the outcomes the family want to achieve, what services will be available to support them – including the HSE's more specialised mental health services - and the targeted timeframe within which this will happen. While most of the work will be on a one-to-one basis, families may also wish to participate in more general family support services that are open to all residents on Respond's estates. As with every aspect of the strategy, it is the family's needs that are paramount, with the Family Resource Worker acting key worker, facilitator and enabler.

The strategy builds on the Respond! experience of working with vulnerable families over many years and views this in light of a clear conceptual understanding of the interdependence between the well-being of individuals, families and communities. That is why Respond! has developed separate strategies for community development[8], family support[9], and this mental health strategy since each is 'nested' within an integrated approach to promoting well-being in its different forms. This approach is itself consistent with the 'ecological model'[10] that informs public policy on children and families as reflected in the National Children's Strategy[11], Agenda for Children's Services[12], the

7 These needs have been established through a two-stage study which involved: first, surveying a representative sample of Respond! households to determine the level of well-being among mothers and children (McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008); second, an in-depth assessment by a clinical psychologist, in association with other Respond! staff, to identify exactly the number of households where there is clear evidence that mothers and / or children have mental health difficulties (Amm, 2009; Walsh, 2010).

8 Respond!, 2007.

9 McKeown, 2011.

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

11 National Children's Strategy: Our Children – Their Lives, 2000.

12 Agenda for Children's Services: A Policy Handbook, 2007.

National Framework for Early Childhood Education (Síolta[13]), and Early Childhood Curriculum Framework (Aistear[14]).

The 'better being' and mental health strategy is based on a large body of scientific evidence about family functioning and programme effectiveness. That is why the rationale for the strategy and its implementation has been spelt out since this ensures that the strategy is based on sound reasoning and solid evidence and is therefore more likely to achieve its outcomes. In light of this, each aspect of implementation has been carefully considered including staff responsibilities and competencies, training and supervision, risk management, monitoring and evaluation, timeframe, and cost.

We now summarise the core elements of thought and action that make up the strategy.

2. Definition of Family

In Ireland, the Constitution defines family as founded on marriage[15]. However the more conventional understanding recognises a broader concept, usually referred to as 'de facto families'[16], based on a wider set of intimate relationships between couples, between parents and children, and between extended family members. This wider understanding of family is closer to the definition of family adopted by the United Nations[17], and by the European Convention on Human Rights[18] which Ireland has adopted although, like all international agreements, these are still subject to the Irish Constitution.

Family therefore may be defined as the set of close personal relationships which

13 Centre for Early Childhood Development and Education, 2006.

14 National Council for Curriculum and Assessment, 2009.

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

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

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

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

link people together - sometimes in the same household, sometimes across different households – especially the relationships between parents and their children. These relationships are created socially and biologically, and may or may not have a formal legal status. De facto families therefore are characterised by the range of relationships between couples (including life partners/cohabitees), between parents/guardians and their children, between siblings, between grandparents and their grandchildren, and between extended family members.

In Ireland it is possible to identify a wide range of de facto families but the majority of children, over 70%, still live in families based on marriage; the remainder are divided almost equally between those whose parents are cohabiting (15%) and parents who are living without a partner (14%)[19]. Consistent with this, about a third of births in Ireland are outside marriage although many of these are already in relationships and some proceed subsequently to marry[20].

The legal and de facto understanding of families in Ireland typically centres on relationships between parents and children. However the recent passing of the Civil Partnership Act 2010[21] adds a new dimension to family law by granting legal recognition to same sex couples, as well as giving certain rights and obligations to cohabiting couples. This has particular relevance to families in Respond! estates where a high proportion of families are cohabiting couples (25% compared to 14% in Ireland), and an even higher proportion are one-parent households but may have a partner involved (40% compared to 20% in Ireland). A key provision of the Act is a redress system for financially dependent cohabiting partners who have lived together in an intimate relationship for five years, or two years where there is a child or children of the relationship. This redress scheme may be activated at the end of a relationship, whether by break-up or death, and allows a financially dependent cohabitant to apply to court for certain remedies, including maintenance, property, pension adjustment orders, or provision from the estate of a deceased cohabitant. This Act has implications for Respond's tenancy agreements - since cohabiting couples who constitute a legal civil partnership are entitled to a joint tenancy agreement - but its broader significance lies in giving greater legal status to de facto families.

These considerations highlight how the defining feature of family is relationships, especially those relationships which connect parents and children to each other. This

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

20 According to Fahey and Field (2008:36): 'In Ireland, studies of women who were pregnant outside marriage have shown that such women live in a wide range of partnership circumstances. In one large-scale study (Mahon et al. 1998), which gathered information on over 2,000 women who were pregnant in 1996, 35 per cent of the sample were unmarried but only 11 per cent described themselves as 'single' (that is, as uninvolved in any ongoing relationship). Over 25 per cent (that is, over two-thirds of those who were unmarried and pregnant) reported that they were in a stable relationship of some kind (7.5 per cent cohabiting, 9 per cent 'going steady' and 9 per cent 'engaged'). Furthermore, whatever the relationship status of the mothers at time of giving birth outside marriage, there are indications that large proportions enter into marriage within a few years of the birth of the child, though it is not possible to say how often the man that they eventually marry is the father of the child (Fahey and Russell, 2001).

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

starting point is important since the remit of the strategy is the mental health and better-being of each family member and the relationships which hold them together as a family. It is true that well-being is influenced by other relationships - such as those which are community-based, work-based, or interest-based - but, for the sake of clarity and consistency, the focus of the strategy is on well-being in a family context, and only on other contexts to the extent that they impact on family relationships. The rationale for this, as outlined in the next section, is founded on the scientific evidence that families are one of the greatest influences the well-being of each individual, and particularly influential on the well-being of children.

The recognition of the de facto nature of families also highlights why a family and a household are not the same thing, even though the collection of official statistics consistently merges the two. It is of course recognised that there can be more than one family in a household but equally – and the reality is that this is increasingly the case in Respond! estates, as elsewhere – there can be one family in more than one household as when parents are living apart and the father is not living with the children. One of the consequence of merging the concepts of household and family is that 'it makes no allowance for non-resident parents who may have a substantial degree of contact with their children. Even without contact, it is arguable that non-resident parents still retain a role and significance within that family, much like the missing piece of a jigsaw which is always present by its absence; the vast amount of case study material on children who are placed for adoption or in care, or children who remain attached to a non-resident parent after divorce, testifies to the abiding presence of the absent parent'[22]. This confusion between family and household often creates the misapprehension – in public policy and services as much as in popular culture – that fathers who do not live in the same household as their children are not part of the family. This consideration needs to be borne in mind in order to ensure that the Respond! strategy is inclusive of all family members, and the known benefits of fathers in the lives of children (See Appendix Two below).

3. Rationale for Strategy to Promote Mental Health and Better-Being

The rationale for the strategy to promote better being and mental health among parents and children is that families are universally acknowledged to have deep and enduring effects on the well-being of individuals and society. This was clearly articulated by the Commission on the Family in 1996: 'The experience of family living is the single greatest influence on an individual's life and the family unit is a fundamental building block for

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

society. It is in the family context that a person's basic emotional needs for security, belongingness, support and intimacy are satisfied. These are especially important for children. Individual well-being has a high priority as a measure for family effectiveness and as an objective of family policy. Continuity and stability in family relationships should be recognised as having a major value for individual well-being and social stability, especially as far as children are concerned. Joint parenting should be encouraged with a view to ensuring as far as possible that children have the opportunity of developing close relationships with both parents which is in the interests of both children and their parents. The fundamental human activity of care, intimacy and belongingness can take place in a variety of family forms. Policy should recognise the diversity and provide appropriate supports where necessary'[23].

The Commission's view is supported by a substantial body of scientific evidence to show the importance of family for the well-being of individuals and society. This evidence falls into two broad categories: the benefits that normal healthy family relationships confer on (i) adults and (ii) children. The converse also applies and there is substantial evidence that children and adults can be harmed significantly when family relationships are dysfunctional and unhealthy.

In the case of adults, much family research has focused on the difference in well-being between adults who are married and those who are single, where marriage is a proxy indicator of how family relationships impact on well-being. Remarkably, and almost without exception, the research evidence shows that marriage is more strongly associated with adult well-being than almost any other variable[24]. It is true that these studies do not establish a causal link between marriage and well-being – and designing such as a study would be difficult - so it is a matter of debate whether marriage makes people happier or happier people marry, though the likelihood is that the causation works both ways. According to one review of the evidence, the benign effect of marriage can be explained as follows: "on average, marriage seems to produce substantial benefits for men and women in the form of better health, longer life, more and better sex, greater earnings (at least for men), greater wealth, and better outcomes for children"[25]. Other reviews show that separated and divorced adults have the highest rates of acute and chronic medical conditions and are at increased risk of admission to mental hospitals and committing suicide[26]. Similarly, studies have shown that just as good marriages have benefits for physical and mental health, bad marriages have negative consequences associated with depression in women and poor physical health

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

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

25 Waite, 1995:499

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

in men[27]. One recent review of the evidence found that 'troubled marriages are reliably associated with increased distress and unmarried people are happier, on the average, than unhappily married people'[28].

In the case of children, the best scientific evidence, established over many years, is that the quality of interaction between a parent and a child is the best predictor of a child's normal healthy development. This was well-established by researchers in the field of attachment theory in the early part of the last century[29], and has been re-established in this century by studies such as the US NICHD Study of Early Child Care. According to this study: 'one of the most important and consistent predictors of child cognitive and social development was the quality of the mother-child interactions. The more sensitive, responsive, attentive, and cognitively stimulating the mother was during observed interactions, the better the children's outcomes. This result was the same when researchers examined attachment security, language development, pre-academic letter and number skills, and social behavior'[30]. Although most studies have focused on mother-child interactions - partly reflecting the differentiated roles of mothers and fathers in child-rearing and the convenience, from a research perspective, of focusing exclusively on this relationship – the benefits of parent-child interactions seem to inhere in the qualities of the caring adult rather than his or her gender, as more recent research on fathers demonstrates (See Appendix Two below).

This evidence underpins the general rationale for the strategy and the importance accorded by Respond! to supporting families. This is articulated in Respond's recent strategy statement as follows: 'Respond's goal is to provide housing and assist in the building of stable communities for those on low incomes or otherwise in need of housing. We seek to ensure that such communities will foster the growth of the individual resident and that of the whole community. We aim to assist our communities to grow to the stage where sufficient local community leadership exists to enable residents to access the services of, and participate fully in, the structures of wider society. To that end, we invest in personal and community development activity and family supports in order to build the capacity of residents for such a role. The family should be and is at the centre of the opportunity for a holistic approach in the development of both communities and the individuals within those communities' [31].

27 Kiecolt-Glaser and Newton, 2001.

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

29 Bowlby, 1979.

30 NICHD Study of Early Child Care and Youth Development, 2006:23.

31 Respond! 2007a: 3; see also 2007b.

4. Objective of Strategy to Promote Better-Being and Mental Health

The overall objective of the strategy is improve the well-being of families by supporting an identifiable minority of parents and children who, from time to time, may experience mental health difficulties. In order to achieve this objective, it is necessary to understand the nature of well-being and the factors which influence it.

Well-being is about the enjoyment of life. It is a way of describing the quality of life and happiness of individuals, families, communities and society itself. The concept has deep roots in almost every philosophical and religious tradition, and has been revived in recent times as a way of offering a more holistic understanding of what constitutes a full life. In the area of health, for example, it has been used to promote an understanding of health as 'more than the absence of illness'[32], just as mental health is now seen as 'broader than the absence of mental disorders'[33]. Informed by this perspective, a new field of research has been created, called positive psychology, in order to understand what makes people well instead of the more traditional focus of psychology on pathologies[34]. In the field of economics, there has been a parallel realisation that the welfare of societies is not adequately measured by its income and a broader understanding based on the concept of well-being is required[35]. In the area of philosophy, there are equally important questions about the sources of well-being since the answers to these questions have relevance for how one seeks well-being[36].

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

33 Expert Group on Mental Health Policy, 2006:16

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

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

36 It is true that well-being appears to be associated with certain states and circumstances, both internal

In the context of families, well-being is constituted by the experiences of individual family members (notably satisfaction with life, capacity to solve problems and absence of significant difficulties) and by the quality of relationships which hold these individuals together (both the couple relationship and the parent-child relationship). This approach was adopted in the 2008 study for Respond![37] – and a number of similar studies[38] – and the combined analysis of these studies revealed some of the determinants of well-being for parents and children, as summarised in Figure 1[39].

and external, but these are not constant over time or between individuals. For example, income is usually associated with well-being but its influence varies between people and can change according to context and circumstances. This suggests that well-being, as the term implies, is a quality of being itself; to be is to be well. Well-being is experienced because it already exists, not because it is created anew. Indeed it could not be experienced unless it already existed, and would not be sought unless it was known to be part of our nature. In the same way as educators speak of intelligence as being revealed through the process of learning and unlearning, so well-being is manifested by removing obstacles which block one from experiencing it. This perspective is important because it underlines how well-being is like the sun; it never ceases to shine even though we speak of it as rising and setting, and of shining only when the sky is cloudless. Similarly, well-being always shines but thoughts and feelings can cloud it over. This is the metaphysical foundation of positive thinking because it allows life's adversities to be framed as passing difficulties rather than permanent deficits, and to recognise that since well-being is the condition which sustains life itself, everyone is already well but just not fully aware of it.

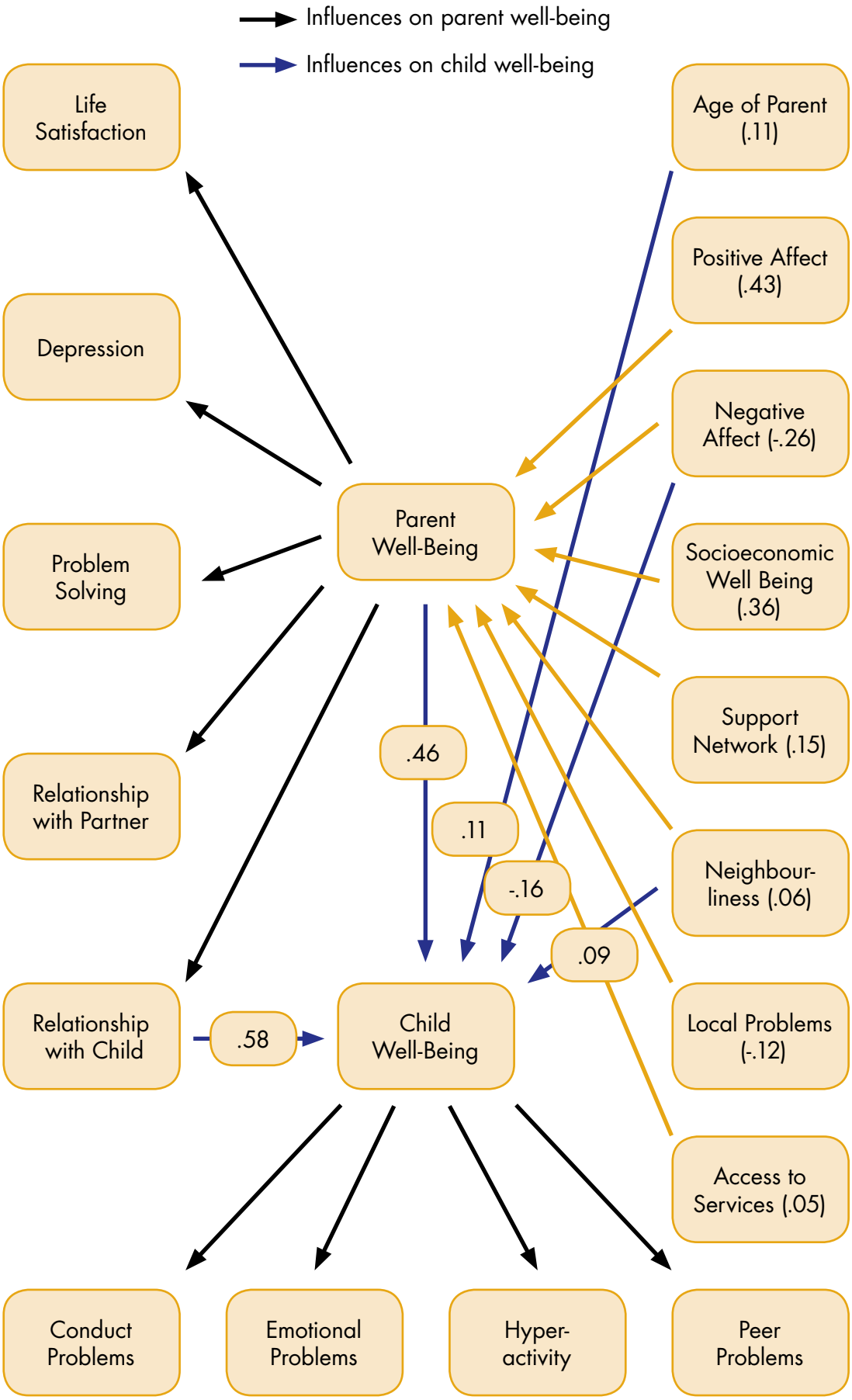
37 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008:23-28.

38 The other studies, which used a similar research design and employed a common set of measurement instruments, are: McKeown and Haase, 2007; Haase, McKeown, and Pratschke, 2008; Haase, 2009.

39 Collectively, these studies constitute a sample of 1,634 households. This is not representative of the national population but the sample can be used to assess the properties of measurement instruments that were used and the determinants of parent and child well-being.

Respond Housing Association

Figure 1. Influences on the Well-Being of Parents and Children



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

For parents, the key influences on well-being are:

- psychological attributes (notably the parent's positive affect and negative affect[40])
- economic resources (notably the parent's education, employment and financial position[41])
- informal supports (notably the parent's support network in times of need and the level of neighbourhood trust and reciprocity)
- community characteristics (notably the appearance and safety of the area and access to shops, transport, schools and libraries).

Significantly, the well-being of children is overwhelmingly influenced by their relationship with parents and the well-being of their parents, with some additional influences provided by characteristics of the parent (notably age and negative affect) and the housing estate in which they live (notably neighbourliness as indicated by trust and reciprocity between neighbours). This implies that children are directly influenced by the well-being of their parents as well as indirectly influenced by the factors which influence their parents' well-being. These direct and indirect influences indicate the encompassing quality of parental influences on children as well as their role as mediators of the wider environment and their role in either moderating or magnifying those influences for children.

These findings are consistent with numerous studies on the factors which influence the well-being of children and their parents[42]. In the case of children, these studies usually distinguish between influences which have an immediate and direct influence (usually referred to as 'proximal influences'[43]) and those which have an indirect and more distant

40 Note that positive and negative affect - understood as habitual ways of thinking and feeling - are two independent aspects of the personality, not polar opposites; each person has elements of both, and can be simultaneously strong or weak on both. Positive emotions are typically associated with an action-orientation, geared towards pleasure and reward, and is regarded by psychologists as adaptive to procuring resources for survival. Negative emotions are typically associated with a withdrawal-orientation, geared towards avoiding pain and other undesirable consequences, and is also regarded by psychologists as adaptive for survival by keeping out of danger. Positive emotions are also related to extraversion and socialibility, and to cheerfulness, enthusiasm and energy, while negative emotions are related to fear / anxiety, sadness / depression, and anger / hostility. Both these dimensions mirror optimism and pessimism and, whether one is a 'strategic optimist' or a 'defensive pessimist', both have a role to play in personality, and both have their strengths and limitations. However, in view of the finding that positive emotions have a positive influence on overall well-being - and negative emotions have a negative influence - it is worth emphasising the importance of cultivating positive emotions. The good news about positive emotions is that they are not very dependent upon external circumstances, as the leading researcher in this field has observed: 'People do not require all that much – in terms of material conditions, life circumstances, and so on – to feel cheerful, enthusiastic, and interested in life. Thus, one need not be young or wealthy or have a glamorous, high-paying job in order to be happy. This, in turn, suggests that virtually anyone is capable of experiencing substantial levels of positive affectivity' (Watson, 2002:115).

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

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

43 'Proximal processes' is the term used in the bioecological model of human development to refer to interactions between the developing child and the person, objects and symbols in its immediate external environment These proximal processes are the 'primary engines' of the child's developmental outcomes – whether in terms of competence (intellectual, physical and socio-emotional) or dysfunction (difficulties maintaining

influence (usually referred to as 'distal influences' because mediated through direct influences). Proximal influences typically refer to characteristics such as the personality traits and states of parents as well as the relationships of parents to each other and their children, while distal influences include characteristics such as the socio-economic status of the household, and the level of disadvantage and service provision in the neighbourhood and wider community. Some variables – such as socio-economic status and the parent's personality – have been found to exercise a direct as well as an indirect influence on child well-being[44], suggesting their pervasive influence on the family system.

These results have a number of important implications for the strategy to improve the well-being of an identifiable minority of parents and children who, from time to time, experience mental health difficulties. First, interventions which target direct influences on well-being are likely, other things being equal, to have greater impact than those which target indirect influences. Indeed, interventions which target indirect influences will impact on well-being only to the extent to which they change the direct influences[45]. This understanding draws attention to the need to think of family support as a continuum of direct and indirect interventions and, for each intervention, to take account of the evidence on how it is expected to increase the well-being of parents and their children. In turn, this type of analysis draws attention to the need to think through the implications of intervening with a parent or child, and to become aware of the pathways that one is trying to influence in order to bring about improved mental health.

control and integration of behaviour across situations) - and are influenced by characteristics of the child (disposition, including previous developmental outcomes), its environment (both immediate and remote), and stability since 'proximal processes cannot function effectively in environments that are unstable and unpredictable across space and time' (Bronrenbrenner and Morris, 2006:820).

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

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

Second, any intervention to improve the well-being of parents will also improve the well-being of their children. Indeed, the results suggest that any intervention which improves parental well-being is likely to have more beneficial effects, other things being equal, compared to any intervention directly with children. This, as other research has shown, justifies a multi-dimensional approach to family support[46] while also giving primacy to the role of parents in shaping child outcomes[47], notwithstanding the high drop-out rate usually experienced from parenting programmes especially by more disadvantaged parents[48]. In other words, the findings identify parents as key agents in their own well-being and the well-being of their children. While this does not exclude direct interventions with children – such as pre-school, after-school, youth and sports activities, etc. - the key lever of change in the family system is parents and the factors which directly influence their well-being and their relationship to the child.

Third, the different influences on parental well-being are mutually reinforcing so that, for example, creating a positive mental attitude - whether through engagement and activation in education, employment, informal networks, or community - may generate a psychological momentum which encourages problem-solving and a sense of well-being. Naturally, being positive does not exclude the negative or pretending that life is better because of adversity. Rather it seeks to achieve a balance where positive thoughts and feelings outweigh the negative[49].

46 As one review concluded: 'The evidence is strongest for targeted programmes that follow a clear protocol, but that address multiple issues rather than having a single focus, and can be varied according to individual need and professional judgement' (Karoly, et al, 2005).

47 According to one review: 'the great driving force for deciding the future of children is their parents. No policy designed to break through the glass ceiling that is firmly in place over the heads of all too many children can succeed without parents. The very best governments, communities and families can do is to support parents to enable them to be even more effective agents of change for their children. But communities and governments do have other roles they must play if we are radically to improve the life chances of poorer children' (Field, 2010:18). Another review also confirms the importance of parenting and the corresponding lack of interventions to support it: 'Despite the wealth of evidence on the importance of good parent-child relationships to child well being, and on the negative impact of inter-parent conflict and adult relationship problems (both more likely to occur in circumstances where there are other difficulties), there are few preventive interventions that have aimed to strengthen family relationships, or to address these aspects of risk' (Statham and Smith, 2010:28). A third review identified parents as key to the learning outcomes of children: 'Engaging parents in supporting learning in the home is the most successful way of raising student achievement and is where schools should focus their efforts in supporting parents' (Stratham, Harris and Glenn, 2010:1). A final review summarised the state of knowledge as follows: 'we know that the early home learning environment is the single biggest influence on a child's development – more important than material circumstances or parental income, occupation or education. Indeed, the quality of a child's relationships and learning experiences in the family has more influence on achievement than innate ability, material circumstances or the quality of pre-school and school provision' (Allen, 2011:57).

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

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

The insights of cognitive psychology[50] and positive psychology[51] are directly relevant in this context by showing how a person's psychological and emotional well-being can be increased by changing the way they think about the past, the present and the future[52]. This is consistent with the 'broaden-and-build theory of positive emotions'[53] which suggests that people with more positive emotions tend to have a greater capacity for building friendships and support networks as well as being more creative at solving problems and challenges in everyday life[54]. In other words, people with more positive emotions are more likely to see the world in terms of expansionary 'win-win' options rather than contractionary 'win-lose' options. In addition, cultivating positive emotions has been shown to encourage those qualities which are essential to solving problems such as persistence, flexibility and resourcefulness[55].

Fourth, the realities of limited resources in terms of income, education and employment – and the associated challenges which sometimes accompany these such as indebtedness, depression, addiction – remain substantial constraints on the well-being of parents and, indirectly, on their children. There are no easy answers to these challenges, at least within Respond's remit, but it is necessary to offer sustained support and encouragement to help parents engage in education, training and employment while at the same time seeking to raise the educational expectations and standards of their children. At the same time, it is also clear that child outcomes are unlikely to improve by simply improving the socio-economic status of their parents unless there are corresponding changes in the parent's well-being and in their parenting relationship with the child[56]. This finding is not new but its policy implications in terms of 'preventing poor children becoming poor adults' are only now being realised[57].

This understanding of the nature and determinants of well-being is in line with the approach to family support articulated by the Commission on the Family and which informs the

50 See, for example, www.beckinstitute.org.

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

52 For example, feelings about the past can be changed by questioning the ideology that the past determines the present, and by cultivating forgiveness and gratitude towards past events. Feelings about the present can be changed through living mindfully, savouring the present, and cultivating one's natural strengths, while positive feelings about the future can be increased through hope and optimism. See, for example, Snyder, CR., and Lopez, S., (Editors), 2002, Handbook of Positive Psychology, pp.120-134, New York: Oxford University Press.; see also www.beckinstitute.org

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

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

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

56 This is the clear conclusion from a study of 114 mothers and their children (aged 3-23 months) in Early Head Start in the US which concluded that while 'family risks' (comprising lack of resources, maternal depression and parental stress) are 'highly influential' on children's social-emotional outcomes but their influence is indirect, and mediated through the mother's sensitivity to the child (as measured by acceptance, responsiveness and warmth). 'Parenting quality, in this case maternal sensitivity, can be construed as the mechanism through which these risk factors impinge on children's functioning. From a resilience perspective, such findings suggest that children who are reared in high-risk contexts are not doomed to adverse outcomes. Specifically, the experience of parental warmth and responsivity can place these children on a more positive developmental trajectory. Thus, early interventions programs such as Head Start and Early Head Start, while working to increase the economic self-sufficiency of parents, could also promote positive child outcomes by intervening in their families to reduce parental stress and to enhance parenting quality' (Whittaker, Harden, See, Meisch and Westbrook, 2011:84-85.

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

work of over 100 Family Resource Centres throughout the country. The Commission on the Family characterised this approach as 'empowering of individuals, builds on family strengths, enhances self-esteem and engenders a sense of being able to influence events in one's life'[58]. The Commission endorsed this approach as 'a primary preventative strategy for all families facing the ordinary challenges of day-to-day living, and has a particular relevance in communities that are coping with a stressful environment'[59].

This understanding is also consistent with the Government's mental health policy which is informed by the following vision: 'The vision embodied in this policy is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual. This mental health system should deliver a range of activities to promote positive mental health in the community; it should intervene early when problems develop; and it should enhance the inclusion and optimal functioning of people who have severe mental health problems. Service providers should work in partnership with service users and their families, and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.' [60]

5. Prevalence of Mental Health Needs Among Respond! Residents

This strategy is developed to address the needs of a minority of parents and children in Respond! estates who experience mental health difficulties. These needs have been established through a two-stage study which involved: (i) surveying a representative sample of Respond! households to determine the level of well-being among mothers and children[61]; (ii) an in-depth assessment by two clinical psychologists, in association with other staff in six Respond! estates, to identify exactly the number of households where there is clear evidence that mothers and / or children have mental health difficulties,[62]. We now summarise the results of these studies since they identify the scale of need to be addressed by the strategy.

A limitation of this exercise is that the mental health needs of fathers are not considered. This is due to the fact that the 2008 study was based solely on interviews with mothers, itself due entirely to considerations of cost and convenience. Although mothers and fathers face broadly similar socio-economic challenges, the specific needs of fathers – both those who live in the same household as their children and those who do not – require separate consideration so that the strategy contains actions to support them as individuals and as active parents in the lives of their children.

58 Commission on the Family, 1998:16.
59 Commission on the Family, 1998:16.
60 Expert Group on Mental Health Policy, 2006:14.
61 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008.
62 Amm, 2009; Walsh, 2010: Chapter Six.

5.1. Prevalence of Mothers with Mental Health Difficulties

The 2008 study for Respond! showed that, while a majority of mothers on its estates do not have mental health problems, a minority do[63]. The study estimated that 22-30% of mothers showed signs of depression that may be clinically significant, with a fifth showing signs of hopelessness (20%)[64]. This is broadly in line with the prevalence of mental difficulties cited in A Vision For Change, the Government's policy on mental health: 'The number of people affected by mental health problems at any one time is high – about one in four individuals will have a mental health problem at some point in their lives. Most of these people will not need specialist mental health care or admission to a psychiatric unit.'[65]

Subsequent investigations led by two clinical psychologists in Respond's south-east region, based on 152 households in six estates, estimated that the prevalence of mothers with mental health difficulties was around a third (51, 34%). These estimates were derived by pooling the local knowledge of all Respond! staff and cross-referencing the list of names of mothers who were known to be experiencing mental health difficulties. Further analysis of these cases by the clinical psychologists confirmed the analysis and found that mental health difficulties were associated with addiction, parenting difficulties and relationship problems such as domestic violence[66]. In view of this, and combining the findings from both studies, it is safe to assume that 30% of Respond! mothers have significant mental health problems.

Consistent with this, the proportion of Respond! mothers using sedatives, tranquilisers and anti-depressants (10%) is twice the national average (5%)[67]. The 2008 study also found that a quarter (25%) of mothers have a self-reported disability or chronic illness, nearly three times higher than the estimated national average for females, and these are also more likely to show symptoms of depression[68]. Further analysis showed that mental health difficulties are not just a private matter affecting individual mothers but have ripple effects on all family members and the wider estate[69]. This means that interventions to improve the mental health of these mothers are likely, other things being equal, to have a significant multiplier effects on the well-being of the entire family, especially children, as well as the wider community.

63 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008.
64 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008:30-32.
65 Expert Group on Mental Health Policy, 2006:17.
66 Amm, 2009; Walsh, 2010: Chapter Six.
67 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008:33.
68 Ibid:33 and 37-42.
69 Ibid, 37-42.

5.2. Prevalence of Children with Mental Health Difficulties

The 2008 study for Respond! also showed that, while most children do not have mental health difficulties, a significant minority have 'serious' difficulties (14%) and a further 9% have 'some' difficulties[70]. These rates are somewhat higher than in other population-based studies which are around 10% for the entire population, rising to 20% in disadvantaged areas[71].

Subsequent investigations led by two clinical psychologists in Respond's south-east region, based on 152 households in six estates, estimated that the prevalence of children with mental health difficulties was around a tenth (17, 11%), with almost all of them coming from households where the mother also had mental health difficulties[72]. By combining the findings from both studies, it is safe to assume that 14% of children on Respond! estates have serious mental health problems. The main difficulties manifested by these children are conduct and hyperactivity (particularly among boys) and emotional problems (particularly among girls); among younger children they may manifest as developmental delays.

These difficulties are more likely to be found among older children (7-17 years), in one-parent households, and among children with at least one disability. Significantly, mothers who showed depressive symptoms and who had a weaker relationship with the child were more likely to report that their child had mental health difficulties[73]. This draws attention to the way in which the mental health difficulties of parents and children mutually reinforce each other within the family system; conversely, it also draws attention to the possibility that interventions to address the mental health needs of children, are likely to have significant beneficial effects for mothers, and vice versa.

5.3. Number of Mothers and Children with Mental Health Difficulties

The estimated number of mothers and children with significant mental health difficulties in Respond's family estates is summarised in Table 1. This is derived by applying the prevalence rates in the previous sections – 30% for mothers and 14% for children – to the approximately 3,000 family households which are managed by Respond!. This yields an estimate of 900 mothers and 924 children. Given that mothers with significant mental health difficulties are likely to have difficulty providing adequate parenting to their children, it is safe to state that there are 900 Respond! households which are

70 The terms 'serious difficulties', 'some difficulties', and 'no difficulties' are synonyms for the internationally agreed mental health categories of 'abnormal', 'borderline', and 'normal' respectively which are used for identifying children whose mental health needs meet DSM-IV diagnostic status, sometimes referred to as 'child psychiatric caseness'; DSM-IV refers to Diagnostic and Statistical Manual of Mental Disorders which sets out the diagnostic criteria developed by the American Psychiatric Association (1994).

71 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008:59-61.

72 Amm, 2009; Walsh, 2010: Chapter Six.

73 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008:89-91.

vulnerable and which require some form of targeted intervention to address the mental health needs of mothers and their children.

Table 1: Mothers and Children with Mental Health Difficulties in Respond! Estates

Category	Households	Mothers	Children
Number of households, mothers and children	3,000	3,000	6,600(i)
Percent with mental health difficulties	30%	30%	14%
Number with mental health difficulties	900	900	924

(i) This estimate is based on an average of 2.2 children per household as revealed in the 2008 study[74].

6. Strategy to Promote Mental Health and Better-Being in Context of Other Family Supports

It has become conventional to characterise interventions in health and social services into three types[75]: (i) prevention, designed to stop or reduce the risk of a problem occurring in a population; (ii) early intervention, designed for those already at risk of a problem occurring in a population in order to stop or reduce it; (iii) treatment, designed for those already experiencing problems in order to make them better or stop them getting worse. These three types of intervention – also referred to as primary, secondary and tertiary prevention - depend on the type and severity of need and degree of speciality required to address each.

This classification has also been used to distinguish three types of family support services[76]:

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

74 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008:24.
75 See for example, Stathan and Smith, 2010:21-24.
76 This is based on Gilligan (2000), and is similar to the Hardiker model (2002).

ii. compensatory family support, which aims to compensate for the debilitating effects of family problems such as poverty, mental health difficulties, relationship problems with partner or children, addiction, disabilities, etc. This type of support takes the form of more specialised programmes or interventions delivered on an one-to-one basis to address the factors which threaten the well-being of parents and children in order to improve the family's capacity to provide a nurturing environment for all its members.

iii. protective family support, which aims to protect the child and family from problems that have already developed, particularly where there is child neglect or abuse because the family's capacity to care has been seriously impaired. This type of family support falls within the remit of the child protection system and is the statutory responsibility of the HSE and the Gardaí. Protective family support is usually highly directive, even based on court order, and supports parents to establish some relationships and routines of care for the child that are at least 'good enough'.

Respond's mental health and better-being strategy fits within the 'compensatory' model of family support because it focuses on problems which are already developed and have become manifest. As such, it is complementary to the 'developmental' model which informs Respond's generic family support programme while also linked, as appropriate, to the 'protective' model of family support as stated in its child protection guidelines (See Appendix Four). This means that the mental health and better-being strategy is part of a continuum of interventions which are available within each Respond! estate and accessible to each household as required. In other words, the mental health and better-being strategy is part of a set of 'nested' supports for families.

The linkages between these different types of family support are important in terms of providing a holistic service. Experience in Ireland, as elsewhere, testifies to the fact that system failures to protect children often arise because there is a the lack of developmental and compensatory family supports, or because the child protection system operates in isolation from these developmental and compensatory support services[77]. Within Respond! these linkages are also important, particularly the linkage to its generic family support strategy since it is expected that most referrals to the mental health and better-

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

being strategy will come from this source. Equally important are the forward linkages to the child protection system where this is required.

7. Outcomes of Mental Health and Better-Being Strategy

This strategy is aligned with national objectives and outcomes for mental health services. The Government's mental health policy, as expressed in *A Vision for Change*, articulates an integrated model of service, the outcome of which is a system which benefits all people with a mental health difficulty.

The policy states: 'A comprehensive mental health system exists when mental health activities – from community support groups, to voluntary groups, to primary care, to specialist mental health services – work in an integrated, coordinated fashion for the benefit of all people with mental health difficulties. There is currently no such system in Ireland. The current structure of mental health services, where they are seen as not only separate from other health services, but separate from the community in which they operate, promotes the continuing exclusion and stigmatisation of people with mental health problems. The framework proposed in this policy is a framework for a mental health system where informal supports and local community groups have a recognised role, where primary care is closely linked to specialist mental health services, and where mental health services across the lifespan are integrated and coordinated.' [78]

Respond's mental health and well-being strategy is a part of this evolving national mental health system, and underlines the key role of community services in supporting mental health.

8. Implementation of Better-Being and Mental Health Strategy

Respond's Family Resource Workers have the lead role in implementing the better being and mental health strategy while also working in close collaboration with the Resident Support Workers. Implementation of the strategy has five overlapping elements which are described in this section. The first involves identifying the families who need help (Section 8.1). The second requires building a relationship between the Family Resource Worker and the family (Section 8.2). The third is undertaking an assessment of needs (Section 8.3) while the fourth is preparing a wellness plan (Section 8.4). The fifth element involves a case management system/review of wellness planning progress to support the entire process (Section 8.5).

78 Expert Group on Mental Health Policy, 2006:59.

8.1. Identify Families with Mental Health Difficulties

A majority of parents and children on Respond! estates, as indicated earlier (Section 5.1 and 5.2), do not have mental health problems but a minority do. In the course of visiting a family, the Resident Support Worker may notice signs of stress and, while these signs do not constitute a diagnosis of mental health difficulties, they may indicate that the family could benefit from help or support. The list of indicators in Table 2a is designed to help staff in Respond! become more aware of the signs of stress within families and, where these are present, to bring their concerns to the attention of the Family Resource Worker.

Table 2a: Indicators of Parent Who May Have Mental Health Difficulties

There may be a cluster of indicators which trigger concern by observing the person's appearance (personal cleanliness and clothing), behaviour (staying in the house with curtains drawn all day, fear of going out, inability to prepare family meals), conversation (lacking coherence or continuity), or mood (dark, disturbed). Equally, the parent may report signs that are a cause of concern such as persistent loss of sleep or appetite resulting in constant tiredness; unable to cope with or control the children; having problems which feel overwhelming (such as health, family or financial problems); feeling worthless or suicidal. The home setting may also indicate difficulties though not without corroborating evidence, such as:

- ✓ piles of rubbish may point towards depression in a younger person, or dementia / inability to cope in an elderly person;
- ✓ bottles lying around may indicate addiction issues;
- ✓ curtains closed may suggest depression, addiction, fear or paranoia, dementia, possible illegal activities, suicidal ideation;
- ✓ piled-up mail may indicate depression, financial problems, anxiety, inability to cope;
- ✓ over meticulous cleanliness and neatness may be associated with obsessive compulsive disorder or anxiety;
- ✓ an empty fridge may indicate that an elderly person is unable to cope independently, or a younger person is experiencing depression;
- ✓ hoarding may be a sign of obsessive compulsive disorder or anxiety;
- ✓ inappropriate magazines left lying around could suggest sexual abuse;
- ✓ writing on walls and broken windows could be a sign of conduct disorder, anti-social personality, lack of parental control; where the writing is bizarre this could indicate psychotic thinking; where there are slogans this could be gang-related and anti-social personalities; it could also indicate violent and drug-related activities.
- ✓ In addition, there may be things missing from the home which would be expected in a healthy functioning family such as:
- ✓ lack of toys and children's books in a house where children live which may indicate deprivation and even neglect;
- ✓ fresh food and water not being put out for a pet which could indicate inability to cope, depression or even suicidal thinking.

Table 2b summarises some indicators of a child who may be experiencing stress or mental health difficulties. As with Table 2a, this is not a formal 'diagnostic tool' for assessing mental health difficulties but a way of raising awareness that a child may have needs and that require attention. These indicators are sensitive to the age of the child and may indicate a passing difficulty or something more serious about the child's development, including the possibility that the child is not receiving proper care and may require protection from neglect or abuse.

Table 2b: Indicators of Child Who May Have Mental Health Difficulties

Indicators may be based on a combination of direct observation, reports from the child, or reports from parents, teachers or other significant adults in the child's life. These indicators are usually more reliable when they are part of a persistent pattern rather than one-off events.
Behaviour difficulties may be indicated where the child is:
✓ aggressive, disruptive, difficult to control, or out of control
✓ has difficulty mixing with others and is either bullied or bullies others
✓ involved in anti-social behaviour
✓ generally rude to and inconsiderate of other people's feelings
Emotional difficulties may be indicated where the child is:
✓ worried or often seems unhappy or tearful
✓ anxious, fearful, and lacking in self-confidence
✓ has no friends, rather solitary and usually plays alone
✓ often complains of headaches, stomach-aches or sickness
Neglect may be indicated where the child is:
✓ out late at night, beyond normal bed-time for children of that age, or without appropriate clothing or footwear
✓ appears hungry and undernourished, significantly under-weight or under-height
✓ constantly missing from pre-school, school or after-school
✓ parent appears disinterested in the child's physical, emotional or cognitive development
Abuse may be indicated where the child experiences:
✓ persistent criticism, sarcasm, hostility or blaming, including use of bad language to the child
✓ parent is emotionally unavailable, unresponsive, inconsistent, or overly authoritarian
✓ child is expected to take responsibilities that are not age-appropriate
✓ physical injuries or bruising to the child
✓ sexualised language or behaviour by the child

Respond! childcare services bring it into direct contact with parents and children every day. In the course of delivering the service, childcare staff will notice if a child is presenting behaviour or emotional problems, or generally failing to thrive. Where such a concern is raised, even if it cannot be confirmed, the Childcare Worker will make a referral to the Family Resource Worker who will investigate it further.

This system for identifying families in need reveals how Family Resource Workers fill the role of 'secondary prevention' within Respond!, with Resident Support Workers and Childcare Workers playing a 'primary prevention' role. The effectiveness of the system depends on everyone working closely together.

In addition to the referral system just described, some vulnerable families may also self-refer. A study of 152 families in Respond's south-east region, which were identified by a clinical psychologist as having mental health difficulties, revealed that 'many were already attending counselling'[79]; a finding which indicates that many residents seem well-able to find the help they need[80]. Equally, this study found that 'in many cases people do not seek help because they are not ready to engage in the process of change'[81]. The logical implication of this is that a substantial minority of tenants with identified mental health difficulties may remain untreated. This situation is not unusual even if it is more difficult to acknowledge and accept when those affected are known and may be causing harm to themselves and others.

These considerations also draw attention to the fact that no resident can be obliged to accept a service where there is not a desire or willingness to receive it, except in the following circumstances:

i. where a child is not receiving adequate care and protection and a referral to HSE's child protection services is necessitated[82];
ii. where the behaviour of a tenant is harmful to others on the estate because of criminality, anti-social behaviour or damage to the property of Respond! or other residents.

79 Amm, 2009.

80 This in turn is consistent with research on therapeutic effectiveness which recognises that the characteristics of the person, including self-awareness of the need for help and willingness to accept it, are key determinants of therapeutic outcomes. For a summary of the evidence, see McKeown, 2000; see also www.heartandsoulofchange.com

81 Walsh, 2010:38.

82 This is stated explicitly in Respond's draft child protection policy statement: 'Respond! Housing Association is committed to promoting the highest standards of child protection in line with 'Children First – National Guidelines for the Protection and Welfare of Children' (1999). Respond! is committed to implementing this policy within the organisation and to promoting it on all of our family estates. We believe that children and young people have a right to be brought up in a supportive and safe environment. We undertake to provide such an environment within the organisation and promote it on our estates where the safety of children and young persons is paramount. All staff and volunteers are expected to implement this policy at all times; failure to do so will be seen as a breach under the organisation's disciplinary procedures. Staff are also informed that they have the right to report concerns directly to the appropriate authorities and are protected from civil liability under the 'Protection of Persons Reporting Child Abuse Act 1998' provided they do so 'reasonably and in good faith'. Respond! adheres to the recommendations of the Children First National guidelines for the protection and welfare of children, published by the Department of Health and Children. This policy was put in place in September 2010 and will be reviewed in 2011'.

This strategy draws attention to the more general issue of how to promote awareness of mental health difficulties and the availability of help for those who experience them. It is increasingly recognised that the way information is presented on mental health issues is itself part of the message and experience elsewhere suggests that the term 'stress' has become a more socially acceptable and less stigmatising way of referring to mental health difficulties[83]. Equally, creative use of the web can provide people with access to information about how to deal with the normal stresses and strains of life while also finding out about additional sources of support. This is an issue that merits further consideration, in collaboration with residents, as the strategy unfolds.

8.2. Build a Relationship with the Family

The one-to-one relationship between the Family Resource Worker and the family is central to the outcomes of the strategy. For that reason, it is essential to have a clear understanding of what constitutes a 'helping relationship' and what conditions need to be met in order to 'help' someone.

Respond's work, in all its manifestations, is about helping people to live life to the full. Helping is a natural part of life and something that arises spontaneously because people help, and are helped, all the time through family, friends, and communities. Everyone is a natural helper and people seek professional help only when all other sources have been exhausted [84].

By definition, the help offered by Family Resource Workers is 'professional help' in the sense that it is not part of the tenant's informal sources of help from family, friends and other supports. Research on what determines the effectiveness of professional help, particularly in the case of counselling and psychotherapy, has revealed that all therapies have something in common which make them similarly effective[85]. These common factors are principally the characteristics of the client and the client-therapist relationship[86].

83 A good example of how this type of information can be presented in a non-stigmatising and non-threatening way can be found at the website: http://glasgowsteps.com

84 'Throughout human history, individuals with social and emotional difficulties have benefited from talking with a sympathetic 'other' perceived as being able to offer words of comfort and sound counsel either because of recognised inherently helpful personal qualities, or by virtue of his or her role in the community. … However, even in today's world, the vast majority of individuals who are experiencing psychological distress do not seek help from trained and credentialed professional counsellors and therapists: they obtain relief by talking to individuals untrained in counselling or psychotherapy' (McLennan, 1999:169).

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

86 The other two factors are therapeutic technique and client hopefulness, each of which are estimated to contribute about 15% to outcomes (see McKeown, 2000:Chapter Three). Therapeutic technique seems to work best when, through sensitive and intelligent questioning, it helps the client to gain insight about their situation while simultaneously helping to restore their problem-solving abilities (Miller, Duncan and Hubble, 1997, Chapter Seven; Ogles, Anderson and Lunnen, 1999). By contrast, hopefulness seems to operate more as a 'placebo effect' in the sense that many interventions – therapeutic, medical, even religious – are known to have a beneficial effect simply by virtue of the client's belief that they are effective. In other words, these 'rituals' – such as the ritual of going for help – have the effect of restoring hope in the possibility of improvement which, in turn, has the effect of "mobilising their intrinsic energy, creativity and self-healing potential. Personal agency is awakened by technique" (Tallman and Bohart, 1999, p.100). Conversely, hopelessness is when people feel they can do nothing to improve their situation or when they feel there is no alternative; in other words, they are unable to pursue their goals because their generative capacity for "agency" and "pathfinding" has been lost (Synder, Michael and Cheavens, 1999, pp.180-181).

Beginning with the client, it has been observed that: 'It is the client more than the therapist who implements the change process. … Rather than argue over whether or not 'therapy works', we should address ourselves to the question of whether or not 'the client works!' … As therapists have depended more upon client's resources, more change seems to occur"[87]. This insight has led therapists to a focus on the strengths, resources and resilience which people use to cope with, and overcome problems. At the same time, this approach does not seek to minimise problems since, as the research shows, many vulnerable people and families often need sustained support over a considerable period of time in order to bring about the changes they want.

Turning to the therapeutic relationship, this is seen by many commentators as 'the sine qua non of successful therapy'[88]. It has been suggested that many of the qualities of effective therapist-client relationships – emotionally warm, available, attentive, responsive, sensitive, attuned, consistent and interested - are in fact generic to many relationships both in work and family[89]. The writings of Carl Rogers laid particular stress on the helping relationship by emphasising the need to show clients – and be experienced by clients as showing – unconditional positive regard, accurate empathic understanding, and openness to creative solutions[90]. One review of the literature, based on the findings of over 1,000 studies, recommended three ways to improve the therapeutic relationship:

(1) accommodate the client's motivational level and state of readiness for change;
(2) accommodate the client's goals for therapy; and
(3) accommodate the client's view of the therapeutic relationship[91].

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

These qualities have also been identified as attributes of effective 'key working' since the Family Resource Worker is, in effect, the family's key worker: 'For families, the distinguishing

87 Bergin and Garfield, 1994:825-826.

88 Sprenkle, Blow and Dickey, 1999:334.

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

90 Rogers, 1957.

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

features of 'good' key workers were: proactive contact; a supportive, open relationship; a holistic family-centred approach; working across agencies; working with families' strengths and ways of coping; and working for the family as opposed to the agency. When these elements were in place, families clearly felt the service was beneficial and offered a different form of support from other services they received.'[92].

8.3. Match Needs to Services

The relationship of the Family Resource Worker to the family, while itself an important part of the healing process, is also essential in order to help each family member gain insight into their needs and what supports and services would help in overcoming their difficulties. That is why the Family Resource Worker needs to undertake an assessment to establish if the mental health difficulties being presented by the parent or child reflect an underlying mental illness – and therefore requires medical intervention – or reflects dysfunctional and distorted ways of thinking, feeling and behaving that are amenable to counselling and psychotherapy.

In light of this assessment, and in consultation with the clinical psychologist if necessary, the Family Resource Worker will decide on the most appropriate course of action by bringing insight and knowledge about to the options that may help to overcome the person's difficulties. For parents, these options may involve practical and emotional support that can be organised directly by the Family Resource Worker within the ambit of Respond's resources. Alternatively, or in addition, they may involve accessing more specialised services such as GP, mental health, addiction, indebtedness, etc.

Where children are identified as having a specific need, it may be necessary to arrange for clinical assessment and treatment, either by the HSE's Child and Adolescent Mental Health Services (CAMHS) or by the National Educational Psychological Service (NEPS). As already indicated, where concerns arise about the welfare and protection of children, Respond! will make an immediate referral to HSE's Social Work Department or the Gardaí, in line with its own and national guidelines (see Appendix Four). All of this points to the need for Family Resource Workers to have a detailed knowledge of what services are available and accessible in the area and who to contact. This type of knowledge can also help the family to gain confidence in their Family Resource Worker and to know that they will get the help they need.

8.4. Prepare a Wellness Plan

The wellness plan is an agreement made between the Family Resource Worker and the family covering what outcomes the family want to achieve, what services will be available to support them, and the timeframe within which this will happen. This will be

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

drawn up by the Family Resource Worker, working closely with the family, and linking with other services that may be involved, including Respond's Clinical Psychologist.

The wellness plan will be uniquely tailored to each family. In addition to the one-to-one relationship with the Family Resource Worker, the plan may include inputs from other services such as GPs, MABS, schools, etc. The care planning process requires a high level of cooperation between the family and the professionals and agencies involved. For this reason, responsibilities of all the parties, including the family, need to be made explicit within the wellness plan and coordinated through the Family Resource Worker. Occasional reviews of these working relationships – possibly including the adoption of a protocol to assist cooperation – should be considered to ensure that the family receives the best possible service.

In addition to specifying inputs, the wellness plan will also list the outcomes to be achieved. In essence, outcomes are the improvements which the family hopes to make and the difficulties it hopes to overcome. That is why regular reviews are necessary to ensure that outcomes are being achieved and, if not, that adjustments are made to the wellness plan. Similarly, the wellness plan needs to consider when it is appropriate to leave this exclusively to the individual or family to follow-up. Transition arrangements may be needed to ensure that the family has sufficient support to avoid a relapse.

The main focus of the care plan will be on mental health difficulties and associated problems. While this necessarily implies that many inputs in the care plan will be on a one-to-one basis, families may also wish to participate in the more general family support services that are open to all residents on the estate. As with other aspects of the care plan, it is the family's needs that are paramount, with the Family Resource Worker acting key worker, facilitator and enabler.

8.5. Set Up System to Prepare and Review Wellness Planing

The Family Resource Worker, in the role of key worker, needs to set up a system to record information about the family. This needs to be done in the knowledge that the family has a right, under the Freedom of Information Act (1997 and 2003), to access this information; to have it amended where it is deemed incomplete, incorrect or misleading; and to obtain reasons for any decisions made which affect them.

Given that information about a family is also private to that family, it essential that every reasonable measure is taken by Family Resource Workers, and by Respond! as an organisation, to ensure that the family's privacy is maintained by keeping information safe so that no one, apart from the Family Resource Worker (and/or clinical psychologist), has access to it, except with the written consent of the family. These considerations are a normal part of any system. In its role as landlord, Respond! is already in possession of confidential information about the income and rental payments of each resident

and secure systems are in place to protect the privacy of this information. The wellness planning system for the better being and mental health strategy also needs to have a similar level of security.

In practical terms, there are guidelines which Family Resource Workers should follow in recording any information about families. These include:

- Writing to typing notes in clear and unambiguous language;
- Focusing on recording facts;
- Record opinions only if necessary and labelling them as such;
- Recording as close as possible to the time when the meeting or event happened;
- Record in chronological order with accurate date and time entries.

9. Staff Competencies to Implement Better-Being and Mental Health Strategy

Three types of staff competency are necessary to implement the better being and mental health strategy in order to make sure that actions are effective in delivering outcomes. These competencies are: (i) knowledge; (ii) skills; and (iii) attitudes. The Respond! Family Resource Workers, who will implement the strategy, have these competencies but they are made explicit here to ensure a proper alignment between strategy and competency, and to raise awareness of the need for staff to continually reactivate and revitalise these competencies.

The knowledge required to implement the strategy includes knowledge about family and family well-being, community development, family support programmes, local services, and legal obligations. Given that Resident Support Workers will work in close collaboration with Family Resource Workers, this knowledge is required by both in order to ensure that they share the same background knowledge about what is important in the process of supporting families.

9.1. Knowledge of Family and Family Well-Being

Most of the knowledge required by staff to implement the strategy is already contained in this document, especially knowledge about families and family well-being. Additional information is provided in the appendices covering the main family support programmes in use and available in Ireland (Appendix One), the importance of fathers for child outcomes (Appendix Two), the factors that are normally associated with effective help (See Appendix Three), and Respond's child protection policy (Appendix Four).

9.2. Knowledge of Community Development

The better-being and mental health and strategy involves one-to-one work with parents and children and, as such, involves an individualised rather than a group or community approach. At the same time, community development is central to the Respond! way of working and to the delivery of its strategy of general support for all families. The key element in a community development approach is that residents are involved collectively in defining, analysing and responding to their needs. While the focus in the better being and mental health strategy is on the individual rather than the group, the principle still applies that it is the resident who decides what actions are taken to improve their situation. This, in turn, requires skill on the part of the Family Resource Worker to create and support the resident's sense of capacity to overcome their difficulties and to help them stay focused on solutions rather than problems. At the same time, as residents begin to overcome their difficulties, they may wish to become more involved in community activities on the estate.

9.3. Knowledge of Family Support Programmes

The strategy of general support for all families involves, where possible, delivering group-based programmes which are open to all residents on the estate. This is not the remit of the better-being and mental health strategy but it is nevertheless important that Family Resource Workers are aware of these programmes and facilitate participation in them as and when appropriate (See Appendix One for a list of these programmes).

9.4. Knowledge of Local Services

Knowledge of local services is essential in order that staff can assist families in accessing local services. In addition to knowledge of the different services, it is desirable that staff have the contact details for all key agency personnel and, where possible, to have made direct contact with them. Ideally, this information will be available within Respond! in electronic and hard-copy format, and updated regularly to facilitate easy hand-over from one staff member to another as the need arises. As indicated, the better being and mental health strategy is likely to identify some parents and / or children who may require a more specialised service in areas such as mental health, psychological assessment, child protection, addiction, domestic violence, etc. A Respond!-wide approach to making such referrals is required to ensure that referrals are only made after discussion and agreement by the staff team and, wherever possible, with the consent of the parent and / or child. Table 3 outlines a possible universal form for making Respond! referrals to external agencies.

Table 3: Referral From Respond! Housing Association

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

9.5. Knowledge of Legal Issues Affecting Families

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

The first concerns the protection of children. The key provision in the National Guidelines for the Protection and Welfare of Children is that the HSE and / or the Gardaí 'should always be informed when a person has reasonable grounds for concern that a child may have been abused, or is being abused, or is at risk of abuse'[93]. Respond! has incorporated this provision into its own child protection guidelines (See Appendix Four). It is worth noting that, under The Protection of Persons Reporting Child Abuse Act, 1998, the law provides immunity from civil liability to persons who report child abuse, provided it is done 'reasonably and in good faith'.

93 Department of Health and Children, 1999:37.

The second area concerns laws protecting the personal rights of each individual to privacy – notably the Data Protection Acts (1988 and 2003) and the Freedom of Information Acts (1997 and 2003) - since these rights are acknowledged in the Constitution[94] and in international law[95]. As a consequence, a resident can request to see any information held about him / her by Respond!; to have it amended where it is deemed incomplete, incorrect or misleading; and to obtain reasons for any decisions made which affects him/her. This implies that particular care is needed in how staff record, share and store information. It also implies that information about a resident is shared only on 'need to know' basis[96].

The third area is acting at all times with the consent of the family. Consent is a fundamental aspect of each person's right to self-autonomy and deciding what happens to them. It is regarded as a basic rule of common law and an absolute right which is enshrined in the Irish Constitution, and in Irish and international law. In healthcare, for example, the practice is that consent must be obtained for a medical examination, treatment or investigation[97]. This applies equally to interventions to address mental health or other difficulties encountered by a person. The form of the consent – whether written or implied – is somewhat less important than the process by which informed consent is given and requires a genuine process of communication where the person is able to decide, on an informed and continuing basis, what they would like to happen to them. In the case of children, informed consent of their parents is necessary; in rarer cases of severe mental illness, the right to act without consent can only be exercised, under the Mental Health Act 2001, 'where the consultant psychiatrist considers that the treatment is necessary to safeguard your life, to restore your health, to alleviate your condition or to relieve your suffering, and you are incapable of giving such consent because of your mental disorder'[98].

The fourth area concerns family law. While family law is itself quite complex, it is

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

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

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

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

98 www.citizensinformation.ie

important to be aware that the recent passing of the Civil Partnership Act 2010[99] adds a new dimension to family law by granting legal recognition to cohabiting couples. This Act has implications for Respond! tenants since cohabiting couples who constitute a legal civil partnership - by living together in an intimate relationship for five years, or two years where there is a child or children of the relationship – are entitled to a joint tenancy agreement. A key provision of the Act is a redress system which allows a financially dependent cohabitant to apply to court for certain remedies, including maintenance, property, pension adjustment orders, or provision from the estate of a deceased cohabitant.

9.6. Skills and Attitudes

The core skills required of Family Resource Workers in order to implement the better being and mental health strategy include the ability to: (i) develop one-to-one relationships with each family member; (ii) assess the needs of each family member with them; (iii) draw up a wellness plan to reflect the outcomes that family members want to achieve; (iv) match needs to services; (v) manage the case with care and respect for the rights of each family member; (vi) work effectively with other staff in Respond! and; (vii) working effectively with other agencies. Table 4 summarises the set of attitudes corresponding to each of these skills.

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

Table 4: Skills and Attitudes Required to Develop and Implement Local Strategy

Skills	Associated Attitude and Disposition
Develop one-to-one relationships with each family member	➢ Listen attentively and empathically ➢ Be warm, positive and encouraging ➢ Trust the person's capacity to overcome difficulties so that they learn to trust their own capacity ➢ Show a willingness to act as an advocate
Assess the needs of each family member as required	➢ Be non-judgemental by seeing problems as natural and normal so that the person will feel less judgemental about their difficulties ➢ Work to support the person express his/her needs ➢ Use the expression of needs to encourage reflection, as appropriate, on how the person defines and relates to their difficulties
Draw up a wellness plan to reflect the outcomes that family members want to achieve	➢ Encourage the person to 'own' the wellness plan as their blueprint for a better future ➢ Model a positive can-do attitude and create hopefulness ➢ Keep the plan practical and realistic so that achievements are possible ➢ Find meaningful examples to show progress is possible ➢ Respect the boundary that a person may not wish to change, or change little ➢ Recognise that failure to plan is planning to fail ➢ Act as an advocate for the person to make sure the wellness plan is implemented
Match needs to services	➢ Be creative and knowledgeable about the options that are available ➢ Support the person to access services but also encourage them to take responsibility ➢ Build relationships with professionals in other services so that they cooperate with the wellness plan ➢ Value learning, especially from mistakes as when actions are not working effectively
Manage the referral with care and respect for the rights of each family member	➢ Treat each family member with the same care and respect that you would like to receive ➢ Be aware of the family's right to privacy and to receive help only if they consent to it
Working effectively with other staff in Respond! to develop and implement the strategy.	➢ Develop healthy relationships with other staff ➢ Listen mindfully ➢ Reinforce the positive ➢ Enjoy team-work
Working effectively with outside agencies to develop and implement the strategy	➢ Build relationships of trust ➢ Identify 'win-win' situations ➢ Persevere in face of disappointment

10. Training Requirements For Better-Being & Mental Health Strategy

Training is required to ensure that staff have the knowledge, skills and attitudes to deliver the strategy confidently and effectively. By its nature, this training must provide staff with a clear conceptual understanding of the rationale for the strategy and the set of skills and attitudes to work with parents and children in a way that builds trust and strengthens their natural capacity to overcome difficulties and live life to the full.

The minimum basic requirement is that training should cover the topics listed in Table 5. This training would combine the presentation of material, discussion and sharing of experience and expertise, as well as experiential exercises such as role playing. In addition, staff would receive a resource pack of all materials presented and encouraged to read it.

Table 5: Staff Training Required to Implement Strategy

Knowledge
➢ What is a family?
➢ Why are families important?
➢ What influences family well-being?
➢ What are the different types of family support?
➢ What is the essence of a helping relationship?
➢ What is a community development approach to helping families?
➢ What are the needs of families in Respond! estates?
➢ What outcomes will the strategy seek achieve?
➢ What actions will produce these outcomes?
➢ How will the strategy link with other services both inside and outside Respond!?
➢ How to monitor and evaluate if the strategy is achieving its outcomes?
➢ What are some of the legal issues involved in supporting families?
Skills
➢ How to build relationships with families
➢ How to assess mental health needs
➢ How to match needs to services
➢ How to prepare a wellness plan
➢ How to work effectively with other Respond! staff to develop and implement strategy
➢ How to work with external agencies to develop and implement strategy
Attitudes
➢ Clear awareness of self, and one's patterns of thought, feeling and relating
➢ Empathic understanding of how others, especially families, see themselves and the world
➢ Recognising the deep equality of all while respecting diversity and boundaries
➢ Acting in a way that is positive, practical, pragmatic and for the best outcome for families
➢ Commitment to ensure that process leads to action and outcome
➢ Openness to collaborative working within Respond! and with outside agencies
➢ Taking responsibility for learning through reflective practice and constructive criticism

11. Supervision and Support for Better-Being and Mental Health Strategy

The underlying rationale for the strategy is that close personal relationships, particularly in the family, are central to the well-being of parents and children. For the same reason, it is also important that staff who deliver the strategy have supportive relationships at work in the form of structured supervision and guidance. In other words, supervision is not only about staff accountability, but involves a commitment to nurture and guide staff so that they have the tools to engage successfully with families. As such, supervision is not an alternative to Respond's human resource policies; it is a particular form of support necessitated by the requirements of supporting families. Supervision requires an openness to reflective practice, both individually and as part of a group, and an openness to accept honest and constructive criticism. In the same vein, it implies a healthy relationship to one's weaknesses as well as one's strengths, and a recognition that this relationship directly influences how one relates to others, including families in Respond's estates[100].

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

Typically, supervision provides an opportunity for staff to reflect, with their supervisor, on questions like those listed in Table 6. Through this process, staff are facilitated to grow, just as, through the strategy, they facilitate families to grow.

100 The similarity between how one relates to oneself and how one relates to others is based on the understanding in developmental psychology that a person's sense of self and others derives from the primal relationship between the child and the primary care-giver, usually the mother. As a result of this primal relationship, 'the infant develops expectations of the caregiver's behaviour and complementary beliefs about himself or herself. For example, an infant who has experienced a history of contingent responsiveness from a primary caregiver will develop a model of that caregiver as available, and expect such behaviour. That child will also develop a complementary sense of self that he or she is worthy of responsive care. … More generally, these internalised working models are seen as providing a framework for future interaction, resulting in a repetition of the early attachment relationship' (Bronfrenbrenner and Morris, 2006:816). The three main types of attachment are: secure attachment, insecure-avoidant attachment, and insecure-anxious attachment (Bowlby, 1979; Ainsworth, 1991). A secure style is where others are regarded as reliable and available and is associated with a warm, positive and reassuring style of interaction. An insecure-avoidant style is where others are regarded as uninterested or unavailable and is associated with an interaction style that is cold, competitive and controlled. An insecure-anxious style is where others are seen as unreliable or difficult and leads to an interaction style characterised by anxiety, stress and lack of confidence. These core concepts are widely used to explain different patterns of interaction among adults but are also used to help those who work in the caring professions (doctors, nurses, social workers, family workers, etc) to become more aware of their interaction style and how it relates to their experiences of attachment (see for example Janssen, Macleod and Walker, 2008).

Table 6: Questions for Staff to Explore in Supervision

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

Supervision can be one-to-one or in groups and the strategy includes both options. The supervisor requires substantial professional experience in working with families, either as a clinical psychologist or social worker. One-to-one sessions will be provided to each staff. In each region, group sessions will also be held since this will provide greater variety in range of experience available for reflection and learning.

12. Risk Management of Better Being Strategy and Mental Health Strategy

The objective and outcomes of this strategy are realistic and achievable provided that the risks are properly managed. Table *7* identifies the risks, the likely impact if the risk happens, the probability of the risk happening, and the actions taken to mitigate the risk. Risk is dynamic rather than static and, for that reason, the register of risks in Table *7*, should be updated on a regular basis as the strategy unfolds.

Table 7: Register of Risks to Strategy

Name of Risk	Impact if risk happens	Probability of risk happening	Actions taken to mitigate risk
Staff not properly trained	Low Medium ✓ High	✓ Low Medium High	Staff training programme
Staff not properly supervised	Low Medium ✓ High	✓ Low Medium High	Supervision will be available for all staff involved in the strategy
Residents do not engage	Low ✓ Medium High	✓ Low Medium High	(i) Staff training & supervision. (ii) Publicity campaign to promote strategy
Resources not available for programmed actions	Low ✓ Medium High	✓ Low Medium High	Budget has been ear-marked for programmed actions
External agencies may not engage	Low ✓ Medium High	✓ Low Medium High	The strategy is not heavily dependent on external agencies
Confidential family information disclosed	Low Medium ✓ High	Low ✓ Medium High	(i) Staff aware of need for confidentiality (ii) Measures for storage of confidential information

13. Monitoring & Evaluating Mental Health and Better-Being Strategy

Monitoring and evaluation are important in order to know if this strategy, in combination with the general family support strategy, is making a difference to the well-being of parents and children in Respond! estates. Subject to available resources, the strategy will be evaluated by doing a follow-up of the 2008 study using the same measurement instruments and based on a sample of residents in a sample of estates[101]. This is an appropriate method because the strategy is implemented in all of Respond's family estates and the comparison of two representative samples – one at baseline in 2007 the other at follow-up in 2014 (for example), would allow reasonable inferences to be made about the impact of both strategies combined while taking into account any changes in the composition of those estates. While this approach falls short of a randomised

101 McKeown, Haase, Pratschke, Lanigan, Burke, Murphy, and Allen, 2008.

control trial[102], it would nevertheless provide an indication of impact in the domains measured even if the causal role of the strategy in bringing about those impacts cannot be established beyond doubt. This approach would also be less invasive and less expensive than some of the alternatives.

In addition to this 'macro-level' monitoring, a 'micro-level' review of the strategy will also be undertaken in each estate. This will involve an annual review by staff of the families who received help over the course of the year; parents and, if appropriate, children will also be consulted. This will be done using the set of evaluation questions in Table 8. Revisions will be made to the strategy in light of this review.

Table 8: Evaluation Questions for Annual Review of Strategy

Question
➢ What evidence is available to show that progress has been made in achieving better outcomes for each family?
➢ Can this evidence be corroborated from more than one source?
➢ If the evidence suggests that little or no progress has been made in achieving better outcomes, what are the reasons for this?
➢ What changes are needed to improve the size and sustainability of outcomes?
➢ What are the most important lessons that have been learned from the strategy about how to support families in Respond! estates?

102 A randomised control trial (RCT), also called the experimental method, involves setting up two matched groups using an random process of selection and then offering the programme to one group (usually called the experimental group) while the other group is either placed on a waiting list or offered an alternative programme (usually called the control group). Since both groups are matched prior to the intervention, it is reasonable to infer that any differences which emerge at the end of the programme can be attributed to the programme. RCTs are now regarded as the gold standard among researchers for measuring the efficacy of programmes because the process of randomly allocating subjects to either an experimental or control group ensures that both groups are as perfectly matched as possible. This is because random allocation is a way of controlling for all possible differences – both known and unknown – between the groups other than the fact that one (the experimental group) receives the programme and the other (the control group) does not. Comparing the two groups before and after the programme therefore is a reliable way of assessing if the programme has any effect on the outcomes measured, since this can be the only source of differences between the two groups. In other words, it is reasonable to infer that the programme is the cause of the observed differences between the two groups. It is for this reason that RCTs provide a level of certainty about the efficacy of an intervention which is not achievable through any other research design.

14. Timeframe for Implementating Mental Health & Better-Being Strategy

Table 9: Timeframe for Implementation of Strategy

Activity	Year 1	Year 2	Year 3
Undertake training	Mar-May	-	-
Agree on internal referral procedures within Respond!	Mar-Apr	-	-
Implement strategy	Apr-Dec		
Carry out annual review of strategy	Oct-Nov	Oct-Nov	Oct-Nov
Revise strategy in light of review	Dec	Dec	Dec

15. Cost of Mental Health and Better-Being Strategy

The strategy will be implemented on a pilot basis by employing three Family Resource Workers and one Clinical Psychologist. Provision is also made for commissioning 50 child assessments by an Educational Psychologist. The cost also includes an administrative overhead of 50% to cover other staff costs associated with the programme as well as training, supervision and travel.

Any strategy is only as good as its implementation process, follow-through supports, monitoring and evaluation.

This Respond! Strategy to Promote Better Being and Improved Mental Health for Families should be read in conjunction with the implementation strategy document prepared in-house by Respond!

The work affords an exciting opportunity to work with families and local communities in supporting people to enhance and strengthen their capacity to deal with challenges facing them, to enlarge their networks of support, and to access specialist services where required. The work goes to the core of human living and of building vibrant, supportive communities.

Appendix One:
Programmes for Parents & Children in Ireland

Programme	Community Mothers
Age of Child	0-2 years
Description	The Community Mothers Programme aims to support the development of parenting skills, and enhance parents' confidence and self-esteem. It is delivered by non-professional volunteer mothers, known as 'community mothers', who are recruited, trained and supported by Public Health Nurses. Community mothers are recruited to reflect the ethos of the community and visit parents once a month in their own homes, providing information in a non-directive way to foster parenting skills and parental self-esteem.
Contact Details	www.communitymothers.ie www.hse.ie Community Mothers Programme, 1st Floor, Park House, North Circular Road, Dublin 7. Ph: (01) 838 7122 E: brenda.molloy@mailf.hse.ie

Programme	Lifestart
Age of Child	0-5 years
Description	Lifestart is a programme for the parents of 0-5 year old children. The programme is a parent-directed learning programme on child development and comprises a structured month-by-month curriculum of knowledge, information and practical-learning activity for parents. Lifestart is delivered by trained family visitors in the parent's own home. Its rationale is that, by educating parents on how their children grow and learn, this helps parents to support their child's physical, intellectual, emotional and social development.
Contact Details	www.lifestartfoundation.org Lifestart National Office, Church Street, Sligo, Ireland. Ph: (071) 915 1114

Programme	Parents Plus
Age of Child	(i) 1-6 yrs (ii) 6-11 yrs (iii) 11-16 yrs
Description	Parents Plus was developed in Ireland by John Sharry at the Mater Child and Adolescent Mental Health Service. It consists of three age-related programmes. The focus is to build on parents' strengths and help them to solve discipline problems but also to have more enjoyable and satisfying relationships with their children. The programme includes educational DVD's, a leader's manual, and participant handouts. Homework for the participants is also included in the packs, as well as a text book and a parents' book.
Contact Details	www.parentsplus.ie Parents Plus, c/o Mater Child and Adolescent Mental Health Service, Mater Hospital, Dublin 7. Ph: 086 172 1902 admin@parentsplus.ie

Programme	Positive Parenting Programme (Triple P)
Age of Child	0-18 years
Description	Triple P is a parenting and family support strategy that aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. The programme consists of 7 weeks, the first 4 weeks are face-to-face sessions, next 2 weeks are support phone calls and the final week is certification. In Ireland, a significant number of practitioners – including Public Health Nurses, Family Support Workers, Childcare Leaders, Community Mother Volunteers, Community Development Workers and partner facilitators – have been trained and accredited to deliver Triple P to parents.
Contact Details	www.westcd.leaderpartnership.ie www.triplep.net (Practitioners) www.triplep-staypositive.net E: lwppathlone@eircom.net

Programme	Incredible Years
Age of Child	(i) 2-7 (ii) 5-12
Description	The programme aims is to improve parenting skills by using video clips, role playing and discussion. The Basic Parent training curriculum is delivered over 12-14 weeks with a two-hour session per week. There are also separate programmes for children and teachers. The programmes are being delivered in Ireland by Archways which was established in January 2007 to promote the rollout and evaluation of the Incredible Years programme in Ireland.
Contact Details	www.archways.ie Archways, Carmac House, Oakfield, Clondalkin, Dublin 22. Ph: (01) 457 6433 E: info@archways.ie

Programme	Strengthening Families
Age of Child	0-18 years
Description	This programme offers support and training to families and is used widely but not exclusively with families who have issues of drugs and alcohol abuse. The entire family must commit to a 14-week programme based around learning skills that will lead to responsible decision-making on issues such as drugs, alcohol and addressing conflict in the home.
Contact Details	www.srdtf.ie

Programme	Functional Family Therapy (FFT)
Age of Child	11-18 years
Description	FFT is an evidence based intervention developed in the US. Since September 2007, it is being piloted in Ireland by the Clondalkin Partnership. The programme works with the whole family for this therapy or as many family members as possible.
Contact Details	www.clondalkinpartnership.ie Clondalkin Partnership, Unit D, Nangor Road Business Park, New Nangor Road, Clondalkin, Dublin 22. Ph: (01) 450 8788 E: pjohnston@clondalkinpartnership.ie

Appendix Two:
Understanding the Role of Fathers in Families

It is appropriate to draw attention to the role of fathers in families, particularly in the light of the high proportion of families in Respond! estates (40%) where the father does not live in the same household as the child. A growing body of research suggests that fathers influence the well-being of families and their children in two ways. The first way is through the provision of income and other resources, the economic dimension. The second way is through relationships with the child and its mother, the relational dimension.

The economic dimension of fatherhood arises, in the first instance, from the fact that one-parent households – which are predominantly headed by mothers – have less earning capacity than two-parent households, other things being equal. This, in turn, is compounded by the fact that mothers in one-parent households also tend to have lower levels of education and earning potential compared to mothers in two parent households[103]. As a consequence, one-parent households compared to all other households have a higher 'risk of poverty' (36% compared to 14%)[104] and higher 'consistent poverty' (17% compared to 6%)[105]. This implies, other things being equal, that the absence of fathers contributes to the weak socio-economic position of one-parent households.

The fact that non-resident fathers in one-parent households have themselves lower levels of education and earning potential is also consistent with the fact that these men have poorer marriage prospects[106] while non-resident fathers who are poor are also more likely to lose contact with their children[107]. In this sense, it could be said that one-

103 Recent results from the Growing Up in Ireland study, based on a sample of 11,100 infants, found that 'Mothers in lone-parent families were more likely to be less well educated than those in two-parent families. Lone-parent mothers with two or more children were much more likely to have left school at Junior Certificate or below (54%). This contrasts, for example, with only 17% of mothers in larger two-parent families who had left education at this stage' (Williams, Greene, McNally, Murray and Quail, 2010:32).

104 A person or household is 'at risk of poverty' if their income is below the threshold, which has been set in line with international standards, of 60% of median equivalised disposable income. In 2009, the at risk of poverty threshold for an individual living in Ireland was €12,064 (Survey on Income and Living Conditions (SILC) 2009, 2010:19 and 35).

105 A person or household is in 'consistent poverty if they have an income which is below 60% of median equivalised disposable income and if they are unable to afford at least two out of eleven specified items (Survey on Income and Living Conditions (SILC) 2009, 2010:77-8).

106 In Ireland in 1991, for example, the proportion of single men aged 45-54 in the unskilled manual category was 2.5 times higher than the corresponding proportion of single men in the lower professional category; moreover this association between marriage prospects and economic prospects can be traced over many decades. A few years ago, a team of researchers at the ESRI made a similar point: "The Irish State's policies combine today to perpetuate and even exacerbate class inequalities in family formation and functioning. The life chance of marriage is now more strongly related to one's class of origin as are fertility differentials" (Breen, Hannan, Rottman and Whelan, 1990:121). Similarly in the US, low male earnings not only reduce the likelihood of marriage but also increase the likelihood of divorce (Levine and Pitt, 1995:37) while it has also been argued that the "inability to provide is the root cause of father absence for African American children (Morehouse Research Institute, 1999:12; Wilson, 1996). There is also research evidence which suggests that some women may prefer the prospect of lone parenthood than share child rearing with a young unemployed father (Wilson and Neckerman, 1986; Roberts, 1996). Faced with these circumstances, it is inevitable that young men in disadvantaged communities may face the double exclusion from the worlds of work and family life and are "an extremely excluded and ostracised group in Ireland today" (McKeown, 2001a; 2001b).

107 In a survey of 619 non-resident fathers in the UK in 1995, the authors found that "contact is much more regular if the father is in employment" (Bradshaw, Stimson, Skinner and Williams, 1999a:98).

parent households and their associated poverty levels are a reflection of how the socio-economic system shapes family life. Moreover, as dual earning becomes the norm in two parent families, the relative position of all one earner and no earner families is bound to deteriorate. In these circumstances, the relative risk of poverty in one-parent families is likely to continue to rise.

The implication of this is that the economic situation of households without fathers is likely to deteriorate as dual earning becomes the norm[108] and this, in turn, could have a deleterious effect on the well-being of children. This conclusion is consistent with other studies which suggest that "the contribution of resources, both economic and psychological, from fathers may be the key contributing factor in the educational achievement of young adults"[109]. These considerations draw attention to the importance of the 'provider role' within families – whether performed by fathers, mothers or both – while also highlighting the complementary role of the State in promoting the well-being of families through income transfers and services.

Turning to the relational dimension of fatherhood, a substantial body of research has focused on the relationship between parents (the 'couple' relationship) and how this influences the well-being of children. The broad consensus of these studies is that children are adversely affected by conflict and instability in the relationship between parents. Indeed it is precisely because conflict as well as instability are usually key processes leading to the formation of many one-parent households that children in these households tend to do less well in behavioural and psychological terms than children in two parent households. That is a clear finding from a meta-analysis of 12 different US studies which found that "family structure is more important than poverty in determining behavioural and psychological problems"[110]. Numerous other studies have come up with the same result[111], including some Irish studies[112], leading to the conclusion that 'a child's experience of a loving relationship between its parents – and not just with its parents - may contribute more to its well-being than additional income or having a bedroom of its own'[113].

Instability in the relationship between parents, even in the absence of conflict, has also been shown to have detrimental effects on children. For example, a 20-year US longitudinal study found that "for offspring from low conflict homes, parental divorce was devastating" in terms of psychological distress, support networks and marital

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

109 Furstenberg, 1990:155.

110 McLanahan, 1997.

111 Amato, 1993; Amato and Keith, 1991; Amato, Loomis and Booth, 1995; Cooksey, 1997; Downey, 1994; Goodman, Emery and Haugaard, 1998; Hetherington and Stanley-Hagan, 1997; Hines, 1997; McLanahan and Sandefur, 1994; McLanahan and Teitler, 1999; Najman, Behrens, Andersen, Bor, O'Callaghan, and Williams, 1997; Seltzer, 1994; Thomson, Hanson and McLanahan, 1994

112 Flanagan, 2001; O'Donohoe, 2001.

113 McKeown and Sweeney, 2001:52.

happiness[114]. Moreover, 70% of the divorces in this study involved minor rather than severe marital conflict and this indicates the powerful inter-generational impact of instability on the well-being of children. The author observed: "The most discouraging thing about these findings is the evidence of inter-generational effects. The marriages of children of divorce whose parents did not fight are of lower quality than they would be if their parents had not dissolved their marriage. Not only does this mean that the children of such parents are more likely to divorce themselves, but that their children are apt to experience the same adverse consequences of divorce as their parents. Unless the divorce rate declines, we can expect the same high levels of personal disorganisation in generations to come"[115].

These results, representing the distilled consensus of different studies in different countries, show just how difficult it is to try to separate the influence of fathers from both the economic system and the family system. That is why most of the studies which have tried to estimate the causal influence of one-parent households on child outcomes have found that, when all other considerations have been taken into account, 'the maximum effect of growing up in a single-parent family on children's well-being is small'.[116] At the same time, these studies also show that fathers are important to the well-being of children. For example, the adverse consequences of separation and divorce on children, particularly in low conflict situations, cannot be unrelated to the absence of fathers in the lives of those children. Similarly the benign effects of stable two parent families must also reflect the benign effects which fathers, no less than mothers, have on the well-being of children. One review summarised the implications of this research as follows: "In sum, research suggests that if we are concerned about optimising children's health and development, we should be promoting and supporting both two-parent family structure plus ways to involve fathers in their children's lives – whatever the family form"[117].

A noteworthy feature of these studies is the way in which parent-parent relationships emerge as central to the well-being of children[118] essentially because this relationship, according to one leading team of US researchers, "is bound up with virtually every dimension of offspring well-being"[119]. This view is echoed by another researcher who suggests that involved fathering promotes positive child development in the following way: "the benefits obtained by children with highly involved fathers are largely

114 Booth, 1999:40.

115 ibid:41.

116 OECD, 2009:4. This study found that: 'The highest maximum negative effects are found in Nordic countries, similar in size to effects shown in previous United States research. In most other OECD countries, the single-parent effect is slightly smaller on average than in the United States. A review of techniques for identifying whether observed small effects are in fact the result of cause-and-effect from single parenthood to child well-being delivers a mixed picture. The more sophisticated methodologies typically give a lower or no effect on child outcomes of being brought up by a single parent.' (Ibid).

117 Levine and Pitt, 1995, p.25.

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

119 Amato and Booth, 1997:221.

attributable to the fact that high levels of paternal involvement created family contexts in which parents felt good about their marriages and the child care arrangements they had been able to work out"[120]. This suggests that services to promote the well-being of children need to focus not just on parent-child but on parent-parent relationships as well.

Finally, it is useful to consider how to involve men and fathers can be involved in the family support strategy. The practicalities of making family services more inclusive of fathers is recognised to be a major challenge and research on best practice in this area suggests that two key stages are involved[121]. 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.

A useful checklist by which a service can audit its accessibility to men and fathers is contained in Table A2. This audit is a valuable exercise for all services but particularly those involved in family support services.

120 Lamb, 1997.

121 See Levine, Murphy, and Wilson, 1998; Levine and Pitt, 1995; Burgess and Ruxton, 1996.

Table A2: 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 or patients in clinics, groups or education sessions you facilitate?
✓	Are men actively and continually encouraged to participate?
✓	Staff attitudes
✓	Do you relate differently to men and women clients / patients?
✓	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?

Source: Robertson and Williams, 1998:288.

Appendix Three:
Understanding the Helping Process

Respond's work, in all its manifestations, is about helping people to live life to the full. Helping is a natural part of life and something that arises spontaneously because people help, and are helped, all the time through family, friends, and communities. Everyone is a natural helper and people seek professional only when all other sources have been exhausted: 'Throughout human history, individuals with social and emotional difficulties have benefited from talking with a sympathetic 'other' perceived as being able to offer words of comfort and sound counsel either because of recognised inherently helpful personal qualities, or by virtue of his or her role in the community. … However, even in today's world, the vast majority of individuals who are experiencing psychological distress do not seek help from trained and credentialed professional counsellors and therapists: they obtain relief by talking to individuals untrained in counselling or psychotherapy" [122].

By definition, the help offered by Respond! to its tenants is 'professional help' in the sense that it is not part of the tenant's informal sources of help from family, friends and other supports. For that reason, it is appropriate to review what determines the effectiveness of professional help. This issue has been studied extensively in the case of counselling and psychotherapy. A number of consistent findings are now well-established[123], and their implications are likely to extend to most other domains of professional help.

The first finding is that therapy works in more than seven out of ten cases. This is impressive since it is "considerably larger than one typically finds in medical, surgical and pharmaceutical trials"[124].

The second finding is that there is no significant difference between the effectiveness of different therapies[125]. Given that over 250 different therapeutic models have been identified[126] it is remarkable that all are relatively equal in their effectiveness. As one commentator has observed: "No psychotherapy is superior to any other, although all are superior to no treatment. … This is the conclusion drawn by authoritative reviews … and well controlled outcome studies. … This is really quite remarkable, given the claims of unique therapeutic properties made by advocates of the various treatments available today"[127].

The third finding, linked to the previous, is that all therapies have something in common which make them similarly effective. These common factors are principally

122 McLennan, 1999, p.169.

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

124 Shadish, Ragsdale, Glaser and Montgomery, 1995:347.

125 Asay and Lambert, 1999.

126 Miller, Duncan and Hubble, 1997:1.

127 Weinberg, 1995:45.

the characteristics of the client and the client-therapist relationship[128]. Beginning with the client, it has been observed that: 'It is the client more than the therapist who implements the change process. … Rather than argue over whether or not 'therapy works', we should address ourselves to the question of whether or not 'the client works!' … As therapists have depended more upon client's resources, more change seems to occur"[129]. This insight has led therapists to a focus on the strengths, resources and resilience which people use to cope with, and overcome problems. At the same time, this approach does not minimise problems since, as the research shows, many vulnerable people and families often need sustained support over a considerable period of time in order to bring about the changes they want.

Turning to the therapeutic relationship, this is seen by many commentators as 'the sine qua non of successful therapy'[130]. It has been suggested that many of the qualities of effective therapist-client relationships – emotionally warm, available, attentive, responsive, sensitive, attuned, consistent and interested - are in fact generic to many relationships both in work and family: "it seems no coincidence that so many of the elements of the effective therapist-client relationship appear similar to the 'good enough' parent-child relationship"[131]. Although Freud (1966) wrote about the importance of the therapeutic relationship, especially the role of transference and counter-transference, it was the work of Carl Rogers who emphasised the need to show clients – and be experienced by clients as showing – unconditional positive regard, accurate empathic understanding, and openness to creative solutions[132]. One review of the literature, based on the findings of over 1,000 studies, recommended three ways for improving outcome effectiveness through the therapeutic relationship:

(1) treatment should accommodate the client's motivational level and state of readiness for change;
(2) treatment should accommodate the client's goals for therapy; and
(3) treatment should accommodate the client's view of the therapeutic relationship[133].

These considerations are designed to draw attention to the ordinary, natural and practical ways in which helping occurs. Professional help builds on these qualities, often specialising in particular areas of difficulty, but this supplements rather than

128 The other two factors are therapeutic technique and client hopefulness, each of which are estimated to contribute about 15% to outcomes (see McKeown, 2000:Chapter Three). Therapeutic technique seems to work best when, through sensitive and intelligent questioning, it helps the client to gain insight about their situation while simultaneously helping to restore their problem-solving abilities (Miller, Duncan and Hubble, 1997, Chapter Seven; Ogles, Anderson and Lunnen, 1999). By contrast, hopefulness seems to operate more as a 'placebo effect' in the sense that many interventions – therapeutic, medical, even religious – are known to have a beneficial effect simply by virtue of the client's belief that they are effective. In other words, these 'rituals' – such as the ritual of going for help – have the effect of restoring hope in the possibility of improvement which, in turn, has the effect of "mobilising their intrinsic energy, creativity and self-healing potential. Personal agency is awakened by technique" (Tallman and Bohart, 1999, p.100). Conversely, hopelessness is when people feel they can do nothing to improve their situation or when they feel there is no alternative; in other words, they are unable to pursue their goals because their generative capacity for "agency" and "pathfinding" has been lost (Synder, Michael and Cheavens, 1999, pp.180-181).

129 Bergin and Garfield, 1994:825-826.

130 Sprenkle, Blow and Dickey, 1999:334.

131 Howe, 1999:99.

132 Rogers, 1957.

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

replaces the natural helping process. This perspective is important in the context of Respond's commitment to supporting families because it invites a balanced approach which acknowledges the natural capacity of staff to observe if families are experiencing difficulties and to be supporting in seeking help for them, while also recognising their limitations due to lack of expertise and experience in how to address specific difficulties. This is a delicate balance and is itself cultivated through practice and reflection, including dialogue and support from managers and colleagues.

Appendix Four:
Respond's Child Protection Policy

SUMMARY AND WITHOUT APPENDICES

1. Introduction

Respond! Housing Association is committed to promoting the highest standards of child protection in line with 'Children First – National Guidelines for the Protection and Welfare of Children' (2011). Respond! is committed to implementing this policy within the organisation and to promoting it on all of our family estates. We believe that children and young people have a right to be brought up in a supportive and safe environment. We strive to provide such an environment within the organisation and promote it on our estates where the safety of children and young persons is paramount.

All staff and volunteers are expected to implement this policy at all times; failure to do so will be seen as a breach under the organisation's disciplinary procedures. Staff are also informed that they have the right to report concerns directly to the appropriate authorities and are protected from civil liability under the 'Protection of Persons Reporting Child Abuse Act 1998' provided they do so 'reasonably and in good faith'.

Respond! adheres to the recommendations of the 'Children First; National Guidelines for the Protection and Welfare of Children' published by the Department of Children and Youth Affairs (2011).

This policy was put in place in January 2012 and will be next reviewed in 2013.

Staff Name (Block Capitals) _____

Signed by _____
(Designated Person / National Co-ordinator)

Date: _____

2. Why have a Child Protection Policy?

Respond! is committed to 'Building Communities' in its 130 estates around the country. This includes promoting our estates as positive and safe environments for children and young people on the estate. The Respond! Child Protection policy sets out an approach to be followed within the organisation, including our Childcare Centres and promoted within our estates.

This policy is developed in line with the Department of Children and Youth Affairs 'Children First - National Guidance for the Protection and Welfare of Children (2011)' which states that:

'Consistent with the principles of Children First, every organisation, both public and private, that is providing services for children or that is in regular contact with children should;

(i) Ensure best practice in the recruitment of staff or volunteers, which includes Garda vetting, taking up references, good HR practices in interviewing, induction training, probation and on-going supervision and management;

(ii) Ensure that staff members or volunteers are aware of how to recognise signs of child abuse or neglect;

(iii) Develop guidance and procedures for staff and/or volunteers who may have reasonable grounds for concern about the safety and welfare of children involved with the organisation. ***These procedures should not deviate from the current Children First; National Guidance, but may offer further elaboration to ensure local relevance and applicability;***

(iv) Identify a designated person to act as a liaison with outside agencies and a resource person to any staff member or volunteer who has child protection concerns. The designated person is responsible for reporting allegations or suspicions of child abuse to the HSE Children and Family Services to an Garda Síochaána.

Furthermore, the criminal charge of 'reckless endangerment' was introduced by the Criminal Justice Act 2009 (section 176). This states that:

'A person having authority or control over a child or abuser, who intentionally or recklessly endangers a child by:

(a) causing or permitting any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse or

(b) failing to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation, is guilty of an offence.'

Any allegation or concern regarding abuse of a child must be taken seriously. For that reason it is essential for anyone with a concern to strictly follow the procedures outlined in this document. Particular care should be taken in regard to confidentiality and the sharing of information. The right of children to respect and protection from harm is paramount. At no time should children be put at further risk of harm by delay or inaction.

3. Objectives of the Policy

- ✓ To set out clear consistent guidelines for staff and volunteers within Respond in dealing with alleged or suspected incidents of child abuse or welfare concerns.
- ✓ To create awareness among staff and volunteers of the issues of child protection and abuse.
- ✓ To have a clear consistent system throughout Respond! regarding the identification and response to allegations or suspicions concerning the safety and welfare of children and young persons on Respond! estates.
- ✓ To ensure clear guidelines on staff and volunteer behaviour that protects children, staff and volunteers.
- ✓ Encourage all Respond! family estates to promote child protection and welfare within the estates.

4. To whom does the Policy apply?

The Policy applies in the first instance to all staff and volunteers within Respond! who are obliged to follow the guidelines and procedures set out here. The policy is also to be promoted within all Respond! Family Estates and Community Buildings.

5. What might be a cause for concern?

'Children First' states that child neglect or abuse can often be difficult to identify and may present in many forms. Appendix I (from 'Children First') lists possible indicators for each of these types of abuse. No one indicator should be seen as conclusive in itself or abuse. It may indicate conditions other than child abuse. All signs and symptoms must be examined in the context of the child's situation and family circumstances.

The following guidelines for recognition are taken from 'Children First; National Guidance for the Protection and Welfare of Children' (2011).

The ability to recognise child abuse can depend on a perons willingness to accept the possibility of its existence as it does on their knowledge and information. There are commonly three stages in the identification of child neglect or abuse:

(i) considering the possibility
(ii) looking out for signs of neglect or abuse
(iii) recording of information

5.1. Stage 1: Considering the possibility

The possibility of child abuse should be considered if a child appears to have suffered a serious injury for which no reasonable explanation can be offered. It should also be considered if the child seems distressed without obvious reason or displays persistent or new behavioural problems. The possibility of child abuse should also be considered if the child displays unusual or fearful responses to parents/carers or older children. A pattern of ongoing neglect should also be considered even where there are short periods of improvement.

5.2. Stage 2: Looking our for signs of neglect or abuse

Signs of neglect or abuse can be physical, behavioural or developmental. They can exist in the relationships between children and parents/carers or between children and other family members/other persons. A cluster or pattern of signs is more likely to be indicative of neglect or abuse. Children who are being abused may hint that they are being harmed and sometimes make direct disclosures. Disclosures should always be taken very seriously and should be acted upon, for example, by informing the HSE Children and Family Services. The child should not be interviewed in detail about the alleged abuse without first consulting with the HSE Children and Family Services. This may be more appropriately carried out by a social worker or An Garda Síochána. Less obvious signs could be gently explored with the child, without direct questioning. Play situations, such as drawing or story-telling, may reveal information.

Some signs are more indicative of abuse than others. These include:

(i) disclosure of abuse by a child or young person;
(ii) age-inappropriate or abnormal sexual play or knowledge;
(iii) specific injuries or patterns of injuries;
(iv) absconding from home or a care situation;
(v) attempted suicide;
(vi) underage pregnancy or sexually transmitted disease;
(vii) signs in one or more categories at the same time. For example, signs of developmental delay, physical injury and behavioural signs may together indicate a pattern of abuse.

Many signs of abuse are non-specific and must be considered in the child's social and family context. It is important to be open to alternative explanations for physical or behavioural signs of abuse.

5.3. Stage 3: Recording of information

If neglect or abuse is suspected and acted upon, for example, by informing the HSE Children and Family Services, it is important to establish the grounds for concern by obtaining as much information as possible. Observations should be accurately recorded and should include dates, times, names, locations, context and any other information that may be relevant. Care should be taken as to how such information is stored and to whom it is made available.

5.4. Children with additional vulnerabilities

Certain children are more vulnerable to abuse than others. Such children include those with disabilities, children who are homeless and those who, for one reason or another, are separated from their parents or other family members and who depend on others for their care and protection. The same categories of abuse – neglect, emotional abuse, physical abuse and sexual abuse – are applicable, but make take a slightly different form. For example, abuse may take the form of deprivation of basic rights, harsh disciplinary regimes or the inappropriate use of medications or physical restraints.

6. What Procedure should you follow if you observe, suspect or are made aware of an allegation of child neglect or physical, emotional or sexual abuse?

Staff and volunteers are expected to note/report any signs of possible neglect, physical, emotional or sexual abuse. However, detailed explanations should not be sought as to do so, may place the child/young person at further risk or may jeopardise an investigation. According to 'Children First'; 'Everyone must be alert to the possibility that children with whom they are in contact may be suffering from abuse or neglect. This responsibility is particularly relevant for professionals such as teachers, child care workers, health professionals and those working with adults with serious parenting difficulties. It is also an important responsibility for staff and people involved in sports clubs, community activities, youth clubs, religious/faith sector and other organisations catering for children.

The HSE Children and Family Service should always be informed when a person has reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected. Child protection concerns should be supported by evidence that indicates the possibility of abuse or neglect.'

Note that the most common cause of concern relates to **neglect** of children.

All staff should record the following information in relation to any concerns regarding the welfare of children and young people. All incidents should be recorded and dated and reported to the Designated or Deputy Designated Person. Note that in passing on a concern, you are not alleging abuse.

- Suspicions
- Concerns
- Worrying observations
- Behavioural changes
- Allegations

7. Steps to be followed by Staff and/or Volunteers in reporting a concern regarding Child Welfare:

- You need to be aware of who the Designated Person (and Deputy Designated person) is in your region.
- Inform the Designated Person (or deputy) as soon as possible of your concerns. Do this immediately in the case of immediate danger to a child (see below) and within two working days in other cases. (Note: in Childcare Centres it may be appropriate, in the interest of Child Protection, to also inform the relevant Childcare Leader.)
- The Designated Person should record the incident in an internal 'Incident Form'.
- When the staff person and/or the Designated Person feels reasonable grounds for concern exist a formal report on the allegation/suspicion should be made to the HSE using the standard form. (See earlier section 'What might be a cause for concern'). This report may be completed by the individual staff/volunteer or

by the Designated Person. In reaching this decision, the Designated Person may engage in informal, confidential discussions with relevant HSE personnel.

- The parent/guardian should be informed regarding a formal referral being made to the HSE/Gardaí, unless this is likely to further endanger the child.
- The Designated Person will inform, in writing, the staff member who reported the incident of what action has been taken. Note: under the 'Protection for Persons Reporting Child Abuse Act 1998' a staff member is entitled to report a concern directly to the HSE should they feel that insufficient action is being taken. They are also protected from penalisation by their employer for so doing.
- Should you consider a child's safety to be at immediate risk contact the Designated Person (or Deputy) immediately. If the Designated Person (or Deputy) is unavailable contact the HSE and/or Garda Siochána immediately. A child should not be left in a dangerous situation. This can mean staying with the child until the HSE or Gardaí arrive (note: it is not appropriate to bring a child to another location).
- If a child or young person makes a disclosure of abuse directly to you, please refer to the following section.
- In the interest of confidentiality staff are not to discuss allegations/suspicions with others outside of this process, other than on a 'need-to-know' basis for the purposes of Child Protection.

8. Procedures to be followed by Staff in Respond! Childcare Centres:

Each Respond! Childcare Centre has its own Designated and Deputy Designated Liaison Person, with their own procedures specific to Childcare Centres – including that at least one of the Designated or Deputy Designated Liaison Persons must be on site at all times. These personnel will also follow the procedures set out in this document. In addition they will inform the Respond! Regional Designated Liaison Person of any concerns and copy them on any referrals made to the HSE.

9. Dealing with Disclosures of Abuse

A disclosure is when a child informs an adult directly of their experience of abuse. The handling of a disclosure is an extremely delicate and sensitive issue. It is important to realise that the child/young person is likely to be under severe emotional stress and is depending on an adult for help. Great care must be taken not to damage that trust.

In an event of disclosure:

- Stay calm; do not panic.
- Listen- do not ask leading questions or ask the child to repeat what they are saying unnecessarily. Your role is to support the child – not investigate the incident.
- Accept- believe what they are saying and tell them so.
- Reassure- emphasise that they are not at fault.
- Stay in control- initial response is crucial.
- Be honest about what will happen next- don't make unrealistic promises.
- Record the disclosure in writing as carefully as possible and as soon as possible (within 24 hours and using the language of the child).

- Notify the local designated person immediately.
- Information sharing should be in accordance with Respond's confidentiality policy and only on a need to know basis as required to safeguard the children in question.
- Where appropriate, parents/guardians should be informed and involved in the process.
- Probing questions or explanations should not be sought- they may place the child/young person at further risk and may jeopardise any subsequent investigation.

10. Allegations against Staff and Volunteers

Where allegations are made against staff or volunteers, Respond! has a dual duty of care to the child and to the staff/volunteer. Therefore two parallel procedures are needed. The allegation of abuse will be overseen by the Designated Person. The employment/contractual issues will be managed by the Regional Manager. Both the Designated Person and the Regional Manager will co-operate closely with each other and with the statutory authorities, keeping the welfare of children paramount.

The following steps will be taken:

- The person to whom the complaint is made should hear the complainant in a respectful and confidential manner. The complainant should be informed of Respond's mandatory policy in relation to reporting child protection concerns. Wherever possible, the complainant should be immediately referred to the Designated (or Deputy) Person. If this is not possible, the person hearing the complaint must alert the Designated Person (or Deputy) at the earliest opportunity (not more than one working day). The Designated Person (or Deputy) will inform the Line Manager of the person against whom the complaint has been made at the earliest opportunity. The Regional Manager also needs to be informed at the earliest opportunity.
- The person hearing the complaint/allegation should immediately record the nature, setting and content of the complaint. Recording should be factual and completed on the day the complaint is heard.
- Where possible the person making the complaint should be encouraged to make a written complaint.
- The Human Resources Department will arrange support mechanisms to be put in place for staff against whom the allegation has been made.
- The Designated Person (or Deputy) will consult with the HSE and Garda Siochána on the follow-up of an allegation of abuse against an employee and consider and agree a plan, which recognises and responds to the needs and rights of the alleged victims of abuse and their families. The initial consultation will take place by telephone followed by a face-to-face meeting within 48 hours.
- Unless advised to do otherwise by the Gardaí, the HR Department should advise the employee that an allegation has been made against him/her, and the nature of the allegation. The employee will be afforded an opportunity to respond. The HR Department will note the response and pass this information to the Designated Person who will include this information if a formal report is being made to the

HSE. The employee should be informed of this unless advised to do otherwise by the Gardaí.

- The Designated Person (or Deputy) and the HR Department will assess the level of risk to any children with whom the employee is in contact.
- Where it is decided that protective measures are necessary to ensure that no child is exposed to unnecessary risk the Chief Executive Officer can decide to place the member of staff on administrative leave. Where appropriate the CEO can also reassign the staff person in question to alternative work areas – always ensuring protection is paramount. The HR Manager will be notified and will ensure that employment legislation issues are fully complied with.
- All meetings and discussions in relation to the allegation should be recorded with the decisions reached and the reasons why clearly noted.
- Care must be taken to ensure that actions taken by Respond! Management do not undermine or frustrate any investigation being conducted by the HSE or An Garda Siochána on this.

If any member of staff or volunteer is inhibited for any reason in reporting an incident or allegation of child abuse against another member of staff or volunteer internally, or if they are dissatisfied with the internal response, they should report the matter independently to the HSE and An Garda Siochána.

11. All Respond! staff and volunteers are expected to:

- Have read and understood this policy document.
- Attend such training and induction in Child Protection as determined by Respond! management.
- Support Child Protection Designated Liaison Persons in their role.
- Maintain confidentiality on all Child Welfare concerns except in the interests of protecting children.

11.1. Role of the Resident Support Worker

- In addition Resident Support Workers are expected to:
- Ensure volunteers, youth leaders, etc. active on their estates are appropriately vetted and trained in Child Protection.
- Ensure appropriate Risk Assessments carried out for all events and activities involving children and other vulnerable people on their estates.
- Create awareness on estates of the importance of Child Protection procedures and encourage resident groups to adopt their own Child Protection policies.

11.2. Role of the Childcare Centre Designated Liaison Person

- Receive and process concerns/allegations relating to Child Protection from staff and volunteers in their Child Care Centre.
- Make referrals on allegations and suspicions of Child Abuse and welfare concerns directly to the HSE/Gardaí and liaise with them.
- Inform and liaise with parents/carers where appropriate. Ensure all parents/guardians are aware of the Child Protection policy.

- Liaise with Respond! Regional Designated Liaison Person, ensuring they are aware of any Child welfare concerns from the Child Care Centre.
- Inform their line manager/Regional Manager of any allegations against staff or volunteers.
- Ensure policy and procedures are followed in their Child Care Centre.
- Ensure all staff and volunteers are appropriately trained and informed on Child Protection issues.
- Keep confidential individual records on suspected or actual cases of child abuse regarding the allegation, referral, action taken, liaison with other agencies and monitor outcomes.
- Keep records dated and kept locked and secure in the office of the designated person.

11.3. Role of the Regional Designated Person

(It is advisable that a deputy designated person is also named for each region to ensure consistency and efficiency in the absence of the designated person.)

- Receive and process concerns/allegations relating to Child Protection from staff and volunteers.
- Make referrals on allegations and suspicions of Child Abuse and welfare concerns directly to the HSE/Gardaí and liaise with them.
- Ensure policy and procedures are followed at a regional level.
- Provide information, advice and induction training to staff and volunteers within the respective region.
- Keep confidential individual records on suspected or actual cases of child abuse regarding the allegation, referral, action taken, liaison with other agencies and monitor outcomes.
- Ensure effective channels of communication are maintained with the Regional Manager and the national co-ordinator for child protection.
- Keep records dated and kept locked and secure in the office of the designated person.
- Inform and liaise with parents/carers where appropriate.
- Maintain a data base and liaise with the regional senior members of community services, who are responsible for child protection, HSE, etc.
- Offer support and information on child protection to staff and volunteers within the region, including involvement in induction training.
- Report on a monthly basis to the Regional Manager and to the National Child Protection Co-ordinator. These reports will maintain the confidentiality of individual cases and will provide overviews of the number, nature and locations of incidents.
- It is important that the Designated Person is accessible to all staff.

11.4 Role of the National Child Protection Co-ordinator

- Provide information and advice on child protection throughout Respond!.
- Ensure consistency of approach throughout Respond!.
- Ensure quality standards are upheld.
- Respond to training needs.

- Organise supportive systems and meetings for the named designated persons.
- Ensure the effectiveness of the child protection policy as a working document, through monitoring, evaluation and annual renewals.

11.5. Role of the Resident Support Services Manager

- The Resident Support Services Manager is the line manager for the Designated Liaison Person. (S)he will be aware of the number and nature of referrals to the HSE/Gardaí, without knowing specific details for reasons of confidentiality.
- As line manager of the Designated Liaison Person ensure that all Child Protection policies and procedures are followed in their region.
- In the case of allegations of child abuse against staff/volunteers the Resident Support Services Manager, and the Regional Manager, together with the HR Department will oversee the employment/contractual issues or the employee/ volunteer in question.

11.6. Links to other Respond! Strategies

- Other Respond! strategies, such as the Family Support Strategy, Better Being Strategy, and the Community Development Strategy may overlap with child protection and welfare issues. All staff must follow the guidelines in the Child Protection Policy.
- When these strategies are already engaging with families where there are welfare or protection concerns staff must take due cognisance of this Child Protection Policy. The HSE should be informed of such on-going work and any subsequent support work should be done in consultation with the HSE.

12. Good Practice Guidelines

By developing a code of behaviour the organisation is protecting both the young people and the members of staff/volunteers. The following are guidelines on what Respond! considers to be good practice relating to Child Protection.

12.1. Good Practice

- Staff and volunteers will respect and value children as individuals. Children should be listened to, praised and encouraged and involved appropriately in decision-making.
- Staff should avoid giving lifts in their cars to individual children and young people. Parents and management should be kept informed of transport arrangements for children at all times.
- In cases of disclosures, never promise to keep secrets, the child/ young person needs to be aware that you will have to pass on any serious information regarding the protection and welfare of children.
- Never let allegations made by a child go unchallenged or unrecorded.
- Avoid spending time alone, away from others with a child or young person.
- Always address children and young people in positive terms. Avoid disparaging remarks, sarcasm, etc.

12.2. Inappropriate Behaviour

- Avoid time alone with children/young people.
- Staff will not hit, push or physically chastise any young person.
- Staff should be sensitive to the possibility of developing favouritism, or becoming over-involved or spending a great deal of time with any one child.

12.3. Health and Safety

- Children/young people should not be left unattended or unsupervised.
- A safe environment will be provided.
- Appropriate Risk Assessments will be carried out for all outings, trips etc organised for children/young people (see Appendix III for Risk Assessment Guidelines).
- Staff/volunteers/parents will be made aware of the policy and procedures to which Respond is committed. The full Respond! Housing Association Child Protection Policy is available upon request from info@respond.ie.
- Children should be encouraged to report cases of bullying to either a designated person or a staff/volunteer of their choice.
- All allegations by children or young people will be reported to the Designated Person.
- The appropriate staff (volunteer) to child ratio for safe supervision should be followed. This is recommended as:

Age	Ratio
0-2 years	1 staff for 3 children
2-3 years	1 staff for 4 children
3-7 years	1 staff for 8 children (6 outdoors)
8 years+	2 staff for 20 children (15 outdoors) and one additional staff for every further 10 children.

Please note:

The full Respond! Housing Association Child Protection Policy is available on request from: Respond! Housing Association, Airmount, Dominick Place, Waterford.
Tel: 0818 357901 Email: info@respond.ie

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