springboard
promoting family well-being:
through family support services

Final Evaluation of Springboard
January 2000 to May 2001

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Springboard is a Programme of Support for Vulnerable Families

DECEMBER 2001

Foreword

As Minister for Children I am delighted to publish 'Springboard: promoting family well-being through family support services'. This report is the final evaluation of the three year pilot phase of the Springboard initiative and sets out to answer the question: has Springboard improved the well-being of children and parents and how have its services been received?

The Springboard Family Support pilot projects for children at risk is the first major family support initiative of its kind in Ireland. It was established by the Department of Health and Children in 1998 with approval from the Cabinet Committee on Social Inclusion. Initially 14 projects were established throughout the country aimed at supporting vulnerable families. An important part of the work of Springboard during the pilot phase has been in fully evaluating the services provided and the outcomes for families. This Evaluation Report fills a gap in Irish based research on what works in intensive family support services. My intention is that it will provide a valuable framework for how child and family difficulties should be tackled at local community level and a baseline for quality service provision in supporting troubled families.

This government recognised that family support has been a neglected aspect of family policy. In many instances, it has been overshadowed by interventions which have focused predominantly on child protection. There is now a widespread perception that the child protection aspect of family policy needs to be complemented by a more broadly-based family support structure.

I believe that families should have available to them good quality, locally based, appropriate services as a means of preventing stress and dysfunction and in order to reduce the toll stress might otherwise take on health, well-being and functioning. All Springboard projects have a general strategy of being open and available to all families, parents and children in their communities as well as a more specific strategy of working intensively with those who are most vulnerable. The rationale behind this dual strategy is that Springboard is a resource for all families while simultaneously providing an intensive, non-stigmatising support to those who are most vulnerable.

I am delighted to note that the evaluation has shown that parents and children experienced considerable improvements in well-being while attending Springboard. Virtually every parent and child attributed their improved well-being to the intervention of Springboard.

Tá fís agus aidhmeanna an Straitéis Náisiúnta Leanaí á bhaint amach san obair seo.

This Government remains committed to the further strengthening of policies and services to support families in all areas which have a positive impact on family life. Through its Family Support projects Springboard will build on its quality base and continue to provide a range of best practice services which meet the needs of vulnerable families.

Mary Hanafin T. D
Minister for Children

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1 Background

1.1 Introduction

Until recently, family support has been a neglected aspect of family policy. In many instances, it has been overshadowed by interventions which have focused predominantly on child protection. There is now a widespread perception that the child protection aspect of family policy needs to be complemented by a more broadly-based family support approach. That is the underlying rationale of the Springboard initiative.

Family support is generally seen as a way of promoting healthy relationships in families and preventing dysfunctional relationships from getting worse. As such it can be a form of either primary, secondary or tertiary prevention, a trilogy of interventions which have been cryptically defined as addressing problems either before they happen (primary prevention), before they get worse (secondary prevention) or before it is too late (tertiary prevention)[1].

Family support is an umbrella term covering a wide range of interventions which vary along a number of dimensions according to their target group (such as mothers, toddlers, teenagers, etc.), the professional background of service providers (e.g. Family Worker, Social Worker, Childcare Worker, Youth and Community Worker, Public Health Nurse, Community Mother, Psychologist, etc.), the orientation of service providers (e.g. therapeutic, child development, community development, youth work, etc.), the problems addressed (e.g. parenting problems, family conflict, child neglect, educational underachievement, etc.), the programme of activities (e.g. home visits, pre-school facility, youth club, parenting course, etc.) and the service setting (e.g. home-based, clinic-based or community-based). This diversity indicates that family support is not a homogenous activity but a diverse range of interventions[2].

This chapter describes the background and context to Springboard. We begin in section 1.2 by outlining the changing policy context of family support in Ireland, particularly as reflected in recent Government initiatives. This is followed by a more detailed specification of the aims and objectives of Springboard in section 1.3. We then give a short description of the projects in Springboard in terms of their management structure (section 1.4), throughput of families, parents and children (section 1.5), staffing levels (section 1.6) and activities (section 1.7). Finally, we conclude with a summary and conclusion (section 1.8).

1.2 Policy Context

At the beginning of the millennium, Irish family support services are in an expansionary phase. In 1998, the Government launched Springboard, an initiative of 15 family support projects. In 1999, the Government also committed itself to establishing 100 Family and Community Centres throughout the country in line with a recommendation in the report of the Commission on the Family[3]. In addition, the National Development Plan 2000-2006 contains a substantial allocation of funds to childcare,

1 See Bradbury and Fincham, 1990, p.376.
2 McKeown, 2000.
3 Fianna Fáil and Progressive Democrats, 1999, p.16; Commission on the Family, 1998, p.17.

community and family support and youth services, all of which are supportive, directly or indirectly, of family life[4]. The importance of family support has also been underlined in the Guidelines for the Welfare and Protection of Children which devotes a separate chapter to family support services[5].

An important feature of the policy context is the parallel growth of initiatives to address the lack of co-ordination in statutory services, particularly as they affect the disadvantaged families and communities which depend on them most heavily[6]. The need for these initiatives was highlighted by the Taoiseach in December 1998: "something is missing in the way we have approached the problem up to now. ... We need urgently much closer working relationships between statutory organisations. ... Agencies must take more account of the real needs and experiences of end-users when designing and planning services"[7]. Initiatives to promote greater co-ordination include the Strategic Management Initiative at national level, the promotion of partnerships at local level and especially the RAPID Programme (an acronym for Revitalising Areas by Planning, Investment & Development) which was announced in February 2001 to succeed the pilot Integrated Services Process (ISP). The need for co-ordination is also recognised in the context of family support and is one of the criteria on which the effectiveness of initiatives like Springboard must be evaluated.

This policy context highlights the important issues which are at stake in the Springboard initiative. It also highlights the challenge posed by the initiative to find lessons for good practice which can have broader applicability for both family support and the co-ordination of services more generally.

1.3 Springboard and Family Support

Springboard and Family Support

Springboard is a family support initiative. As such, it falls within the agreed definition of family support in the National Guidelines for the Protection and Welfare of Children which were published in September 1999:
"Family support services aim to achieve the following:

(i) respond in a supportive manner to families where children's welfare is under threat;
(ii) reduce risk to children by enhancing their family life;
(iii) prevent avoidable entry of children into the care system;
(iv) attempt to address current problems being experienced by children and families;
(v) develop existing strengths of parents/carers and children who are under stress;
(vi) enable families to develop strategies for coping with stress;
(vii) provide an accessible, realistic and user-friendly service;
(viii) connect families with supportive networks in the community;
(ix) promote parental competence and confidence;
(x) provide direct services to children;
(xi) assist in the re-integration of children back into their families."[8]

4 Ireland, 1999, pp.192-195; see also the Programme for Prosperity and Fairness, 2000.
5 Department of Health and Children, 1999, Chapter Seven.
6 See, for example, Buckley, 2000.
7 Taoiseach, 1998.
8 Department of Health and Children, 1999a, p. 60.

This vision of family support is consistent with the perspective of the Commission on the Family, whose final report, published in July 1998, recommended an approach to family support "which is empowering of individuals, builds on family strengths, enhances self-esteem and engenders a sense of being able to influence events in one's life, has significant potential 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 in a stressful environment".[9]

The Department of Health and Children were clearly informed by these perspectives on family support when calling for project proposals under the Springboard Initiative in 1998. Its expectation was that:
"Project proposals should demonstrate an ability to achieve the following:

- To identify the needs of parents and children in the proposed area. Specific attention given to those families where child protection concerns exist, to families with on-going health and welfare problems and/or families in once-off crisis situations.
- To target the most disadvantaged and vulnerable families in the area specifically focusing on improving parenting skills and child-parent relationships.
- To work in partnership with other agencies, key groups and individuals in the community and with families to develop programmes of family support services.
- To provide a direct service through a structured package of care, intervention, support and counselling to the targeted families and children, and to families within the wider community".[10]

The Department's expectations of the initiative were further detailed in its invitation to tender for the evaluation of Springboard in 1999: "The Initiatives will work intensively with children mainly in the age group 7-12 who are at risk of going into care or getting into trouble and their families. The Initiatives will all have in common the establishment of formal collaborative structures involving relevant public agencies, the voluntary sector, the local community and the identification or establishment of a local centre within each community which will act as a focal point for the delivery of services for young people".[11]

These considerations suggest that Springboard is designed to have three types of impact at both project and programme level: (1) an impact on the well-being of children (2) an impact on the well-being of parents (3) an impact which improves the organisation and delivery of services. In line with this, our evaluation assesses the impact of Springboard on children (Chapters 4-8), on parents (Chapters 9-13) and on service delivery, as experienced by parents, children and professionals (Chapters 14-15).

1.4 Springboard Projects

Springboard Projects

The evaluation of Springboard is based on 14 projects[12], all located in cities or large towns. Each project is in receipt of an average annual budget of

[9] Commission on the Family, 1998, p. 16.
[10] Department of Health and Children, 1998.
[11] Department of Health and Children, 1999b.
[12] Three additional Springboard projects were set up in 2000 but these have not been included in the evaluation due to their later starting date.

under IR£200,000. The organisational structure of each project is summarised in Table 1.1. This reveals that seven of the projects are managed by Barnardos, two are managed by a Health Board, two are managed by a partnership between a Health Board and a voluntary organisation and three are managed by a voluntary/community organisation.

Table 1.1 Management Responsibility for Each Springboard Project, 1998-2001

Location of Project	Management Structure of Projects			
	Barnardos	Health Board only	Health Board and Voluntary Organisation	Voluntary / Community Organisation
Athlone	yes			
Tullamore	yes			
Thurles	yes			
Limerick	yes			
Cork	yes			
Waterford	yes			
Dublin	yes			
Sligo				yes
Galway: Westside		yes		
Galway: Ballybane		yes		
Galway: Ballinfoyle			yes	
Dundalk				yes
Navan				yes
Naas			yes	

1.5

Throughput of Families, Parents and Children

Throughput of Families, Parents and Children

In the period between start-up and the end of August 2000, as indicated in Table 1.2, Springboard offered services to 623 families, 685 parents and 1,569 children[13]. This is equivalent to an average of 48 families, 53 parents and 121 children per project.

All Springboard projects have a general strategy of being open and available to all families, parents and children in their communities as well as a more specific strategy of working intensively with those who are most vulnerable; this involves intervening over a relatively prolonged period of up to a year or more, as we shall see below (see Chapters 5 and 7 below). The rationale behind this dual strategy is that Springboard is a resource for all families while simultaneously providing an intensive, non-stigmatising support to those who are most vulnerable. Most staff time is devoted to these vulnerable families and for this reason the evaluation system for Springboard is based primarily on assessing the changes which have been brought about in the lives of these parents and children.

[13] These figures do not include Tullamore which was not fully operational in this period; nor do they include Letterkenny which was closed in May 2000.

Table 1.2 Families, Parents and Children in Springboard, January 2000 to May 2001

Category	Number in Contact with Springboard Start-up to August 2000	Number in the Evaluation System Start-up to May 2001
Families	631	207
Parents	685	191
Children	1,569	319

1.6 Staffing in Projects

Staffing in Projects

The total number of persons employed in Springboard is 111[14]; as indicated in Table 1.3 this is equal to 84 full-time equivalent staff. More than half of all staff are full-time (58, 52%) while the remainder are employed part-time (53, 48%). The average number of full-time equivalent staff per project is 6.0. On average, and speaking from a purely statistical point of view, each full-time equivalent staff (excluding administrative staff and staff on FAS Programmes) sees about 36 parents and children and each works intensively with about 10 of these.

Table 1.3 Staffing Levels in Springboard in September 2001

Category	Direct Contact with Clients	Admin--istration	FÁS Programmes	Total
Full-time staff	50	8	0	58
Part-time staff	24	6	23	53
Total staff	74	14	23	111
Total Full-time Equivalent (FTE) Staff	62	11	11	84
Average FTE per Project				6.0

1.7 Springboard Activities

Springboard Activities

All projects are engaged in a wide range of family support activities including: (1) individual work such as one-to-one sessions with clients to assess needs and offer advice, counselling and support; (2) group work and activities such as parenting and personal development groups, breakfast clubs, coffee mornings, homework and after-school activities, classes in arts, crafts, baby-sitting, dancing, cookery, dress-making, swimming, etc; (3) family work such as counselling and therapy, family evenings and outings or accompanying families on visits to hospital, court, school, the Health Board, etc; (4) drop-in facilities for information, advice, recreation, coffee-breaks, etc. In addition to direct service provision, projects also spend time building up inter-agency networks with other services in the community, both statutory (such as schools, health board professionals, Garda Síochána, etc) and voluntary (such as projects covering childcare, youth, community, money advice and budgeting, etc). This work is motivated by the importance which Springboard attaches to an integrated inter-agency approach to service delivery.

[14] This is based on the 14 projects listed in Table 1.1; the three Springboard projects established in 2000 are not included. The data includes staff on programmes such as Community Employment and the Jobs Initiative.

1.8 Summary and Conclusion

Summary and Conclusion

Springboard is a family support initiative designed to improve the well-being of families, parents and children and to improve the organisation and delivery of services more generally. Each project is in receipt of an annual average budget of under IR£200,000. All Springboard projects have a general strategy of being open and available to all families, parents and children in their communities as well as a more specific strategy of working intensively with those who are most vulnerable. In the period between January 2000 and May 2001, Springboard worked intensively with 207 families, 319 children and 191 parents and it is on these that the evaluation is based.

The total number of persons employed through Springboard is 111[15] (equal to 84 full-time equivalent staff) which are almost equally divided between those who are full-time (58, 52%) and those who are part-time (53, 48%). All projects are engaged in a wide range of family support activities including: (1) individual work such as one-to-one sessions with clients to assess needs and offer advice, counselling and support; (2) group work and activities such parenting and personal development groups, homework and after-school activities, classes in arts, crafts, swimming, etc; (3) family work such as counselling and therapy, family evenings and outings, or accompanying families on visits to hospital, court, school, health board, etc; (4) drop-in facilities for information, advice, recreation, coffee-breaks, etc. In addition to direct service provision, projects also spend time building up inter-agency networks with other services in the community, both statutory and voluntary. This work is motivated by the importance which the Springboard attaches to an integrated inter-agency approach to service delivery.

Our purpose in this report is to evaluate the impact of Springboard on the well-being of parents and children and on the delivery of services. In order to do this it is necessary to describe the methodology used in the evaluation and we do this in the next chapter.

[15] This is based on the 14 projects listed in Table 1.1; the three Springboard projects established in 2000 are not included. The data includes staff on schemes such as Community Employment and the Jobs Initaitive.

2 Methodology

2.1 Introduction

This report is designed to answer the following questions: has Springboard improved the well-being of children and parents and how have its services been received? The evaluation system which we devised to answer these questions involved measuring the well-being of children and parents before and after the intervention of Springboard and controlling for a range of background factors. This research design, in conjunction with relatively sophisticated statistical analyses, allows us to draw reasonably robust inferences about the impact of Springboard. For both ethical and economic reasons, it was not possible to use the "ideal" research design in which the impact of Springboard on children and parents is compared with the impact of "doing nothing" on a "control group" of children and parents.

We now explain the instruments used to measure the well-being of children (section 2.2) and parents (section 2.3) as well as the perceptions of Springboard as a service (section 2.4). This is followed by a summary of the dataset of families, children and parents on which the evaluation is based (section 2.4). Against this background we describe the procedures used to analyse the data (section 2.5) and the structure that will be used to present our results in the remainder of the report (section 2.6).

2.2 Measuring the Well-being of Children

We used two sets of questionnaires to collect data on the well-being of children at baseline and follow-up: (1) the Strengths and Difficulties Questionnaire and (2) a staff questionnaire on the child's characteristics.

2.2.1 Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) was created by Robert Goodman at the Institute of Psychiatry in London during the 1990s. It is a brief behavioural screening questionnaire for 3-16 year olds. The 25 item questionnaire is completed by the child (if over 11), the parent (for children aged 3+) and the teacher (for children aged 3+). The questionnaire has been extensively tested for validity and reliability in Britain and Sweden but not in Ireland, although it is being used in clinical practice in Ireland at the Lucina Clinic in Tallaght and the Mater Child Guidance Clinic in Dublin. It has been translated into 30 languages[16].

The Strengths and Difficulties Questionnaire has a number of advantages from the point of view of evaluating Springboard. First, it is much shorter than other standard assessment devises such as the Child Behaviour Checklist which has nearly 120 items compared to only 25 items in the SDQ and yet it is just as effective as an assessment device. Second, it focuses on strengths as well as difficulties; other assessment devices tend to be heavily focused on problems and this can make the assessment process an unnecessarily negative experience for the child and parent. In contrast, completing the SDQ is not a negative experience for teachers, parents and

[16] See Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

children. Third, the SDQ does not require extensive training to use it effectively. Fourth, the SDQ provides a relatively simple way of engaging the child, the parent and the teacher in the work of Springboard and creates an awareness of how the child behaves in different contexts. Fifth, the SDQ provides a simple but effective way of measuring not only the child's difficulties but also the stress, impairment and burden which these difficulties may cause. This is significant because it allows for the possibility that even if Springboard does not impact decisively on the child's difficulties it may help to reduce the stress, impairment and burden which these generate for the child, the parent and the teacher; as we shall see in Chapter Six, it is precisely this scenario which we encounter in the evaluation of Springboard.

2.2.2

Staff Questionnaire on Child Characteristics

Staff Questionnaire on Child Characteristics

The Staff Questionnaire on Child Characteristics collects information on the age and sex of the child, family size and structure, socio-economic status and poverty indicators as well as child-specific dimensions indicated by previous research such as the main problems experienced, previous and current involvement with the Health Board, risk of abuse, risk of entering care and risk of getting into trouble with the law. The follow-up version of this questionnaire measures the same variables as well as the amount of time received by each child through each type of intervention. For simplicity, interventions are classified into five categories: individual work, group work, family work, drop-in and administration.

2.3

Measuring the Well-being of Parents

Measuring the Well-being of Parents

We also used two sets of questionnaires to collect data on the well-being of parents at baseline and follow-up: (1) a self-completion questionnaire on parental attitudes and feelings and (2) a staff questionnaire on the parent's characteristics.

2.3.1

Self-completion Questionnaire on Parental Attitudes and Feelings

Self-completion Questionnaire on Parental Attitudes and Feelings

This questionnaire - which in practice was often completed with the assistance of staff rather than by parents alone - measures four important aspects of parental well-being. The first is parenting capacity as measured by the Parent-Child Relationship Inventory (PCRI). The PCRI was developed, tested and validated in the US with over 1,000 parents, both fathers and mothers. In the abbreviated version which we use, the PCRI measures the parent's relationship with the child in terms of (1) support (2) satisfaction (3) involvement and (4) communication[17].

The second aspect of well-being is the stress level of parents as measured by the General Health Questionnaire (GHQ). The GHQ was created nearly 30 years ago and has been internationally tried and tested as a measure of mental health[18]. In its shortened version, it comprises 12 items and focuses on a person's symptoms rather than personality traits. It has been used in Ireland to measure the impact of unemployment[19] and poverty[20] on psychological distress as well as the impact of psychological distress on visits

[17] See Gerard, 1994. The two dimensions of the PCRI which are not included are limit-setting and autonomy.

to GPs[21]. It has also been used to assess the impact of parenting programmes in Ireland and Britain[22]. One study has used it to assess the impact on mothers of a child and family centre in Dublin[23].

The third aspect of well-being is social support networks which were measured using an adapted form of the social network map[24] by asking parents if they received practical help (such as baby sitting), emotional support (such as someone to talk to) or information/advice (such as how to access services) from any of the following: someone in your own home, extended family, friends, neighbours, someone at work or in school, from statutory agencies, voluntary bodies or community organisations. The response categories were "none", "a little" and "a lot".

The fourth aspect of parental well-being is the degree of ease or difficulty which a parent experiences in coping financially. We know from the 1997 Living in Ireland Survey that 40% of those in poverty (defined as falling below the 60% relative income line) had "extreme difficulty" in making ends meet[25] which implies that the objective and subjective dimensions of poverty are quite distinct aspects of well-being and our evaluation of Springboard lends support to this (see Chapter Seven below).

Staff Questionnaire on Parent Characteristics

The Staff Questionnaire on Parent Characteristics was designed to collect information on family size and structure, socio-economic status and poverty indicators as well as information on problem areas in the life of the parent (such as traumatic childhood experiences). The follow-up version of this questionnaire, in addition to measuring any changes in the baseline situation, also measured the amount of time received by each parent through individual work, group work, family work, drop-in and administration.

Measuring Perceptions of Springboard as a Service

We used two questionnaires to measure how Springboard is experienced by service users and other professionals. We briefly summarise the content of these questionnaires.

Perceptions of Springboard by Parents and Children

A random sample of parents and children were interviewed in each project on their perceptions of Springboard using the following themes: quality of Springboard services, personal and family impacts of Springboard, qualities of Springboard staff, profile of Springboard in the community, Springboard compared to other services, activities which are most helpful in Springboard, suggestions for making Springboard more effective.

2.3.2

Staff Questionnaire on Parent Characteristics

2.4

Measuring Perceptions of Springboard as a Service

2.4.1

Perceptions of Springboard by Parents and Children

[18] Goldberg, 1972; Goldberg and Williams, 1988.
[19] Whelan, Hannan and Creighton, 1991; Hannan and O'Riain, 1993; Sweeney, 1998.
[20] Callan, Layte, Nolan, Watson, Whelan, Williams and Maitre, 1999.
[21] Nolan, 1991.
[22] Mullin, Proudfoot and Glanville, 1990; Mullin, Quigley and Glanville, 1994; Mullin, Oulton and James, 1995; Johnson, Howell and Molloy, 1993; Davis and Hester, 1998, Pritchard, 1999.
[23] Moukaddem, Fitzgerald, and Barry, 1998.
[24] See Tracy and Whittaker, 1990; Kinney, Haapala, Booth and Leavitt, 1990; see also Saleeby, 1992; 1996; 2000; Gilligan, 1991; 1999.
[25] Callan, Layte, Nolan, Watson, Whelan, Williams and Maitre, 1999, p.47.

2.42

Professional Perceptions of Springboard

Professional Perceptions of Springboard

Professionals working in the area of each Springboard project were asked for their views on different aspects of Springboard, including:

- effectiveness in working with selected client groups, organisations and agencies
- staff competence
- adequacy of physical facilities
- quality of relationship between Springboard and Health Boards
- perceived strengths and weaknesses of Springboard
- factors which facilitate and hinder inter-agency cooperation
- Has Springboard lived up to expectations?
- Is Springboard value for money?
- Should Springboard continue to be funded?
- any suggestions for making Springboard more effective

2.5

The Dataset of Families, Children and Parents

The Dataset of Families, Children and Parents

The evaluation has not tried to measure every single activity or intervention within Springboard, as this would be both impossible and pointless from the point of view of assessing its impact. Our purpose in the evaluation is to assess the impact of Springboard on those families, parents and children who have received the most intense forms of intervention and have therefore absorbed the greatest share of Springboard's time and resources. In view of this it is significant, as Table 2.1 reveals, that the proportion of families (33%), parents (28%), and children (20%) in the evaluation system is significantly less than the total throughput of clients. This is not unexpected given that Springboard is a community-based family support intervention and is designed to be open and accessible to all families and not just those with severe problems. At the same time, the families, parents and children in the evaluation system absorb the largest and most significant share of Springboard time and resources and, for that reason, we feel justified in claiming that the main impact of Springboard is most likely to be found among this group of vulnerable families.

Table 2.1 Families, Parents and Children in Springboard, January 2000 to May 2001

Category	Number in Contact with Springboard Start-up to August 2000	Number in the Evaluation System Start-up to May 2001	Estimated Percent in the Evaluation System
Families	631	207	33
Parents	685	191	28
Children	1,569	319	20

The number of families (207), parents (191) and children (319) in the evaluation is based on those for whom there are matching baseline and follow-up data. Baseline data were collected on each family, parent and child as soon as possible after they make contact with Springboard and before any significant intervention is undertaken; follow-up data were collected in May 2001.

2.6 Data Processing and Analysis

Data Processing and Analysis

All questionnaires were computerised; each item of information was keyed twice into the computer and then cross-checked to ensure that no mistake occurred during data entry. The computerised data were then analysed to produce the tables and graphics in the Technical Appendix to this report. In order to render each chapter as accessible as possible, it was decided to combine all of the tables and graphics into a Technical Appendix which appears at the end of this report. Unless otherwise specified, all references are to tables and graphics in the Technical Appendix, and are labelled with the prefix "A" (for example, Table A1.1, etc).

In addition to the basic data processing, we also carried out extensive statistical analyses on the data in order to identify the key variables which influence programme impacts on children, parents and families. This took the form of Structural Equation Modelling to identify the influence of each variable on the impact measure, while holding all the other variables constant. As already indicated, we do not have a group of families (usually referred to as a "control" or a "comparison" group) to compare with Springboard families, and thus we are not in a position to compare the impact of Springboard with the impact of either doing nothing or doing something different. However, the use of Structural Equation Modelling allows us to control for a range of background variables and thus assess the extent to which changes in the well-being of parents and children are attributable to Springboard. This, as we shall see, is quite valuable not only from the perspective of assessing impact but also in terms of throwing light on the factors which influence the effectiveness of interventions and the implications for good practice.

2.7 Structure of Report

Structure of Report

The remainder of the report describes the results of the evaluation. Chapter Three describes the main characteristics of families. This is followed by a profile of the children (Chapter Four), a description of interventions with children (Chapter Five), an assessment of changes in well-being experienced by children (Chapter Six), an examination of Springboard's impact on children (Chapter Seven) and a review of case studies of the most improved children (Chapter Eight). Similarly, there is a profile of the parents (Chapter Nine), a description of interventions with parents (Chapter Ten), an assessment of changes in well-being that were observed (Chapter Eleven), an analysis of Springboard's impact on parents (Chapter Twelve) and a review of case studies of the most improved parents (Chapter Thirteen). In Chapter Fourteen we report on how a random sample of parents and children experienced the services of Springboard while in Chapter Fifteen we report on how professionals perceive Springboard. Finally, in Chapter Sixteen, we present a summary of our findings, draw conclusions and make our recommendations.

3 Profile of Families

3.1 Introduction

This chapter describes the main characteristics of families who were clients of Springboard in the period between January 2000 (baseline) and May 2001 (follow-up). We begin with a brief analysis of the number of families and children in Springboard (section 3.2) followed by a description of family size (section 3.3) and household type (section 3.4). The employment status of parents (section 3.5) and the main source of family income (section 3.6) are then described. This is followed by an analysis of parents' occupational status (section 3.7), type of accommodation (section 3.8) and whether the families concerned are settled or Travellers (section 3.9). Finally there is a brief summary of the key findings (section 3.10).

3.2 Number of Families

Between January 2000 and May 2001, Springboard worked intensively with 207 families, comprising 319 children and 191 parents (Tables A3.1, A4.1 and Table A9.1). The caseload of families, children and parents varies between projects due to different styles and intensities of intervention and the different contexts in which projects are working (see Table A2.1).

3.3 Parents in Family Home

A majority of families (54%) have only one parent living in the family home (Table A3.1); in more than nine out of ten cases that parent is the biological mother (Table A3.2) and is single (Table A3.3); conversely, a majority of biological fathers (55%) do not live in the family home. Less than three out of ten biological parents (28%) are married to each other (Table A3.3).

The profile of Springboard families differs greatly from the composition of Irish families in general. In Ireland, 86% of families with children live in a household comprising children and their two married parents, 12% live in a household comprising children and the mother only, and 2% live in a household comprising children and the father only[26]. In other words, one-parent households are over-represented in Springboard by a factor of nearly four and two parent households are under-represented by a factor of nearly two.

3.4 Family Size

Family size is measured by the number of children. The majority (73%) of families have between two and five children (Table A3.4). The average number of children per family is 3.8; this is higher than the average number of children in households in Ireland (2.6)[27]. However there are also a number of larger families: one fifth of families (34, 19%) have six or more children. Most children are full siblings but 20% of families have half-siblings (Tables A3.5 and A3.6). A small number of families (6, 3%) also have grandchildren living with them (Table A3.7).

[26] Census of Population, 1996, Volume 3, Table 4. In 2% of two parent households in Ireland, the parents are cohabiting rather than married.

[27] Census of Population, 1996, Volume 3, Table 6. These are households in which at least one child under the age of 15.

3.5

Employment Status of Parents in Family Home

Employment Status of Parents in Family Home

We begin with the employment status of mothers, as we have more complete information on this group (this reflects the fact that most of the information on parents in the evaluation was collected from mothers as a majority of fathers are not living with their children in the family home). A majority of mothers classified themselves as either full-time parents or unemployed at both baseline (64%) and follow-up (59%) (Table A3.9). About four in ten mothers (41%) were in employment in May 2001, slightly higher than the corresponding proportion (36%) when the family first made contact with Springboard. In other words, there has been a small increase in the percentage of mothers in employment between baseline and follow-up. Mothers in employment tend to be part-time rather than full-time.

Data on fathers is too incomplete to draw reliable conclusions. The data that is available on fathers in the home indicates that six out of ten of these fathers (60%) are now in employment, slightly above the corresponding proportion (56%) when the family first made contact with Springboard (Table A3.8). More than one third of fathers (37%) are unemployed, most of these (90%) being long-term unemployed (Table A3.10). For comparative purposes it is worth noting that the national average unemployment rate in August 2001 was 3.7%[28], exactly one tenth of that experienced by Springboard fathers. Only two fathers are described as being on home duties.

These statistics suggest that the employment position of families has changed little since coming into contact with Springboard, and this reduces the likelihood that improvements in the well-being of children and parents are due to changes in the proportion of parents at work.

3.6

Main Source of Income in Household

Main Source of Income in Household

The vast majority (90%) of families derive their income, either partly or wholly, from social welfare payments (Table A3.12). Between baseline and the follow-up in May 2001 there was a slight reduction in the proportion of households who are wholly dependent on social welfare, from 46% to 41%, which is broadly in line with the changes in labour market participation described in the previous section. Conversely the proportion of households who depend on both social welfare and employment rose from 43% to 49%, which is also consistent with the fact that most of the growth in employment among both mothers and fathers was in part-time rather than full-time employment. These considerations indicate a modest improvement in the economic situation of families against a background of overall stability.

All parents were asked how easy or difficult it was for them to make ends meet and their responses indicated that more than three quarters (78%) had difficulty making ends meet, with almost one third (31%) having “great difficulty” (Table A3.13). As we have seen in Chapter Two, the 1997 Living in Ireland Survey found that 40% of those in poverty (defined as falling below the 60% relative income line) had “extreme difficulty” in making ends meet[29].

[28] Quarterly National Household Survey, Second Quarter, 29 August, 2001.
[29] Callan, Layte, Nolan, Watson, Whelan, Williams and Maitre, 1999, p.47.

3.7

Occupational Status of Parents in Family Home

3.8

Type of Accommodation

3.9

Settled and Traveller Families

3.10

Families Known to Health Board

3.11

Summary

Occupational Status of Parents in Family Home

The vast majority of fathers (82%) and mothers (77%) living in families, and for whom there is information, are in the semi-skilled or unskilled manual category (Tables A3.14 and A3.15). In Ireland, the proportion of the population in semi-skilled and unskilled manual categories is only 18%[30].

Type of Accommodation

The vast majority (77%) of families live in a house or flat which is rented from the Local Authority (Table A3.16). A small number of families (16, 8%) rent their home from a private landlord. A tenth of families (22, 11%) own the house in which they live. This pattern contrasts strongly with the national picture where approximately 80% of homes are owner-occupied, 10% are rented from the Local Authority and 10% are rented privately[31]. A majority of Springboard families (63%) have been in their present accommodation for less than six years (Table A3.17). Most of families for whom there is information (71%) seem settled in the sense that they expect to be in their present home in one year's time (Table A3.18).

Settled and Traveller Families

The vast majority (86%) of families come from the settled community (Table A3.19). A minority (14%) come from the Travelling community. In Ireland there are approximately 4,500 Traveller families[32]. This is equivalent to 0.7% of all families with children. In other words, Traveller families are significantly over-represented in Springboard projects - by a factor of 20 - relative to their size in the total population. One family is described as 'refugee'.

Families Known to Health Board

Two thirds of all families (66%) are known to the Health Boards (Table A3.20). This is an exceptionally high figure, given that most families would not be known to the Health Boards in their area, particularly not to the Social Work Department. Health Boards are also a major source of referral to Springboard, particularly among projects run by Barnardos (Table A3.21).

Summary

The key characteristics of the 207 families who received intensive assistance from Springboard between January 2000 and May 2001 are as follows:

- the majority (54%) of families have only one parent living in the family home.

[30] Census of Population, 1996, Volume 7, Occupations.
[31] Census of Population, 1991, Volume 10, Housing, Table 11A.
[32] Department of Environment and Local Government, 1999.

- the average number of children per family is 3.8, higher than in Ireland (2.6).
- six out of ten mothers are full-time parents while four out of ten are in employment, mainly part-time; information on fathers is scarce but those for which there is information suggests an unemployment rate of 37%, ten times the rate in Ireland in August 2001. There was a slight increase in the employment of mothers and fathers (about 5%) between baseline and follow-up in May 2001.
- the vast majority (90%) of families derive their income, either partly or wholly, from social welfare payments and the majority (78%) indicated that they have difficulty making ends meet. There was a slight reduction in social welfare dependency between baseline and follow-up in May 2001.
- the majority of fathers (82%) and mothers (77%) who live in the family home are in the semi-skilled or unskilled manual occupational categories, about four times higher than in Ireland.
- the vast majority (77%) of households live in accommodation which is rented from the local authority.
- the vast majority (86%) of families come from the settled community but a significant minority (14%) come from the Travelling community.
- two thirds of families (66%) are known to the Health Boards who, in turn, are a significant source of referrals to Springboard.

From these findings it can be stated that the population of Springboard families differs from the population of families in Ireland generally, in that one-parent households are over-represented by a factor of nearly four while two parent households are under-represented by a factor of nearly two; fathers who reside with their children are also under-represented by a factor of nearly four. The employment status of mothers is similar to that of mothers generally while the unemployment rate of fathers is ten times higher than the national average.

The vulnerability of these families is indicated by their high levels of dependency on social welfare, their weak socio-economic status, their difficulty in making ends meet, and the fact that many have already come to the attention of the Health Board. Although most are settled, Travellers are over-represented by a factor of 20 relative to their size in the national population. All of the signs are that these are relatively poor families and in need of family support services - exactly the intended target group of Springboard.

Our analysis noted that a modest improvement of about 5% took place in the employment status of mothers and fathers between baseline and the follow-up in May 2001, much of it due to a rise in part-time employment. This in turn had a modest impact in terms of reducing social welfare dependency. From the perspective of the evaluation, this improvement is likely to have made only a modest contribution to improvements in family well-being during this period, although we were unable to control for changes in family income. In other words, the economic situation of these families seems to have been relatively stable throughout the evaluation period, and changes in family well-being are therefore likely to be attributable to Springboard interventions.

4 Background Characteristics of Children

4.1 Introduction

This chapter describes the background characteristics of children who were clients of Springboard in the period between January 2000 (baseline) and May 2001 (follow-up). We begin by describing the age and sex of children attending Springboard projects in this period (section 4.2). We also examine the number and percentage of children who live or have lived inside and outside the family home (section 4.3). We examine the number of one- and two-parent households (section 4.4) and the amount of contact between non-resident fathers and their children (section 4.5). The percentage of children from settled and Traveller communities is then reported (section 4.6) as well as the range of problems experienced by children (section 4.7). The participation of children in school (section 4.8) and in out-of-school leisure activities (section 4.9) is also analysed. Staff assessment of the child's cooperativeness with the work of Springboard is also reported (section 4.10). Finally, there is a brief summary of the key findings of the chapter (section 4.11).

4.2 Age and Gender of Children

There is a higher percentage of boys (55%) than girls (45%) in Springboard (Table A4.1). The majority of children (61%) are in the 7-12 age group with one quarter in the 2-6 age group (25%) (Table A4.2). In other words, the majority of children are in the Primary School age group. The average age of children is 8.8 years and is younger in Barnardos projects (8.2) than in other projects (9.2).

4.3 Children In and Out of the Family Home

The vast majority of children (94%) were living in their family home when they first made contact with Springboard (Table A4.3). The small number of children (18, 6%) who were living away from their family home tended to be with family and friends (Table A4.4). However it is significant that nearly one fifth (49, 18%) of children have lived away from their family home at some time in the past (Table A4.5); this would not be the normal experience for the vast majority of Irish children.

4.4 Children in One- and Two-parent Households

We have already seen that more than five out of ten families live in one-parent households (see Chapter Three, section 3.2). It is consistent, therefore, that more than half (53%) of all children are living in one-parent households (Table A4.6). Similarly, just under half (47%) of children are living in two-parent households.

4.5 Contact with Non-resident Fathers

Given that more than half the children (55%) are not living with their biological father it is significant that nearly two thirds of these children (62%) still see their biological father with varying levels of frequency; equally significant, however, is the fact that more than one third (35%) never see their biological father (Table A4.7). Research in the UK suggests that contact between non-resident fathers and their children is increased when there is an amicable relationship with the child's mother and when the father is in employment, living close, has only one child and lives in a household without children[33].

4.6 Settled or Traveller

The vast majority (82%) of children, like families, come from the settled community (Table A4.8). A significant minority (18%) come from the Travelling community. In Ireland there are approximately 4,500 Traveller families[34]. This is equivalent to 0.7% of all families with children. In other words, Traveller children are significantly over-represented in Springboard projects - by a factor of 25 - relative to their share of the total population.

4.7 Strengths and Difficulties of Children

The strengths and difficulties of children were measured using the Strengths and Difficulties Questionnaire (SDQ). As explained in Chapter Two, this scale is completed by the child, the parent and the teacher and the results allow the child's well-being to be classified as "normal" (80% of the population), "borderline" (10% of the population) and "abnormal" (10% of the population). In our usage of this scale we have adhered to all of the standardised procedures but have altered the labels to refer to children who have "no problems" (normal), children who have "some problems" (borderline) and children who have "serious problems" (abnormal). In addition, the SDQ measures the effect of these symptoms on the burden caused to the child and others. Given the demonstrated validity and reliability of this measure we will use it in our assessment of the impact of Springboard on children (see Chapters Six and Seven below).

The results of the SDQ underline how the "problems" of children are perceived quite differently by the child, the parent and the teacher. In Springboard, children are least likely to see themselves as having problems with only one fifth (21%) reporting serious difficulties (Table A4.9). By contrast, parents and teachers report that nearly half the children (49% and 47% respectively) have serious difficulties. Equally, however, parents and teachers tend to experience the same children quite differently. Parents are more likely to see children as having serious problems in the areas of conduct, emotion and peer relations while teachers are more likely see hyperactivity[35] as a problem[36].

[33] Bradshaw, Stimson, Skinner and Williams, 1999a; 1999b.
[34] Department of Environment and Local Government, 1999.

The SDQ scores of parents and teachers point to a prevalence of serious problems among Springboard children which is five times higher than that found in the general population of children. That is probably to be expected given that Springboard is specifically targeted at vulnerable families and their children. Nevertheless, this raises the question as to why more than one third of the children (37% according to both parents and teachers) are reported as having no problems.

The SDQ scores of parents and teachers consistently rate boys as having more serious problems than girls (Table A4.10). According to parents and teachers, nearly five out of ten boys (49% and 47% compared to parents and teachers respectively) have serious problems compared to about four out of ten girls (41% and 37% respectively).

SDQ scores also vary by age but not in a simple pattern (Table A4.11). For parents, the proportion of children with serious difficulties decreases as children get older so that 53% of 2-6 year olds have serious difficulties compared to 38% of 13-16 year olds. For teachers, the reverse is the case: the proportion of children with serious difficulties increases as children get older so that 39% of 2-6 year olds have serious difficulties compared to 60% of 13-16 year olds. These findings highlight how the definition of a child's "problems" is highly dependent upon the personal and professional expectations of adults.

When we analysed age and sex together (see Table 4.1) we found that, in the pre-teen years, boys have more problems than girls but, in the teenage years, the pattern is reversed with girls having more problems than boys. This is in agreement with the international literature on the prevalence of difficulties among children[37]. In line with this, a study of about 2,000 Primary School children in Dublin in the early 1990s found that 16% had a clinically-significant psychological disorder with a much higher prevalence among boys than among girls[38]; by contrast, a study on nearly 800 sixteen year olds in the North Eastern Health Board region during 1996 found that 21% had a clinically significant psychological disorder with a much higher self-reported prevalence among girls than boys[39].

Table 4.1 Percent with Serious Difficulties (Parents' SDQ Scores) of Boys and Girls by Age

	Pre-Teenage (up to 12)		Teenage (13+)	
	Boys	Girls	Boys	Girls
% Serious Difficulties	58	23	29	42

[35] The proportion of children having serious hyperactivity problems is 44% according to parents and 49% according to teachers (Table A4.9). This does not constitute a diagnosis of ADHD (Attention Deficit Hyperactivity Disorder) although it is significant that 50% of all referrals to child psychiatry clinics in the US are for ADHD (see for example, McNicholas, 2000).

[36] In this analysis we tend to give somewhat greater credence to the SDQ scores of parents than of children or teachers because parents report a much higher level of difficulty than the children themselves and because parents are likely to have a more complete picture of their children's difficulties than teachers particularly when the average age of children in Springboard is 8.8 years. At the same time we are mindful that parents are not the only valid and reliable source of information on the well-being of children.

[37] See Verhulst, and Koot, 1992, Chapter Five.

[38] Fitzgerald and Jeffers, 1994.

[39] Lawlor and James, 2000.

4.8

Problems Experienced by Children

The most frequently-cited problems among children, according to staff, are behaviour problems and emotional problems (Table A4.12). Staff estimate that about half of all children have problems in one or both of these areas which are either fairly serious, serious or very serious. This is consistent with the analysis of SDQ scores in the previous section. In addition, staff estimate that nearly four out of ten children (37%) are experiencing emotional abuse while around one quarter are experiencing neglect (27%) and/or witness domestic violence (23%). One quarter of children (26%) also have problems with non-attendance at school. More than six out of ten children (62%) have two or more problems each although nearly one quarter (23%) are judged to have none (Table A4.13).

4.9

Schooling

The vast majority of children (82%) are at school and most of these (84%) are attending Primary School (Tables A4.14 and A4.15). This is clearly consistent with the fact that the majority of children are in the 7-12 age group. A small number of children (21, 7%) are not at school, having dropped out or experienced bullying etc. (Table A4.16).

4.10

Participation in Out-of-school Leisure Activities

The vast majority of children (66%) do not participate in organised out-of-school leisure activities (Table A4.17). The significance of this is difficult to interpret since it depends, to some extent at least, on the amount of organised leisure activities within the school and the participation of children in these activities. Although there are no national data on the participation of school-going children in sports and physical activities, it is known that more than nine out of ten 16-18 year olds in Ireland engage in sport, particularly soccer, basketball and swimming[40]. It is significant that, in the course of public consultation for the National Children's Strategy in 2000, which involved 2,488 children and young people, the "most pressing issue" raised by the children and young people was "the absence of leisure and recreation facilities and activities".[41]

4.11

Cooperativeness of Child

The vast majority of children (93%) are described by Springboard staff as either "very cooperative" or "cooperative" in terms of keeping appointments and participating in its activities (Table A4.18). A small minority (7%) were described as "uncooperative".

[40] Department of Education and Health Promotion Unit, 1996, p.17; see also Behaviour and Attitudes, 1999.
[41] National Children's Strategy, 2000, p.22.

4.12 Summary

Summary

This chapter described the background characteristics of children when they first made contact with Springboard. The key findings to emerge are:

- Springboard sees more boys (55%) than girls (45%).
- the majority of children (61%) are in the 7-12 age group with one quarter (25%) aged 2-6 years.
- the vast majority of children (94%) were living in their family home when they first came into contact with Springboard. However nearly one fifth (34, 17%) have lived away from home at some time in the past.
- just over half (53%) of all children are living in one-parent households; conversely, just under half (47%) are living in two-parent households.
- roughly half of the children (55%) are not living with their biological father. Nearly two thirds of these children (62%) see their biological father, but more than one third (35%) never see him.
- approximately half of all children, according to the SDQ scores of parents and teachers, have serious difficulties; this is five times higher than in the general population of children. Boys are more likely to have serious problems than girls. Parents experience older children as having less problems than younger children.
- in the opinion of staff, about half of all children have emotional or behaviour problems and, perhaps related to this, nearly four in ten experience emotional abuse. Roughly one quarter experience neglect and/or witness domestic violence.
- the vast majority of children (82%) are at school and most of these (84%) are at Primary School; a significant minority of children (21, 7%) have dropped out of school.
- the majority of children (66%) do not participate in organised out-of-school activities.
- the vast majority of children (93%) are cooperative with Springboard.

These results indicate that children using Springboard are mainly of Primary School age; despite their young age, there is already a 7% drop-out rate from school. One-parent households are over-represented by a factor of three. Despite the high level of non-resident fathers, two thirds of these fathers maintain some level of contact with their children. Children using Springboard are five times more likely than the general population of children to have serious difficulties, especially boys. A significant proportion of children are perceived by staff to experience emotional abuse and/or neglect and this, in conjunction with a low level of participation in out-of-school leisure activities, suggests that many Springboard children have relatively few fun activities in their lives. The vast majority of children are very cooperative with the work of Springboard. Despite their small numbers, Traveller children are significantly over-represented in Springboard. Overall these results provide clear evidence that Springboard, as intended, is well targeted at vulnerable children and families.

5 Springboard Interventions with Children

5.1 Introduction

This chapter describes the interventions undertaken by Springboard with children. The analysis begins by looking at the overall duration of interventions as measured by the total number of weeks during which the child attended the projects (section 5.2). This is followed by an overview of the interventions undertaken with these children (section 5.3). A more detailed description of each intervention is offered in sections 5.4 to 5.8. Since Springboard is typically only one of the agencies involved with each child and family, the chapter also lists the number of other agencies involved (section 5.9). Finally there is a brief summary in section 5.10.

5.2 Duration of Intervention

Most of the children (64%) have been attending Springboard for 6-18 months (Table A5.1). The average attendance is 46 weeks, which is nearly a year. This is similar to the mean number of weeks (48) attended by parents.

5.3 Overview of Interventions

Table 5.1 summarises the total number of hours devoted to each type of intervention. This reveals that each child received an average input of 103 hours from Springboard staff in the period between first contact and May 2001; this is a good deal more than the average amount of time devoted to each parent (82 hours). On a weekly basis, this is equivalent to 2.2 hours per week, compared to 1.7 hours per parent per week.

Source: Compiled from Table A5.2 (Individual Work), Table A5.3 (Group Work), Table A5.4 (Family Work), Table A5.5 (Drop-In Work), Table A5.6 (Administration) and Table A5.7 (Total). Total and Mean Hours were estimated by taking the mid-points of the categories 1-2 hours and 2-4 hours, and by assuming that a day workshop lasts for 6 hours and a weekend workshop for 12 hours.

Group work is the main form of intervention with children and absorbed 41% of staff time in the period to May 2001; by contrast, the main form of intervention with parents is individual work. Family work (16%), individual work (11%), and drop-in (10%) each received a relatively small proportion of staff time with children. On average, the administration of the caseload of children absorbed less than one quarter (22%) of all staff time, this being the time required to organise meetings, liase with other agencies, write notes, letters and reports, process referrals, assemble evaluation data, etc.

Table 5.1 Hours of Intervention with Each Child

Interventions	Mean Hours	
	N	%
1. Individual Work	12	11
2. Group Work	42	41
3. Family Work	17	16
4. Drop-in	10	10
5. Administration	22	22
Total	103	100

5.4 Individual Work

Individual work typically involves one-to-one sessions with the child for the purpose of assessing needs and meeting therapeutic goals. This intervention absorbed 11% of total intervention time and amounted to an average of 12 hours per child. The main types of individual work, according to staff, are one-to-one talking, counselling and helping, arts, crafts and outings, as well as after-school activities (Table A5.8).

5.5 Group Work

Group Work

Group work refers to interventions with groups and typically involves either focused sessions for the purpose of meeting therapeutic goals or activity-based programmes for the purpose of acquiring life skills and developing support networks. This intervention absorbed 41% of total intervention time and amounted to an average of 42 hours per child. The main types of group work, according to staff, were arts, crafts and outings, as well as after-school activities with a focus on personal development and social skills (Table A5.9).

5.6 Family Work

Family Work

Family work usually involves sessions with two or more members of the family for the purpose of assessing needs and meeting therapeutic goals. This intervention absorbed 16% of total intervention time and amounted to an average of 17 hours per child. The main types of family work, according to staff, were family meetings and outings as well as general support and encouragement to address family issues (Table A5.10).

5.7 Drop-in

Drop-in

Drop-in is where the child visits the centre and engages in unstructured activities such as meeting others, participating in recreational activities and generally having fun. This intervention absorbed 10% of total intervention time and amounted to an average of 10 hours per child. The main types of drop-in, according to staff, were listening and talking, offering information and advice, providing a play-room as well as dropping into the child's home for a visit (Table A5.11).

5.8

Administration

Administration

Administration is a crucial ingredient in the work of Springboard because it is the mechanism by which inter-agency responses and interventions are planned, organised and delivered. This typically absorbs time in organising meetings, writing notes, letters and reports, processing referrals, completing evaluation forms, etc. This work absorbed 22% of total intervention time and amounted to an average of 22 hours per child.

5.9

Other Agencies Involved

Other Agencies Involved

Springboard might be described as "a service without walls" in the sense that it is expected to provide a co-ordinated and integrated response to the needs of children, parents and families by drawing upon the resources of all relevant agencies. This approach requires sensitivity to ensure that families are not inundated by agencies on the one hand, and that they receive all the agency support they need, on the other. About eight in ten (78%) Springboard children are involved with other agencies, the two main ones being schools (53% of cases) and Health Board Social Workers (41% of cases) (Tables A5.12 and A5.13). In a significant minority of cases there is also involvement by youth services (31%), neighbourhood youth projects (19%) and child psychiatric services (19%). Apart from Springboard, there was no other agency involved with a fifth (22%) of the children.

5.10

Summary

Summary

On average, children have been attending Springboard for 46 weeks. Staff in Springboard spent an average of 103 hours on each child in the period up to May 2001 which is equivalent to an average of 2.2 hours per child per week. The main form of intervention with children is group work, which absorbed 41% of total intervention time. Other forms of intervention included individual work (which absorbed 11% of total intervention time), family work (which absorbed 16% of total intervention time), drop-in work (which absorbed 10%) and administration (which absorbed 22%). In addition to Springboard, other agencies were involved with nearly eight out of ten children, the two main ones being schools (53% of cases) and Health Board Social Workers (41% of cases).

These results suggest that Springboard has worked intensively with children and has involved other agencies in that work. Projects devote more time to children than to parents and the preferred style of intervention with children is group work compared to individual work with parents. The crucial question in the present context is whether the interventions of Springboard staff, as measured by the amount of time spent on each child, makes any difference to the well-being of those children. In order to answer this question we must first identify the changes experienced by children (which is the theme of Chapter Six - the next chapter) and then analyse the link between those changes and the amount of time spent by Springboard staff (which is the theme of Chapter Seven - the following chapter). We now address each of these questions in turn.

6 Changes Experienced by Children

6.1 Introduction

This chapter describes some of the changes that were observed in children's attributes and behaviour in the period between January 2000 (baseline) and May 2001 (follow-up). This is done by comparing the baseline situation with the follow-up situation on a number of key variables. The main variable through which change is measured is the Strengths and Difficulties Questionnaire (SDQ), although other variables are also used, including school attendance, risks to the child as perceived by Health Boards and keeping out of trouble with the law. We report on changes in SDQ scores in sections 6.2 to 6.6, before describing other changes in sections 6.7 to 6.12. We end the chapter by summarising the overall impact in section 6.13.

6.2 Change in SDQ - Total Difficulties

The SDQ total difficulties score is computed by adding together scores on the sub-scales of this measure, with the exception of the pro-social scale. The extent of change can be seen by comparing the mean at baseline with the mean at follow-up. This is done in Table 6.1 and reveals that there was a significant reduction in mean SDQ scores, particularly according to the responses provided by parents[42], which indicates that a significant improvement took place over the period. This improvement is both statistically and clinically significant and involves all of the dimensions of the SDQ (conduct, hyperactivity, emotion, peer relations and prosocial behaviour) in approximately equal measure (see Tables A6.4 to A6.18). Because this improvement may be due to factors other than Springboard, the assessment of the impact of the intervention will be tackled separately in Chapter 7.

The extent of the clinical improvement can be measured by focusing on (1) improvements among children with serious difficulties only or (2) by focusing on all children who show any improvement in their difficulties (for example by moving from "serious difficulties" to "some difficulties" or from "some difficulties" to "no difficulties"). According to the first criterion, based on parents' SDQ scores, there were 135 children with serious difficulties at baseline and this fell to 103 children at follow-up, a reduction of 24% (Table A6.2). According to the second criterion, based again on parents' SDQ scores, 73 children showed an improvement between baseline and follow-up, an improvement of 26% (Table A6.2). In other words, there was a clinically-significant improvement in the SDQ scores of one quarter of all children between baseline and follow-up.

An interesting feature of the results in Table 6.1 is that children in Barnardos projects (according to the SDQ scores of teachers) improved by more than children in other projects while children in other projects (according to the SDQ scores of parents) improved by more than children in Barnardos projects. This reflects the fact that parents and professionals often differ in their perceptions of a child's well-being, a fact for which further evidence is adduced in Chapter 7.

[42] In this analysis we tend to give somewhat greater credence to the SDQ scores of parents than of children or teachers because parents report a much higher level of difficulty than the children themselves and because parents are likely to have a more complete picture of their children's difficulties than teachers particularly when the average age of children in Springboard is 8.8 years. At the same time we are mindful that parents are not the only valid and reliable source of information on the well-being of children.

Table 6.1 Mean Scores on SDQ Total Difficulties at Baseline and Follow-up

SDQ Total Difficulties	Project Category	Baseline Score	Follow-up Score	Mean Change	SD* of Mean Change	P-value	N	Statistically Significant? (alpha = .05)
Parent Responses	Total	16.40	14.07	2.33	-5.79	0.000	282	Yes
	Barnardos	15.21	14.35	.86	-4.86	0.066	111	No
	Other	17.18	13.89	3.29	-6.14	0.000	171	Yes
Child (Self) Responses	Total	14.26	12.71	1.55	-5.64	0.004	115	Yes
	Barnardos	15.26	13.32	1.95	-4.29	0.063	19	No**
	Other	14.06	12.59	1.47	-5.88	0.016	96	Yes
Teacher Responses	Total	15.44	14.17	1.27	-8.38	0.030	206	Yes
	Barnardos	15.07	12.79	2.28	-8.85	0.033	71	Yes
	Other	15.64	14.90	.74	-8.10	0.290	135	No

*SD= Standard Deviation. **This is not statistically significant because of the small number of matched cases.
Note: Differences in means were tested using the paired-samples t-test (significance level based on two-tailed distribution) in SPSS V8.0 with listwise deletion of missing values. This procedure compares the means of two variables for a single group, computes the differences between values of the two variables for each case and tests whether the average differs from 0. The significance level depends on (a) the magnitude of the mean difference (b) the standard deviation of the mean difference and (c) the sample size. The larger the mean difference, the more likely this is to be statistically significant. The smaller the standard deviation of the mean difference, the more likely the mean difference is to be statistically significant. The larger the sample size, the more likely the mean difference is to be statistically significant (due to the higher power of the test).

A key question in this context is how the performance of Springboard compares to similar interventions with vulnerable children elsewhere. That question is not so easy to answer given the diversity of interventions that come under the rubric of family support services and the fact that all interventions with vulnerable families and children tend to be slower in making an impact when compared to interventions with the "average" child or family. This is clear from our review of research on the effectiveness of a wide range of interventions with vulnerable families[43]: "intervention is less effective where problems are severe (such as addiction, personality disorder), of long duration (such as prolonged abuse or neglect in childhood) and multiple (such as marital and parenting difficulties compounded by addiction)[44]. Other studies have shown that interventions in families where parents have difficulty managing difficult or aggressive behaviour in children tend to be less successful with families who are socially disadvantaged, socially isolated or face other forms of adversity such as problems experienced by the mother[45]". Clearly, all of these factors are relevant in assessing the relative performance of Springboard. We have not been able to identify evaluations of interventions that are directly comparable to Springboard in terms of their scope and standardised measurements, and are led to the view that Springboard itself might best be regarded as a benchmark

[43] McKeown, 2000:10
[44] See Bergin and Garfiled, 1994
[45] See Gough, 1999, 115; Vetere, 1999:153-155

against which the performance of other interventions with vulnerable children could be judged, particularly in an Irish context. Viewed from that perspective, Springboard appears in a quite favourable light when compared to the outcomes of interventions like the Early Start Pre-School Programme[46]. Overall therefore it is safe to conclude that the intervention of Springboard has had a positive impact on the children, a conclusion which is further reinforced in the subsequent sections of this chapter.

6.3 Change in SDQ - Amelioration of Problems

Change in SDQ - Amelioration of Problems

In addition to measuring changes in symptoms, the SDQ also measures changes in the way those symptoms are experienced by the child. This is done by asking if the child's problems are getting better, getting worse or staying the same. The answers to this question indicate that the impact of Springboard on the lives of children is perceived to be significantly greater than is indicated by change in their SDQ scores and symptoms. For example, more than half the children (55%) and more than four in ten parents (44%) believe that the child is "much better" since coming to Springboard. In general, the experience of improvement seems to vary inversely with the severity of the child's difficulties so that those with the most severe difficulties experienced the least improvement, in the opinion of children, parents and teachers (Table A6.2, A6.23, A6.24).

One explanation for the perceived improvement in children's problems since coming to Springboard - independently of changes in underlying symptoms - is that projects have encouraged a sense of hope among children, parents and teachers that problems can be overcome. This interpretation is consistent with research on the effectiveness of therapeutic interventions, which has identified hope as a key ingredient in helping clients to "mobilise their intrinsic energy, creativity and self-healing potential".[47] Another interpretation of the perceived improvement, particularly as reflected in the SDQ scores of parents, is that Springboard improves the support networks of parents (see Chapter Ten below), which in turn improves their parenting capacity and this may help them feel less isolated and therefore less burdened by their own and their children's difficulties.

6.4 Change in SDQ - Helpfulness of Project

Change in SDQ - Helpfulness of Project

The questionnaire also asked if the project was helpful to children in any other ways, such as providing information or making their problems more bearable. The results provide a strong indication that Springboard is perceived as helpful. The proportions who felt that Springboard helped either 'quite a lot' or 'a great deal' were 81% (according to the children), 81% (according to the parents) and 42% (according to the teachers) (Tables A6.25, A6.26, A6.27). Again, the perceived helpfulness of Springboard seems to vary inversely with the severity of the child's difficulties so that those

[46] Educational Research Centre, 1998; see also Kellaghan, 1977; Kellaghan and Greaney, 1992; Kellaghan, Weir, O'hUallachain and Morgan, 1995. Another Irish study of interventions with vulnerable families (see Moukaddem, Fitzgerald and Barry, 1998), albeit based on a very small population compared to that used in either Springboard or the Early Start Pre-School Programme, showed a more favourable performance than either of these interventions but this could not be regarded as a reliable benchmark in view of the small number of cases involved and the possibility of bias through the self-selection of those cases.

[47] Tallman and Bohart, 1999, p.100; see also Synder, Michael and Cheavens, 1999; Miller, Duncan and Hubble, 1997, Ch 5; McKeown, 2000, p.12.

with the most severe difficulties experienced Springboard as least helpful, in the opinion of children, parents and teachers (see Tables A6.28, A6.29 and A6.30).

The inverse relationships between the severity of children's problems and the perceived helpfulness of Springboard in ameliorating them draws attention to the challenge involved in addressing the needs of those children who experience, and are experienced as having, serious difficulties. Staff in Springboard respond to this challenge by devoting more time to children whose problems are more severe, as we shall see in the next chapter.

6.5 Change in SDQ - Burden to Child

Change in SDQ - Burden to Child

An important feature, indeed a strength, of the SDQ is its measurement of the extent to which symptoms upset or distress the child or interfere with everyday life in areas such as home, school, friends or leisure. This effect is typically experienced as a burden to the child and others and it is increasingly seen as important in clinical practice to take account of symptoms and the distress and impairment they cause. As Goodman has observed: "Because symptoms alone are not a good guide to the presence or absence of psychiatric disorder in childhood and adolescence, the current operational diagnostic criteria for most child psychiatric disorders stipulate that the diagnosis cannot be made unless the relevant symptoms result in the young person experiencing substantial distress or social impairment (American Psychiatric Association, 1994; World Health Organisation, 1994)"[48].

Table 6.2 Nature of Changes in SDQ - Burden to Child

SDQ Burden to Child	No Change %	Improvement %	Deterioration %
Child Scores	90	7	3
Parent Scores	66	28	6
Teacher Scores	60	28	12

Source: Tables A6.31, A6.32, A6.33.

The extent to which the child is burdened by his or her symptoms is measured on a four-point scale from 'not at all' or 'only a little' (which we describe as 'small burden'), to 'quite a lot' ('medium burden') and 'a great deal' ('large burden'). The changes which occurred between baseline and follow-up in May 2001 are summarised in Table 6.2 and show that more than one quarter (28%) of the children - in the perception of parents and teachers - experienced an improvement in the burden caused to themselves by their symptoms. As we have seen above, this is similar to the proportion of children whose symptoms have improved (section 6.2). Encouragingly, children with a large sense of burden were also more likely to experience a reduction in that burden between baseline and follow-up.

[48] Goodman, 1999, p.791.

6.6 Change in SDQ - Burden to Others

Change in SDQ - Burden to Others

In addition to measuring burden to the child, the SDQ also measures burden to others, by asking if the child's difficulties make it harder for those around him or her to cope (for example, for family, friends, teachers, etc.). The answers to this question are summarised in Table 6.3 and show that more than one third of children experienced a reduction in the burden to others caused by SDQ symptoms between baseline and follow-up.

Table 6.3 Composition of Change in SDQ - Burden to Others

SDQ Burden to Others	No Change %	Improvement %	Deterioration %
Child Scores	42	43	15
Parent Scores	34	41	25
Teacher Scores	47	33	20

Source: Tables A6.34, A6.35, A6.36.

6.7 Change in School Attendance

Change in School Attendance

School attendance is measured by comparing the number of days which the child actually attended with the number of days the child should have attended. In this way, the average percentage attendance at baseline and follow-up was calculated. The results indicate that the average attendance of Springboard children at baseline was 83%, rising to 84% at follow-up in May 2001 (Table A6.37). These figures highlight how serious is the problem of school attendance among Springboard children and how little it has changed since coming in contact with the projects despite a wide range of creative initiatives being used including breakfast clubs, homework clubs and other out-of-school activities. Given that the primary school year lasts for 183 days, an attendance rate of 84% means that the child misses 30 school days, equivalent to six weeks.[49] The seriousness of the school attendance problem among Springboard children does not seem to be reflected in the fact that only 17 of these children are known to have been contacted by a School Attendance Officer (Table A6.38) although this may be due to the fact that School Attendance Officers do not operate in many of these areas.

6.8 Change in Lateness for School

Change in Lateness for School

All teachers were asked to assess the frequency with which children arrived late to school both at baseline and at follow-up in May 2001. The results show that a substantial proportion of children (38%) experienced little change, while those who changed were equally likely to improve (31%) as to deteriorate (31%) (Table A6.39). In aggregate terms, therefore, there has been no change in terms of the number of children coming late to school.

[49] National data on school attendance in Ireland has not been published since 1983/84 when the average school attendance rate was 92% (Department of Education, 1994: 6).

Change in Coming to School Hungry

Teachers were also asked to assess, both at baseline and follow-up, the frequency with which children arrived at school hungry. Given that half of the children never came to school hungry at baseline, it is not surprising that the majority of them (60%) showed no change at follow-up while those who changed were marginally more likely to improve (22%) than to deteriorate (18%) (Table A6.40). In other words, there was a marginal improvement in this variable with fewer children arriving to school hungry over the intervention period. At the extreme, there were 20 children who, at baseline, were always or often hungry when arriving at school compared to 12 at the follow-up in May 2001.

6.9 Change in Coming to School Hungry

Change in Coming to School Without Lunch

Information was provided by teachers at both baseline and follow-up on whether children ever came to school without lunch. Given that half of the children never came to school without lunch, it is again not surprising that the majority (64%) showed little or no change, while those who changed were equally likely to improve (18%) as to deteriorate (18%) (Table A6.41). In aggregate terms therefore there has been no change in terms of the number of children coming to school without lunch.

6.10 Change in Coming to School Without Lunch

Change in Risk to the Child

One of the core objectives of Springboard is to reduce the risk to the child of being abused or going into care. In principle, this is a straightforward objective, but one that is notoriously difficult to measure in practice given the organisational, professional and personal factors which influence the definition of risk[50]. In this evaluation, Health Boards were asked to assess the risk to the child on a four-point scale: high risk, moderate risk, low risk, no risk.

Beginning with the risk of abuse, the majority of children (69%) were deemed to be at low or no risk when the baseline was completed. It is not surprising therefore that half the children (50%) showed no significant change in their risk of abuse. The remaining children, however, were nearly five times more likely to have a reduced risk (41%) than an increased risk (9%) in comparison with the baseline (Table A6.42). As a result, the proportion of children deemed by the Health Boards to be at moderate-to-high risk of abuse was halved while attending Springboard.

A similar pattern emerges in the Health Board's assessment of risk of going into care. Three quarters of all children (75%) were assessed as being at low or no risk of going into care when the baseline was completed. It is not surprising, therefore, that nearly six out of ten (58%) showed no change in this risk factor at follow-up in May 2001 (Table A6.43). Moreover, those children whose risk status changed were five times more likely to be assessed

6.11 Change in Risk to the Child

[50] See for example, Jacobs, Williams and Kapuscik, 1997; Whittaker, 1997; Rossi, 1992a; 1992b.

as reduced risk (35%) than increased risk (7%). As a result, the proportion of children deemed by the Health Boards to be at moderate-to-high risk of going into care was halved while attending Springboard. From a Health Board perspective, therefore, there was a decisive reduction in the risk of children being abused or going into care since coming in contact with Springboard.

6.12 Change in Trouble with the Law

Change in Trouble with the Law

Most of the children in Springboard are of an age - 86% are under 13 years (see Table A4.2) - where they are unlikely to get into trouble with the law. Nevertheless, the baseline data records nine children as having been cautioned by the Juvenile Liaison Officer at or before admission to the project. At the follow-up in May 2000, five of these had been cautioned again along with eight other children (Table A6.44). It would be unwise to draw any firm conclusions from such small numbers about the role of Springboard in preventing children from getting into trouble with the law.

It is recognised that measuring prevention is notoriously difficult since, in the absence of a control group, it is impossible to isolate the preventative effect of a programme like Springboard. In terms of arrests, two children were arrested at baseline and this rose to four at follow-up although the absolute numbers are clearly too small to draw conclusions (Table A6.45). It is clearly too early to assess the impact of Springboard on children's ability to keep out of trouble with the law, given their young age and the relatively small numbers who seem to be currently at risk.

6.13 Conclusion

Conclusion

This chapter described the main changes that have taken place in certain attributes and behaviours of children who participated in Springboard in the period between January 2000 and May 2001. This was done by comparing the baseline situation when contact was first made with Springboard with the follow-up situation in May 2001 on a number of key variables, most notably the Strengths and Difficulties Questionnaire (SDQ) and variables such as school attendance, risks to the child as perceived by Health Boards and keeping out of trouble with the law. The main results can now be summarised as follows:

- One quarter of all children (25%) showed clinically significant improvements in their SDQ symptoms while attending Springboard.
- More than half the children (55%) and more than four in ten parents (44%) believe the child's problems are "much better" since coming to Springboard.
- Springboard is perceived as helpful by more than eight out of ten children and parents.

- One quarter of parents and teachers believe the children are less burdened by their SDQ symptoms while about one third of them see the child as less burdensome to others.
- The average school attendance of children is 84% and has changed little since coming in contact with Springboard. In aggregate terms, there has been no change in the proportion of children coming late to school (at around 30%) or without lunch (at around 8%) although there has been an reduction in the number of children coming to school hungry (now at 7%).
- In the opinion of Health Boards, the proportion of children deemed to be at moderate-to-high risk of abuse or going into care was halved while attending Springboard, reflecting both objective changes in the well-being of children and the Health Board's confidence in Springboard's ability to manage these cases successfully.

These findings prompt three reflections. The first is that a clinically-significant improvement (understood as a shift from having "serious difficulties" to having "some difficulties" or from having "some difficulties" to having "no difficulties") has been experienced by one quarter of all children and, accordingly, the children are less burdened by their difficulties and are less burdensome to others. Perceptions that children's problems are "much better" are even higher than the clinically-significant improvements. A key question in this context is how the performance of Springboard compares to similar interventions with vulnerable children elsewhere. That question is not so easy to answer given the diversity of interventions that come under the rubric of family support services and the fact that all interventions with vulnerable families and children tend to be slower in making an impact when compared to interventions with the "average" child or family. This is clear from our review of research on the effectiveness of a wide range of interventions with vulnerable families[51]: "intervention is less effective where problems are severe (such as addiction, personality disorder), of long duration (such as prolonged abuse or neglect in childhood) and multiple (such as marital and parenting difficulties compounded by addiction)[52]. Other studies have shown that interventions in families where parents have difficulty managing difficult or aggressive behaviour in children tend to be less successful with families who are socially disadvantaged, socially isolated or face other forms of adversity such as problems experienced by the mother[53]". Clearly, all of these factors are relevant in assessing the relative performance of Springboard. We have not been able to identify evaluations of interventions that are directly comparable to Springboard in terms of their scope and standardised measurements, and are led to the view that Springboard itself might best be regarded as a benchmark against which the performance of other interventions with vulnerable children could be judged, particularly in an Irish context. Viewed from that perspective, Springboard appears in a quite favourable light when compared to the outcomes of interventions like the Early Start Pre-School Programme[54]. We are safe in concluding therefore that Springboard has had a positive impact on children and its achievements will serve as a benchmark

[51] McKeown, 2000:10
[52] See Bergin and Garfiled, 1994
[53] See Gough, 1999, 115; Vetere, 1999:153-155
[54] Educational Research Centre, 1998; see also Kellaghan, 1977; Kellaghan and Greaney, 1992; Kellaghan, Weir, O'hUallachain and Morgan, 1995. Another Irish study of interventions with vulnerable families (see Moukaddem, Fitzgerald and Barry, 1998), albeit based on a very small population compared to that used in either Springboard or the Early Start Pre-School Programme, showed a more favourable performance than either of these interventions but this could not be regarded as a reliable benchmark in view of the small number of cases involved and the possibility of bias through the self-selection of those cases.

against which the performance of other interventions with vulnerable children and families can subsequently be judged.

Second, a key element in the strategy underlying Springboard is to shift the emphasis of intervention with vulnerable families from child protection to family support. As a result, a key test for Springboard is its capacity to manage and improve the well-being of children who are deemed by the Health Boards to be at risk of abuse or even going into care. In this respect Springboard has been singularly successful with the result that, in the assessment of Health Boards, the number of children at moderate-to-high risk of being abused or going into care was halved. In this sense therefore, the strategy of addressing child protection concerns through the family support approach of Springboard is working well and points the way towards more effective and holistic form of intervention with vulnerable families.

Third, there has been very little improvement in the school-related aspects of children's lives according to the indicators that we have used. Many of the creative initiatives being used by Springboard to promote educational participation and attainment - breakfast clubs, homework clubs and other out-of-school activities - are likely to have a beneficial effect but do not seem to be impacting directly on school attendance. The average level of absenteeism from school is alarming and has changed little between January 2000 and May 2001. It should also be noted that the parents of these children are often early school leavers themselves (see Chapter 9 below) and the experience of many projects in Springboard is that some parents do not place a high value on their children's education. As a result, children are losing an average of 30 school days each year which, even without other forms of adversity in their lives, will be difficult to make up and will cumulatively impair them as they move into adult life. Similarly, there has been no change in the proportion of children coming late to school or even the proportion of children coming to school without lunch. These findings indicate that the school-related aspects of children's lives cannot be left solely to the pioneering interventions of Springboard but require a more focused approach by the schools themselves, working in tandem with parents and other agencies.

It is tempting to think of the changes, and sometimes lack of changes, described in this chapter as emanating entirely from Springboard. That would be unjustified since Springboard is only one of many influences on the lives of these children. Equally, however, it is appropriate to ask if Springboard has had any influence on the changes just described. That is the question which we address in the next chapter by focusing on child well-being as seen through the eyes of their parents.

7 Impact of Springboard on Children

7.1 Introduction

The main variable for measuring change in the well-being of Springboard children is the Strengths and Difficulties Questionnaire (SDQ). The analysis in the previous chapter indicated that about one quarter of all children showed significant improvements between January 2000 and May 2001, while a much higher proportion reported that the problems of children were "much better". It is necessary, therefore, to examine if these changes in the well-being of children can be traced to the influence of Springboard and to look more generally at the factors which influence children's difficulties. We do this by statistically analysing the influence of each variable on the SDQ so that a more complete picture can be built up of the factors which contribute to change in the lives of these children. By controlling for changes in family background, socio-economic context and other variables, we can reach more confident conclusions about the impact of Springboard. We begin therefore by describing the type of statistical analysis undertaken (section 7.2) and then present the results in three clusters of findings. First, we analyse the coherence and robustness of the SDQ and the items used to measure it (section 7.3). Second, we report on the factors which influence the SDQ, either directly or indirectly, at baseline and follow-up (section 7.4). Third, we report on the factors which do not influence SDQ (section 7.5). Finally, we briefly summarise the key findings (section 7.6).

7.2 The Statistical Analysis

We use a technique called Structural Equation Modelling[55] to analyse the impact of Springboard on the well-being of children. The Structural Equation Model uses regression equations to simultaneously estimate the association of each variable with a latent 'SDQ' variable at baseline ('SDQ' 1) and at first follow-up ('SDQ' 2). The sub-dimensions of the SDQ are treated as indicators for this latent variable, which allows us to control for measurement error. The strength of the relationships depicted in the model is measured by a standardised regression coefficient which expresses change in a common metric (standard deviation units); a coefficient between 0.0 and 0.25 indicates a small effect, between 0.25 and 0.5 a moderate effect, and above 0.5 a large effect. Positive regression coefficients indicate a direct relationship (i.e. high values on the first variable co-occur with high values on the second variable), whilst those with a minus sign before them indicate an inverse relationship. Because the regression coefficients are standardised they can be compared with each other. Each regression coefficient measures the impact of a given variable, controlling for all other variables which affect the outcome measure. The overall fit of the model to the data is estimated in Structural Equation Modelling using statistics which measure its 'goodness of fit' and are designed to test if the model provides an adequate representation of the data in statistical terms. A computer programme called EQS was used to estimate the model and calculate the coefficients.

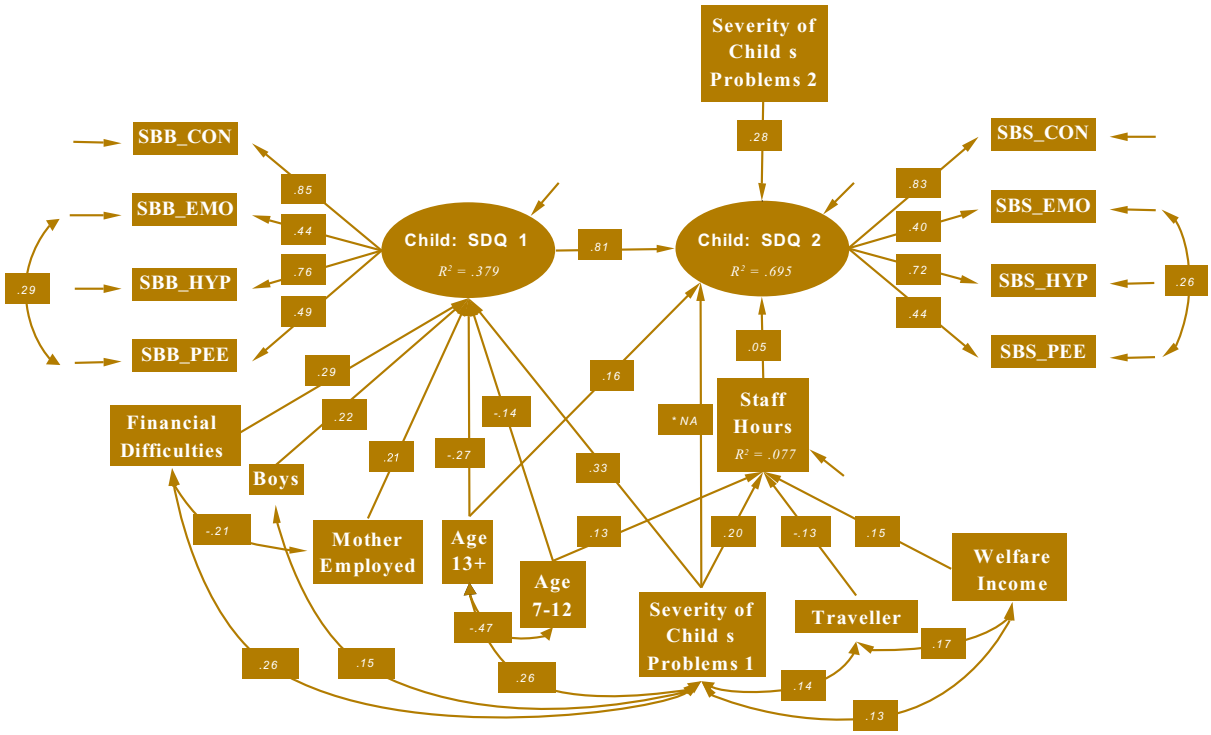
[55] See Kaplan, 2000.

One of the key advantages of this method of analysis is that it allows us to overcome the limitation of not having a control or comparison group; this limitation would otherwise prevent us from assessing the impact of Springboard. However this limitation can be overcome - at least in part - using Structural Equation Modelling, by controlling for the separate influence of a range of variables so that, for example, we estimate the impact of staff input hours on the SDQ while controlling for other influences on children's difficulties. In other words, we can estimate the impact of Springboard staff hours independently of the influence of any other variable. At the same time, the model examines the influence of a range of variables on the SDQ. In this way, it is possible to assess the extent to which changes in SDQ may be due to Springboard (as measured by staff input hours), other variables (such as changes in severity of child's problems, etc.), or indeed factors for which there is currently no information in the evaluation system (measured by the 'error' or 'disturbance' term).

Structural Equation Models draw on the a priori hypotheses of the researcher, and provide strong statistical tests of the adequacy of those ideas. Therefore, we begin by constructing a theoretical 'map' of the complex relationships between the variables in the model, including 'measurement' and 'structural' components. We then assess the 'goodness of fit' of the model and, if this is deemed acceptable, proceed to interpret the coefficients estimated from the data. Although the structure of the models reported on here was determined in a priori fashion, "modification indices" were used to obtain a parsimonious structure of correlations between exogenous variables; variables which had no significant effects were excluded from the model. This procedure was necessary due to the large number of explanatory variables considered. Although this process may have 'capitalised on chance' (in the sense that the model was progressively refined), the changes introduced were confined to relatively 'peripheral' components of the model.

The results of Structural Equation Models may be presented graphically in the form of a path diagram, so-called because the diagram traces the path of influence of each variable. The full path diagram for the first model is presented in Figure 7.1a and an abbreviated format is presented in Figure 7.1b.

Figure 7.1a Full Path Diagram Showing Factors Which Influence the Impact of Springboard on the Strengths and Difficulties (SDQ) of Children



Notes:

1. SDQ data is based on parents' responses to the SDQ questionnaire about child's symptoms.
2. All coefficients are standardised and all effects are statistically significant, with the exception of the direct programme impact of Springboard, which is not significant.
3. Equality constraints were placed on the factor loadings and error variances of equivalent indicators of the SDQ over time. This helps to ensure that the meaning of the latent variable (i.e. 'SDQ' 1 and 'SDQ' 2) remains constant.
4. Correlations were specified between the error terms of equivalent indicators over time, due to their specific similarity, but these are not shown in the graph.
5. Correlations were specified between the 'Peer Relations' and 'Emotional Symptoms' subscales, as these were found to have a particularly close association during the analysis of data from the first follow-up; only two of these correlations are shown in the diagram.
6. The coefficient marked "*NA" was excluded because it is not directly interpretable, and functions within the model as a statistical control which enables us to assess the effect of changes in the severity of children's problems on the 'SDQ'.

A number of graphical conventions are used in the path diagram which need to be borne in mind in order to interpret it correctly:

- causal relationships are represented by straight arrows pointing from cause to effect, and these arrows correspond to regression coefficients in the statistical model. The standardised regression coefficients are provided for each relationship.
- observed variables are shown as rectangles containing the names of the variables (such as SBP_CON1, in the upper left-hand corner of the diagram) and latent variables are depicted as ellipses (such as 'SDQ' 1 and 'SDQ' 2).
- curved, two-headed arrows represent correlations between variables, and the strength of the correlations is indicated by a standardised coefficient. Correlations do not imply a causal relationship between the variables concerned, but merely indicate that their values tend to co-vary in a systematic manner.
- error variances (for observed variables) or disturbance terms (for latent variables) are indicated by straight arrows pointing at a single variable and represent the variance in that variable not accounted for by the causal factors included in the model.
- the goodness of fit is estimated for each model; in Figure 7.1a this is high because the CFI coefficient exceeds 0.95 (the precise value is .97) and the RMSEA is below .05 (.033 to be exact), widely-accepted criteria for good model fit. This means that no important relationships between the variables in the model have been omitted from the model.

In the following three sections, we will analyse the substantive results arising from the model.

7.3 Coherence of SDQ

Coherence of SDQ

A core assumption about the SDQ is that it measures something fundamental or 'latent' in each child that might be called well-being or functioning; correspondingly, the four dimensions which make up the SDQ total difficulties score measure different facets of this fundamental latent concept (pro-social attitudes are excluded in the calculation of total difficulties in SDQ). We tested this assumption using factor analysis on the parents' responses; the results based on children's and teachers' responses are not included here but are similar to the parents' results[56]. These results, as displayed in Figure 7.1a, indicate that the four dimensions of conduct, emotions, hyperactivity and peer relations have a moderate to strong statistical relationship with the 'SDQ' both at baseline ('SDQ' 1) and first follow-up ('SDQ' 2). Conduct and hyperactivity have particularly strong associations with SDQ, thus indicating that these items capture most accurately the latent qualities of the SDQ. We can be confident therefore that SDQ is a statistically robust scale in terms of validity and reliability as indeed studies elsewhere have found[57]. At baseline ('SDQ' 1), the four indicator variables had a mean factor loading of 0.64 and at follow-up ('SDQ' 2) the mean factor loading was 0.60, which implies that this measure

[56] In this analysis we tend to give somewhat greater credence to the SDQ scores of parents than of children or teachers because parents report a much higher level of difficulty than the children themselves and because parents are likely to have a more complete picture of their children's difficulties than teachers particularly when the average age of children in Springboard is 8.8 years. At the same time we are mindful that parents are not the only valid and reliable source of information on the well-being of children.

[57] See Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

has strong internal coherence. However, Figure 7.1a shows that emotional symptoms and peer relations have a specific similarity which goes beyond the SDQ, but this does not compromise the measurement qualities of the index.

An important feature - indeed a strength - of the SDQ is its measurement of the extent to which symptoms upset or distress the child or interfere with everyday life in areas such as home, school, friends or leisure. When conducting preliminary analyses, we estimated models for SDQ burden (as measured by Q5, Q6 and Q7 in the questionnaire) as well as SDQ symptoms. There were no significant differences in the results of these analyses, so we will therefore confine our attention to the objective measure of child well-being provided by the SDQ.

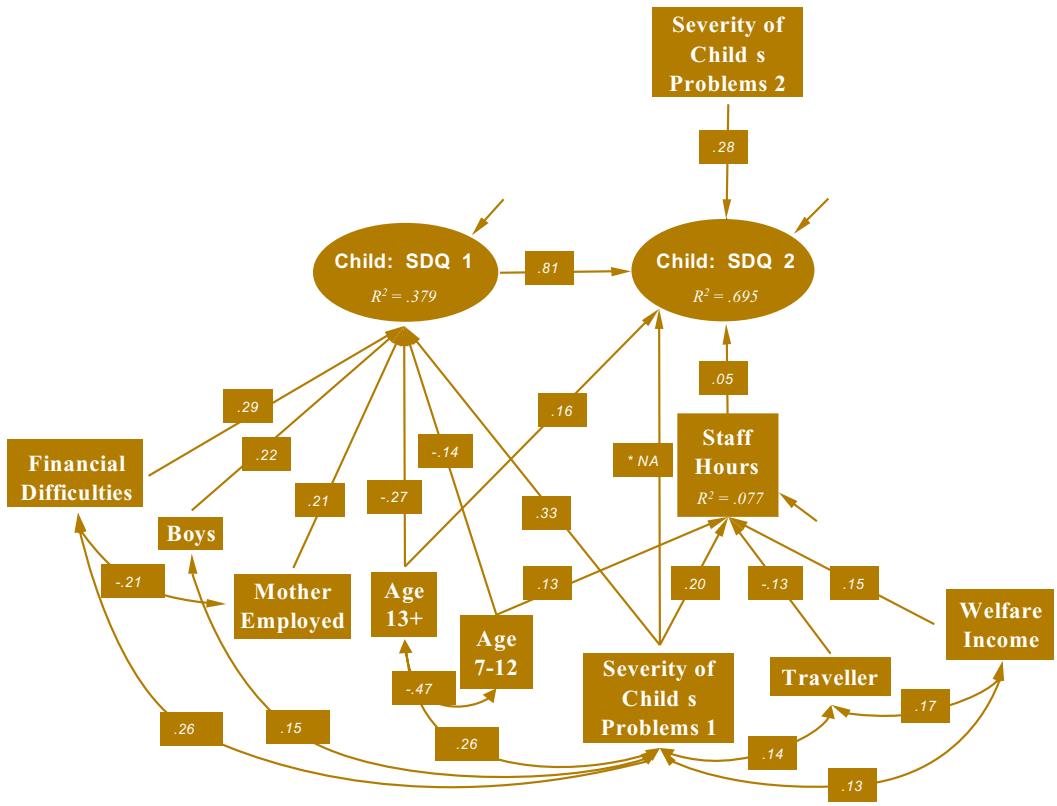
7.4

What Factors Influence Children's Well-being?

What Factors Influence Children's Well-being?

The key results of the statistical analysis are presented in abbreviated form in Figure 7.1b and the remainder of the chapter makes reference to this diagram. Six key findings emerge, and will be discussed in the following paragraphs.

Figure 7.1b Abbreviated Path Diagram Showing Factors Which Influence the Impact of Springboard on Children's Strengths and Difficulties (SDQ)



7.41

Stability of SDQ Scores

Stability of SDQ Scores

The main influence on a child's well-being at follow-up ('SDQ' 2) is the child's well-being at baseline ('SDQ' 1). This is a very strong association (+0.8), indicating that the attributes and behaviours in question are highly stable. No comparable data is available from elsewhere about the stability of children's difficulties. In practice this means that the forces for stability - even when the stable condition in question may not be indicative of well-being - are often greater than the forces for change.

7.42

Influence of Springboard

Influence of Springboard

The amount of hours spent by Springboard on each child had no influence on the change in child well-being (i.e. on 'SDQ' 2, controlling for 'SDQ' 1). The regression coefficient (+0.05) is statistically indistinguishable from zero. A similar result emerged from the evaluation of Westside Neighbourhood Youth Project in Galway, which found no relationship between "levels of self-esteem and involvement with the project"[58], although perceptions of the project by children, parents, staff and referrers were quite positive. This is a challenging finding and suggests that time does not accurately reflect other dimensions of Springboard's intervention such as the skills and approach of staff, the model of intervention used as well as the characteristics, perceptions and hopefulness which clients themselves bring to their encounter with Springboard.

7.43

Severity of Children's Problems

Severity of Children's Problems

The severity of problems experienced by the child - notably abuse, neglect, family violence, anti-social behaviour, not attending school, etc, as assessed by Springboard staff - has a moderate influence (+0.33) on children's difficulties at baseline ('SDQ' 1). Changes in the severity of problems had a moderate effect on changes in well-being between baseline and follow-up ('SDQ' 2) (+0.28). In other words, children with more severe problems when they first came in contact with Springboard had higher SDQ scores and, to the extent that their problems deteriorated, their well-being also disimproved. We saw in Chapter Four that at least one third of children experience some form of abuse or neglect. This finding confirms what is already well-known, namely that addressing the underlying problems of abuse and neglect in the child's life is essential to improving their well-being. Further inspection of the "severity of child's problems" variable reveals a number of interesting associations. For example, boys are more likely to have severe problems than girls (+0.15) and to have higher SDQ scores (+0.22) (see Chapter Four above for a discussion of the interaction of age and sex in the determination of SDQ scores). Older children (i.e. 13 years and over) are likely to have more severe problems than younger children (+0.26) even though it is younger children who present as having higher SDQ scores. This somewhat paradoxical finding may be explained by the fact that SDQ scores are based on the parents' perceptions whereas the severity of child's problems are based on staff perceptions and it is possible that parents may come to see as normal what Springboard staff see as a severe problem. Traveller children

[58] Canavan and Dolan, 2000, p.131.

present as having more severe problems than other children but they tend to receive less staff time than other children; this needs to be seen in the context that projects experience particular difficulties engaging Traveller families and interventions are sometimes interrupted because these families move home more frequently than settled families. When the characteristics of parents are taken into account, it emerges that children who experience severe problems of abuse, neglect and so on, are more likely to have parents who have financial difficulties in making ends meet (+0.26) and are wholly dependent on social welfare income (+0.13), a finding which suggests that the objective and subjective aspects of poverty both diminish the well-being of children.

Mothers' Employment

7.4.4

Mothers' Employment

The children of employed mothers tend to have greater difficulties ('SDQ'1) than the children of full-time mothers (+0.21), although employed mothers are also less likely to have financial difficulties than full-time mothers (-0.21) which, as we have just seen, has an ameliorative effect on the severity of child's problems (+0.26) and on children's difficulties (+0.29). This result underlines the importance of employment (see Chapter Three above) to the well-being of mothers but also indicates the threat which employment holds to the well-being of their children, possibly because of inadequate childcare while the mother is at work or because the child's existing difficulties make separation from the mother even more difficult. It may well be that the overall net effect of mother's employment on the well-being of children is positive but this cannot be automatically assumed in the light of this finding. It is significant that a similar finding emerged from a recent longitudinal study, based on data from the British Household Panel Survey, which found that, after controlling for factors such as parents' education, occupation and family type, the longer mothers spent in employment while their children were aged one to five years, the poorer those children's subsequent educational attainment and the higher their risk of unemployment and psychological stress when they reached the age of 20 years and over; interestingly, the same study also found that father's employment during this stage of their children's lives had much less impact and it tended to be in the opposite direction to mothers with longer periods of father's employment being associated with reduced risk of economic inactivity and psychological stress although also associated with reduced educational outcomes[59]. Another recent British study has come up with the same result[60] although there is less consensus from the findings of American studies[61]. This is an issue which merits careful consideration not only within Springboard - where 41% of mothers are in employment, mainly part-time (see Chapter Three) - but within Ireland more generally, given that the emphasis in public policy on increasing the participation of mothers in the workforce is not always matched by an equal emphasis on the provision of adequate and affordable childcare. In view of this finding, it is salutary to remember that, of all women in the labour force (42%), the group with the highest participation is that of lone mothers with child(ren) under 15 (52%) followed by married women with child(ren) under 15 (49%)[62]. Among Springboard families, the circumstances surrounding the employment of mothers can pose complex trade-offs between family members and between different aspects of the 'family system'.

[59] Ermisch and Francesconi, 2001.
[60] Joshi and Verropoulou, 2000.
[61] Haveman and Wolfe, 1995; Baydar and Brooks-Gunn, 1991; Belsky and Eggebeen, 1991.
[62] See McKeown and Sweeney, 2001:26, Box 15.

7.45

Influences on Staff Time

Influences on Staff Time

A number of factors influence the amount of time received by each child. The most important is the severity of the child's problems at the time of first contact with Springboard: the more severe the problems as assessed by staff the more time they receive (+0.20). Paradoxically, Traveller children receive less time than other children (-0.13), although there is a tendency for staff to assess their problems as being more severe (+0.14). The children of parents who are wholly dependent on social welfare tend to receive more staff time than other children (+0.15) which is consistent with the fact that these children also have more severe problems (+0.13). On balance, therefore, it would appear that staff time is allocated on the basis of need.

7.46

Other Variables

Other Variables

A number of additional relationships emerged from the analysis as being statistically significant but for reasons of space are not included in Figures 7.1a and 7.1b. For example, there is a strong inverse relationship (-0.58) between mothers in employment and social welfare dependency and a moderate association (+0.37) between social welfare dependency and financial difficulties which again points to the role of employment in promoting the well-being of mothers. Financial difficulties were also found to be associated with being a Traveller (+0.23). The analysis also revealed that children attending Barnardos projects improved less (according to the SDQ scores of their parents though not of their teachers) than children in other projects (+0.14) which is in line with the analysis of changes in mean SDQ scores above (see Chapter Six).

7.5

What Factors Do Not Influence SDQ?

What Factors Do Not Influence SDQ?

The results in Figure 7.1b are significant, not just because of the factors which are included but also because of the factors which, because they are not significant, are excluded. Detailed statistical analyses were carried out to estimate the influence of a range of variables on children's well-being at baseline and on the changes which occurred between baseline and follow-up. The other variables which we tested and found not to have a statistically-significant effect are as follows:

- children's difficulties are highly stable and do not appear to change easily or quickly.
- the amount of hours spent by Springboard staff on each did not have a satatistically-significant infulence on choldren's well-being.
- child's participation in organised out-of-school activities
- number of parents in household
- frequency of contact with non-resident father
- employment of father
- severity of parents' problems
- family known to the Health Board
- parents' support network
- number of agencies involved.

7.6

Summary and Conclusion

Summary and Conclusion

This chapter used Structural Equation Modelling to analyse the factors which influence the SDQ, this being the main impact variable for measuring change in the well-being of Springboard children. The results of the analysis show that SDQ is a robust measure in terms of validity and reliability and this adds to the confidence generated by other studies[63], that it is a strong measure of child functioning and well-being. The key findings to emerge from the analysis are as follows:

- children's difficulties are highly stable and do not appear to change easily or quickly.
- the amount of hours spent by Springboard staff on each child did not have a statistically-significant influence on children's well-being.
- the severity of problems experienced by the child - notably abuse, neglect, family violence, anti-social behaviour, not attending school, etc, - influences children's difficulties as well as changes in difficulties between baseline and follow-up; children who experience severe problems are more likely to have parents with financial difficulties and who are wholly dependent on social welfare income, a finding which suggests that deficits in the family's relational and material well-being diminish the child's well-being.
- the children of employed mothers tend to have greater difficulties than the children of full-time mothers, although employed mothers also have less financial difficulties.
- the amount of staff time received by each child is influenced by the severity of the child's problems although, paradoxically, Traveller children received less time despite having more severe problems. Children whose parents are wholly dependent on social welfare tend to receive more staff time than other children.

These results have several implications. First, they indicate that if the role of Springboard is measured by the amount of staff time spent on each child then it has had no role in bringing about the improvements in child well-being which we have documented (see Chapter Six). This is a particularly challenging finding given that, over a period of 48 weeks, each child received an average of 2.2 staff hours per week. However, it is possible that staff time does not accurately reflect the way in which Springboard intervenes with children. For example, unstructured 'play' activities and informal interactions with staff members may have a greater impact on children than scheduled 'interventions'. After all, Springboard was perceived by children, parents and teachers as helpful and is described as bringing about improvements in children's problems (see Chapter Six above). Springboard is also experienced by children and parents as offering a service which is better than any other service (see Chapter Fourteen below). Finally, the employment situation of these families changed little between January 2000 and May 2001 (see Chapter three above). It seems reasonable, therefore, to conclude that Springboard made a positive contribution to the lives of these children although we have been unable to identify the precise way through which the input of staff made that impact.

The results of this analysis serve to underline the importance of adopting a "system" or "strengths"[64] perspective to understanding changes in the well-

[63] See Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

being of children and the importance of client characteristics and strengths in bringing about change. We know from other research that the two main influences in bringing about therapeutic change are client characteristics (40% of change) and the therapeutic relationship (30% of change)[65]. In light of these results, it is clear that more sensitive measures of the therapeutic relationship are required in subsequent evaluations. Equally, however, it is clear from our analysis that changes in client characteristics - particularly reductions in the severity of problems such as abuse, neglect, family violence, not attending school, etc. - are central to improving child well-being.

Second, the strength of the association between SDQ scores at baseline and follow-up indicates that there is no 'quick-fix' solution to the problems of children, particularly children in vulnerable families who have serious problems. In other words, the forces for stability - even when the stable condition in question may not be indicative of well-being - are often greater than the forces for change. This is probably obvious to most people, but there is often a presumption that new initiatives like Springboard can solve problems that others have found intractable. It is clear from the results analysed here that children with serious problems cannot expect a 'miracle cure'. This is in line with the known impacts of other interventions with children both in Ireland[66] and elsewhere[67].

Third, the analysis suggests that poverty - both in objective terms (as measured by social welfare dependency) and in subjective terms (as measured by financial difficulties in making ends meet) - increases the severity of children's problems. At the same time, one of the routes out of poverty, through the employment of mothers for example, is not without its dilemmas. This arises because the children of employed mothers tend to have more difficulties (according to their SDQ scores) than the children of full-time mothers. On the other hand, employed mothers also have fewer financial difficulties than full-time mothers, which helps to reduce the severity of their children's problems. The reason for the negative effect of mother's employment - which is mainly part-time - on child well-being may be due to inadequate childcare while the mother is at work or because the child's existing difficulties make separation from the mother even more difficult. These results are consistent with a recent longitudinal study, based on data from the British Household Panel Survey, which found that, after controlling for factors such as parents' education, occupation and family type, the longer mothers spent in employment while their children were aged one to five years, the poorer those children's subsequent educational attainment and the higher their risk of unemployment and psychological stress when they reached the age of 20 years and over; interestingly, the same study also found that father's employment during this stage of their children's lives had much less impact and it tended to be in the opposite direction to mothers with longer periods of father's employment being associated with reduced risk of economic inactivity and psychological stress although also associated with reduced educational outcomes[68]. Another recent British study has come up with the same result[69] although there is considerably less consensus from the findings of American studies[70]. This is an issue which merits careful consideration not only within Springboard but

[64] Saleeby, 1992; 1996; 2000.
[65] For a review, see McKeown, 2000, pp.7-16.
[66] Kellaghan, 1977; Kellaghan and Greaney, 1992; Educational Research Centre, 1998; see also Kellaghan, Weir, O'hUallachain and Morgan, 1995.
[67] Hill, 1999; Hellinckz, Colton, and Williams, 1997.
[68] Ermisch and Francesconi, 2001.
[69] Joshi and Verropoulou, 2000.

also in a national framework, given that the emphasis in public policy on increasing the participation of mothers (and fathers) in the workforce is not always matched by an equal emphasis on safeguarding the well-being of children. In view of this finding, it is salutary to remember that, of all women in the labour force, the group with the highest participation is that of lone mothers with child(ren) under 15 (52%), followed by married women with child(ren) under 15 (49%)[71].

Fourth, the results highlight how the definition of a "child with problems" is heavily dependent on one's perspective. In this chapter we have seen how parents see younger children as more likely to have severe problems even though Springboard staff assess older children as more likely to have severe problems. Similarly, in the previous chapter, we saw that teachers assessed older children as having more problems while parents saw younger children as having more problems (see Chapter Six above). These somewhat paradoxical findings seem to arise from the different perceptions of parents and professionals as to what is "normal" for children and are indicative of the complex issues which arise when intervening with families, even at the point of assessing the needs and difficulties of children.

Fifth, our analysis revealed that Traveller children present as having more severe problems than other children, although they tend to receive less staff time than other children. However this needs to be seen in the context that projects experience particular difficulties engaging Traveller families and interventions are sometimes interrupted because these families move home more frequently than settled families. This suggests that there may be a role for training to help staff gain a better understanding of Traveller culture and the issues entailed when intervening in Traveller families.

[70] Haveman and Wolfe, 1995; Baydar and Brooks-Gunn, 1991; Belsky and Eggebeen, 1991.
[71] See McKeown and Sweeney, 2001:26, Box 15.

8 Case Studies of Most Improved Children

8.1 Introduction

As part of the evaluation, each project prepared a case study on the most improved child. The purpose of the case studies, which are synthesised in this chapter, is to provide an insight into the life of each child and the difficulties they encounter, and to illustrate the improvements which they experienced since attending Springboard. In this way it is hoped to deepen our understanding of the change process within Springboard and throw further light on the statistical patterns identified in the previous chapters. Our analysis begins with a comparison of the most improved children in the case studies with the general population of Springboard children (section 8.2). We then discuss the key themes around which the case studies were written: reasons why the case was chosen (section 8.3), brief description of child and family (section 8.4), objectives of intervention (section 8.5), description of interventions, including ideas and models of practice used (section 8.6), outcomes (section 8.7), obstacles to change (section 8.8), project learning (section 8.9), time spent on case (section 8.10) and case management (section 8.11). We conclude (section 8.12) by drawing out some more general implications from the case studies.

8.2 Profile of Most Improved Children

The children in the case studies range in age from 5 to 15 with an average age of about 10 years, slightly older that the average age of Springboard children which is about 9 years. The case studies have more boys than girls (79% compared to 21%) which is quite different to the total population of Springboard children (55% boys and 45% girls). The most improved children are more likely to come from households with only one parent (57%), similar to Springboard children generally (53%) and these are almost equally divided between parents who are single and those who are separated. The households in the case studies also tend to have a slightly larger number of children (4.1) than Springboard households generally (3.8).

In terms of scores on the Strengths and Difficulties Questionnaire (SDQ), children in the case studies began with much greater difficulties than the average child in Springboard but also made much more progress between the baseline and the second follow-up (Table 8.1). As a result, the most improved children now have less difficulties than the average child in Springboard. Thus the children in the case studies are, as intended, somewhat untypical of Springboard generally, but serve to reveal the true potential of this initiative when working at its most effective, since these children have improved dramatically relative to Springboard children generally, particularly in the eyes of their teachers and the children themselves.

Table 8.1 Mean Scores on SDQ Total Difficulties at Baseline and Follow-up in Total Springboard Population and Case Study Sample of Springboard Children

Mean SDQ Score Total Difficulties	Baseline		Follow-up		Change	
	Total*	Cases**	Total*	Cases**	Total*	Cases**
Child Scores	14.41	20.00	12.83	12.88	-1.58	-7.12
Parent Scores	16.51	18.75	14.01	13.50	-2.50	-5.25
Teacher Scores	15.72	20.30	14.11	12.30	-1.61	-8.00

*Total refers to the total population of Springboard children. **Cases refers to the most improved children in the case studies.

8.3

Reasons Why Cases Were Chosen

Reasons Why Cases Were Chosen

The reason why the child was chosen in most cases is due to the significant improvement in its SDQ scores, a fact which points to the reliability of the SDQ as a measure of the child's progress. In addition, cases were selected to illustrate how the project approaches its work, particularly the importance of working with parents and other family members, to bring about improvements for each child. Cases were also selected to show the importance of inter-agency work and the need to work at the "child's pace".

8.4

Presenting Problems of Child and Family

Presenting Problems of Child and Family

Most of the children exhibit a pattern of behaviour problems at home and at school involving angry outbursts and, perhaps because of this, they have difficulty making and sustaining friends. Some are bullied, fewer bully. They often appear unhappy, lacking in confidence and self-esteem and unable to express what is bothering them. Many of the children are under-performing at school due to poor concentration and hyperactivity. Among older children, there is evidence of getting into trouble with the law and using drugs and alcohol around the age of 15. The problems of two children - one with a school phobia and one with ADHD (Attention Deficit Hyperactivity Disorder) - seem to occur in families which present no functional problems.

Many of the parents are unable to cope with the problems which their children are presenting. Many also have, or have had, damaging relationships with the fathers of the children and this inhibits their parenting capacity, particularly when compounded by financial difficulties and overcrowding. Even in the two families where the child's problem seems unrelated to family functioning, the parents have great difficulty in coping with the demands of a child with difficulties. In many instances, parents and children feel isolated and unable to cope with their problems without outside assistance.

8.5 Objectives of Intervention

Objectives of Intervention

A key objective in all cases is to provide an opportunity for the child and the parent(s) to talk about the problems, to work out solutions and to find support in implementing those solutions. In many cases, the twin objectives of the intervention are to build up the child's self-esteem and confidence while also addressing behavioural and emotional problems through individual work. In addition, many projects have the objectives of giving the children positive experiences of group activities, increasing their involvement in leisure activities (thereby reducing the risk of involvement in drugs, alcohol and crime) and improving school attendance. These interventions are complemented with objectives to support the parents and strengthen the parent-child relationship.

8.6 Interventions, Ideas and Models of Practice Used

Interventions, Ideas and Models of Practice Used

All interventions are informed by the philosophy of being "strengths-based" and "solution-focused". The key elements which constitute the intervention in virtually every case involve:

- Individual work with the child through the medium of some activity (art, crafts, sensory work, etc) to address emotional and behaviour problems.
- Group work such as after-school clubs, summer programmes, sport and leisure activities, outings, etc. for the purpose of promoting social skills, reducing isolation and creating fun.
- Parent support through one-to-one discussion, home visits, practical help in setting family routines or housing maintenance as well as inclusion in group programmes for parents.
- Involving other agencies in the overall plan to support the child and parent(s), notably Social Workers, Psychologists and Teachers.
- Holding review meetings with parents and professionals to assess progress and adapt to changing needs.

These interventions are tailored to the unique circumstances of each case and usually involve a combination of centre-based and home-based work.

8.7 Outcomes

Outcomes

The outcomes of the intervention have already been summarised quantitatively in the SDQ scores (section 8.2 above). The case studies add a qualitative dimension to this by highlighting how the intervention of Springboard typically results in children presenting as happier, more self-confident, having more friends, attending and performing better at school, being more involved in leisure activities and having a better relationship with their parent(s). The original presenting problems - such as disruptive behaviour, anger management, hyperactivity, isolation from peers, difficulties at school - may not have disappeared entirely, but their debilitating effects have been significantly reduced through participating in

a broader network of peer and adult supports. This too tends to improve the well-being of parents who feel closer to their children and are better able to cope with their difficulties. These case studies serve to highlight the importance of support networks for the well-being of children, in the same way that support networks are also important to the well-being of adults.

8.8 Obstacles

Obstacles

The main obstacle in virtually every case is the reluctance of parents, and to a lesser extent children, to engage with the project. Many parents are slow to trust services and are fearful that their vulnerabilities may be exposed even to the point of losing their children. All of the projects successfully overcame this obstacle by allowing trust and confidence to build up over time and by allowing the intervention to proceed at a pace that suited the parent(s) and the child. A second obstacle encountered by some projects arose from conflict between parents which makes it difficult to keep both of them involved for the sake of the child. Each parent may also take a different approach to their child's problems which can be a further source of conflict. A third obstacle is that many of the problems - particularly poor parenting practices - have been in place for a long time and are difficult to change. Great sensitivity is required in raising issues such as personal hygiene - as was required in the case of a child who was ostracised at school because of head lice - so that families can address their problems while still feeling supported. In all cases, the relationship with parents requires ongoing nurturing through acts which build trust and confidence and which show that, with support, each family has the strength to overcome its difficulties.

8.9 Lessons Learned

Lessons Learned

There is a wide degree of consensus on the key lessons which have been learned by projects from their case studies. The most important lessons are:

1. It is essential to build a trusting relationship with the family. Typically that involves working at a pace which is comfortable for parents and children, usually slow rather than fast. It will also involve facilitating parents and children in setting their own goals and helping them to achieve them.
2. When working with a child, always work with the parents as well as other family members, including the extended family if appropriate.
3. Children need the support networks that come with school, clubs, leisure activities, etc. but are often excluded from these because of their behaviour or emotional problems.
4. Work collaboratively with other members of the staff and seek team and management supervision to ensure that one is working effectively and is supported in one's work.
5. Work in collaboration with other agencies and draw upon their skills and resources to help the child and family.
6. Hold regular reviews with the family to evaluate progress and assess what further interventions are needed.

8.10 Time Spent On Case

Time Spent On Case

On average, the most improved children received an average of 229 hours from Springboard staff, more than twice the amount of time received by children in Springboard generally.

Table 8.2 Amount of Staff Time Received by All Children and by the Most Improved Children

Category Interventions	All Children in Springboard Mean Hrs N	All Children in Springboard Mean Hrs %	Most Improved Children* Mean Hrs N	Most Improved Children* Mean Hrs %
1. Individual Work	12	11	31	14
2. Group Work	42	41	71	31
3. Family Work	17	16	43	19
4. Drop-in	10	10	23	10
5. Administration	22	22	61	27
Total	103	100	229	100

*Based on 11 of the 15 case studies which supplied this information.

8.11 Case Management

Case Management

All projects seem to share a broadly similar template for the management of each case. This involves a number of elements as follows:

- Team discussions where ideas and information are pooled and the key worker is supported;
- Case supervision where the project leader (usually) discusses the case in detail with the key worker;
- Ongoing discussion with the family to review and update goals in the light of what is working;
- Review and evaluation meetings involving all relevant agencies to share information and ensure that the family support plan is properly co-ordinated;
- Effective inter-agency communication and co-operation.

These different levels of management draw attention to the need for a creative and flexible approach to the needs of each child and family and for collaboration between staff in the project as well as with staff in other agencies. Above all, the management of each case requires sensitivity to the needs and strengths of each child and family by all of the professionals involved.

8.12

Summary and Conclusion

Summary and Conclusion

The key findings to emerge from the analysis and synthesis of the case studies show that the most improved children were more likely to be boys than girls and on average received twice as much staff time as children in Springboard generally. In terms of scores on the Strengths and Difficulties Questionnaire (SDQ), children in the case studies began with much greater difficulties than the average child in Springboard, but also made much more progress between the baseline and the follow-up[72].

Most of the children in the case studies exhibit a pattern of behavioural problems at home and at school involving angry outbursts and, perhaps because of this, they have difficulty making and sustaining friends. They often appear unhappy and lacking in confidence and self-esteem; many of the children are under-performing at school due to poor concentration and hyperactivity. Many of the parents - particularly mothers - are unable to cope with the problems which their children are presenting. Many also have, or have had, damaging relationships with the fathers of the children and this inhibits their parenting capacity, particularly when compounded by financial difficulties and overcrowding.

The key elements which constitute the intervention of Springboard in virtually every case involve: (1) individual work with the child through the medium of some activity (art, crafts, sensory work, etc) to address emotional and behaviour problems; (2) group work such as after school clubs, summer programmes, sport and leisure activities, outings, etc. for the purpose of promoting social skills, reducing isolation and creating fun; (3) parent support through one-to-one discussion, home visits, practical help in setting family routines or home maintenance, as well as inclusion in group programmes for parents; (4) including other professionals in the overall plan to support the child and parent(s) notably Social Workers, Psychologists and Teachers; (5) holding review meetings with professionals and the parent(s) to assess progress and adapt to changing needs.

The intervention of Springboard typically results in children presenting as happier, more self-confident, having more friends, attending and performing better at school, being more involved in leisure activities and having a better relationship with their parent(s). The main obstacle to change in virtually every case is the reluctance of parents, and to a lesser extent children, to engage with the project, an obstacle which all of the projects successfully overcame.

The key lessons learned by staff from their case studies are: (1) it is essential to build a trusting relationship with the family; (2) when working with a child, always work with the parents as well as other family members, including the extended family if appropriate; (3) children need the support networks that come with school, clubs, leisure activities, etc. but are often excluded from these because of their behaviour or emotional problems; (4) work collaboratively with other members of the staff and seek team and management supervision to ensure that one is working effectively and is supported in one's work; (5) work in collaboration with other agencies and

[72] We are aware that some of the improvement in SDQ scores may be a statistical artefact, sometimes referred to as "regression to the mean", since children with higher SDQ scores have more scope for improvement than children with lower scores but we are unable to separate this from the true impact of Springboard's intervention due to the absence of a control group.

draw upon their skills and resources to help the child and family; (6) hold regular reviews with the family to evaluate progress and assess what further interventions are needed.

All projects seem to share a broadly similar template for case management involving: (1) team discussions; (2) case supervision; (3) ongoing discussion with the family; (4) review and evaluation meetings involving all relevant agencies; (5) effective inter-agency communication and co-operation.

These findings suggest three important implications. The first is that work with the most improved children is invariably accompanied by parallel interventions with parents. This is consistent with our overall analysis of Springboard in Chapter Seven above and Chapter Twelve below which shows that the main determinant of a child's well-being (as measured by the Strengths and Difficulties Questionnaire) is the well-being of its parents (as measured by the Parent-Child Relationship Inventory and the General Health Questionnaire). Correspondingly, interventions which improve the well-being of parents will tend to improve the well-being of children. This finding is also supported by other studies[73]. The evidence from the case studies not only corroborates this finding but also shows that staff in the projects are already fully aware of its significance and implications.

Third, the case studies and the reflections of staff on those case studies suggest that greater importance needs to be placed in subsequent evaluations on the role of children's support networks in promoting well-being. In this evaluation, we collected information on the support networks of parents but not of children, and our analysis in Chapters Twelve and Fourteen below shows that support networks are important to the well-being of parents. Had we collected similar information on the support networks of children we might also have found that these too are crucial to their well-being. This is suggested by the fact, as revealed through the case studies, that children with behaviour and emotional problems tend to be isolated from their peers while interventions by Springboard to get them more involved in after-school projects, clubs, summer programmes and leisure activities seems to have a very positive effect. Accordingly, we think that more robust measures of children's support networks would be appropriate in subsequent evaluations.

[73] Canavan and Dolan, 2000; Herbert, 1988.

9 Background Characteristics of Parents

9.1 Introduction

This chapter describes the background characteristics of 191 parents who were clients of Springboard at some time in the period between January 2000 and May 2001. A good deal of information on the characteristics of parents has already been presented in the profile of Springboard families (see Chapter Three above), particularly their occupational and employment status, their source of income and type of accommodation and does not need to be presented again. Accordingly, the present chapter is relatively short and describes the gender of parents (section 9.2), the problems they experienced in childhood (section 9.3), the problems which they are currently experiencing as parents (section 9.4) as well as their stress levels (section 9.5), parenting capacity (section 9.6), support networks (section 9.7) and cooperativeness with Springboard (section 9.8). We conclude with a summary of the key findings (section 9.9).

9.2 Gender of Parents

Most parents are mothers (88%), reflecting the proportion of lone mother households in the Springboard population (54%) but also reflecting a greater engagement with mothers in two parent households (Tables A9.1 and A9.2). Although more than four out of ten households have two parents (46%), only one in ten fathers are involved in Springboard. This reflects the dual reality that mothers often have primary responsibility for the care of children and, as if to reinforce this, family support services - and social services generally - are typically orientated towards supporting mothers rather than fathers. As one reviewer put it, family support is characterised by "the predominant focus on mothers and the apparent invisibility of fathers"[74]. Indeed there is a good deal of research and practice to suggest that fathers tend to be avoided by professionals - and possibly vice versa - and there is a great uncertainty among professionals about how to approach fathers and work with them[75].

9.3 Problems Experienced as a Child

The formative influences of childhood affect all adults in their different roles, including their role as parents. Collecting information on the childhood experiences of parents is a sensitive matter and in more than four out of ten cases (44%) it is difficult to know if no problems were experienced as a child or if the information was simply not collected (Table A9.3). Despite this, the returns indicate that more than one quarter (28%) of parents experienced emotional abuse as children, while a fifth (22%) had parents with an alcohol problem and experienced domestic violence (20%) and physical abuse (20%). More than four out of ten (44%) left school at a relatively young age (Table A9.4). Further analysis of the problems experienced by parents as children shows a very strong association between alcoholism, domestic violence, physical abuse and emotional abuse, thereby

[74] Roberts and Macdonald, 1999:63; see also French, 1998:187-188; Rylands, 1995; Murphy, 1996:95.
[75] See McKeown, 2001, Chapter Seven; Buckley, 1998:7.

forming a syndrome that might be called the "abusive alcoholic family", in which a significant minority of parents are known to have grown up (Table A9.5).

9.4 Problems Currently Being Experienced

Problems Currently Being Experienced

Comprehensive information was collected by staff on the problems currently experienced by parents (Table A9.6 and A9.7). Two thirds (66%) of parents had at least two serious problems when first coming into contact with Springboard. The two most serious problems - defined as problems which are seen by staff as fairly serious, serious or very serious - are difficulty managing the children (53%) and couple/marital problems (46%). Both of these point to deficits in terms of relational well-being. One third of all parents (36%) have debt problems and one quarter (27%) live in bad housing which point to deficits in terms of material well-being[76]. Beyond this, the prevalence of alcoholism and psychiatric illness in these families appears extremely high: one third (34%) of parents or their partners have an alcohol problem while one quarter (25%) of parents or their partners have a psychiatric problem. In Ireland the prevalence of excessive drinking[77] and psychiatric illness[78] is estimated to be about 10% thus indicating a much higher concentration of these problems among Springboard families. Indeed it is hard not to detect a similarity between the childhoods of many Springboard parents as described in the previous section and their current experience of family life, itself a telling lesson in the intergenerational transmission of family problems for which we adduce further evidence in Chapter Twelve below.

9.5 Stress Levels

Stress Levels

Stress levels are measured using the General Health Questionnaire (GHQ) as described in Chapter Two above. The 12 item version of this scale is used (GHQ-12) along with the "GHQ scoring method"[79]. Although scores on this scale do not constitute a diagnosis, they indicate that parents whose level of stress is above the threshold would, if assessed independently by a clinician, have a 50% probability of showing signs of "psychiatric disturbance"[80].

At the time of first contact with Springboard, as Table 9.1 shows, two thirds of parents (65%) were showing signs of being stressed and half of these were extremely stressed. This is higher than virtually every other sub-group of the Irish population for which we have data, with the exception of men and women in distressed relationships who go for couple counselling. This can be seen from a comparison with the data in Table 9.2.

[76] See McKeown and Sweeney, 2001, Chapter Six for a discussion of the concepts of relational and material well-being.
[77] Webb, 1991, p.107.
[78] Study Group on the Development of Psychiatric Services, 1984:7 and 153; Commission on the Status of People with Disabilities, 1996:284-289, Appendix A.
[79] Goldberg and Williams, 1988, Chapter Three.
[80] Goldberg and Williams, 1988, p.5.

Table 9.1 Stress Levels of Parents (Based on GHQ), at First Contact with Springboard

GHQ	Below GHQ Threshold	Above GHQ Threshold	Well Above GHQ Threshold	Total
% of Parents	35	32	33	100

Below the GHQ threshold refers to parents who scored in the range 0-2.
Above the GHQ threshold refers to parents who scored in the range 3-7.
Well above the GHQ threshold refers to parents who scored in the range 8-10.
Source: Table A11.1.

Table 9.2 Irish Population Above GHQ Threshold for Various Categories of Men and Women.

Category	Men Above GHQ Threshold* %	Women Above GHQ Threshold* %
Single (1)	13.1	14.9
Married (1)	15.7	17.2
Separated/divorced (1)	22.5	44.3
Widowed (1)	15.5	29.6
Employed and married (1)	6.5	9.4
Employed and single (1)	4.5	7.2
Unemployed and married (1)	40.4	24.7
Unemployed and single (1)	29.8	30.9
Spouse unemployed (1)	12.3	27.6
Self & spouse unemployed (1)	43.4	33.3
Persons in poverty (2)	48	48
Couples in counselling at ACCORD (3)	85	93
Couples in counselling at MRCS (4)	86	89
Total	15.1	19.0

*The GHQ threshold score is two which means that those above the threshold scored three or more.
Sources: (1) Whelan, Hannan and Creighton, 1991; (2) Callan, Layte, Nolan, Watson, Williams and Maitre, 1999:49; (3) McKeown, Haase, Pratschke, Rock and Kidd, 2001:47; (4) McKeown, Haase and Pratschke, 2001:48.

9.6 Parenting Capacity

Parenting Capacity

Parenting ability was measured using the Parent-Child Relationship Inventory (PCRI), a US-based standardised measure created in the 1990s[81]. As explained in Chapter Two, four aspects of parenting are measured using this scale: feeling supported as a parent, being satisfied with oneself as a parent, the quality of a parent's communication with the child(ren), and

[81] Gerard, 1994.

parental involvement with the child(ren). There are no threshold scores; the higher the parent's score on each dimension the better their experience of parenting. There is no data on how Irish parents score on this scale so US norms are our only guide.

In order to analyse parenting ability more closely, we classified parents as "weak" if their score fell into the 0-25 percentile (meaning that they are similar to the weakest 25% of parents in the US calibration sample), as "modest" if their score fell into the 25-50 percentile (meaning that they are similar to between half and three quarters of all US parents), and as "strong" if their score fell into the 75+ percentile (meaning that they are similar to the strongest quarter of all US parents). Using this classification the results in Table 9.3 show that more than half of all Springboard parents are weak. This is twice the proportion of parents in the US population classified as weak. Conversely just over 10% of Springboard parents could be considered strong compared to 25% of US parents.

Table 9.3 Mean Scores on Parent-Child Relationship Inventory (PCRI) at First Contact with Springboard

Mean PCRI Score	Weak (%)	Modest (%)	Strong (%)	Total (%)
1. Support	74	20	6	100
2. Satisfaction	64	29	7	100
3. Involvement	38	39	23	100
4. Communication	41	47	12	100
US Parents	25	50	25	100

1. Support in the PCRI refers to "the practical help and emotional support which the client receives as a parent" (Gerard, 1994, p.9).
2. Satisfaction in the PCRI refers to "the enjoyment a client receives from being a parent" (Gerard, 1994, p.10).
3. Involvement in the PCRI refers to "the client's propensity to seek out his or her children and manifest an interest in their activities" (Gerard, 1994, p.10).
4. Communication in the PCRI refers to "the clients' awareness of how well they communicate with their children in a variety of situations including simple conversation" (Gerard, 1994, p.10).

Source: Tables A11.5, A11.6, A11.7 and A11.8.

9.7

Support Networks of Parents

Support Networks of Parents

As explained in Chapter Two, the term support network refers to the support which a parent receives in the form of practical help (such as baby sitting), emotional support (such as someone to talk to) and information/advice (such as how to access services) from any of the following: someone in the home, extended family, friends, neighbours, someone at work or in school, someone from a statutory agency, voluntary body or community organisation. In a manner similar to the technique of social network mapping, the level of each type of support was measured on a three point

scale: 0 = none, 1 = a little, and 2 = a lot, yielding a maximum total score of 18[82]. Parents were then classified as having weak, medium and strong support networks.

Table 9.4 Support Networks of Parents on First Contact with Springboard (%)

Type of Support	Weak Support	Medium Support	Strong Support
Practical Help	27	33	40
Emotional Support	38	28	34
Information / Advice	35	30	35
Average	33	30	36

Weak support refers to parents who score 0-3. Medium support refers to parents who score 4-6.
Strong support refers to parents who score 7+.
Source: Table A11.1.

The results in Table 9.4 reveal that, on average, one third of parents have weak supports, one third have medium supports and one third have strong supports. Parents seem particularly strong (40%) in the area of practical supports. As with the PCRI scores in the previous section, these results suggest relatively poor targeting of parents with weaker support networks.

9.8 Cooperativeness of Parents

The work of Springboard is dependent on winning the cooperation of parents in matters such as keeping appointments and participating in jointly-agreed programmes of intervention. According to staff, the vast majority of parents are cooperative or very cooperative (94%) (Table A9.9). A small minority of 10 parents were described as uncooperative and one parent was described as very uncooperative.

9.9 Summary

The key findings to emerge from this chapter are as follows:

- nine out of ten parents in Springboard are mothers.
- more than one quarter (28%) of parents experienced emotional abuse as children, while a fifth (22%) had parents with an alcohol problem and experienced domestic violence (20%) and physical abuse (20%).
- the main current problems of parents are managing the children (53%) and couple/marital problems (46%) as well as debt problems (36%) and bad housing (27%). Beyond these, the levels of alcoholism (34%) and psychiatric illness (25%) seem much higher than among the general population[83].
- two thirds of parents showed signs of stress, as measured by the GHQ, when they first contacted Springboard.

[82] See Tracy and Whittaker, 1990; Kinney, Haapala, Booth and Leavitt, 1990.
[83] See Webb, 1991, p.107; Study Group on the Development of Psychiatric Services, 1984:7 and 153; Commission on the Status of People with Disabilities, 1996:284-289, Appendix A.

- in terms of parenting capacity as measured by the PCRI, more than half are weak which is twice the proportion of US parents who would be classified as weak, the only comparative norm available.
- one third of parents have weak support networks, one third have medium support networks and one third have strong support networks.
- the vast majority of parents (94%) are experienced by staff as cooperative or very cooperative.

These findings indicate that a majority of Springboard parents have high levels of stress and weak parenting capacity and have at least two serious problems in their lives while some are also coping with a history of abusive childhood experiences. On the other hand, the majority have medium to strong support networks.

The prevalence of alcohol problems in the lives of at least one third of Springboard families mirrors the childhood experiences of some of these parents where we found a strong association between alcoholism, domestic violence, physical abuse and emotional abuse. This draws attention to the way in which family problems can be transmitted over the generations, a reality for which we adduce further evidence in Chapter Twelve below. This, in turn, underlines the importance of interventions like Springboard to break the cycle of dysfunctional behaviours in families. Overall these results provide clear evidence that Springboard is well targeted at vulnerable parents and families, as intended, and therefore meets a necessary condition if it is to achieve its core objective namely, to improve their well being.

Finally, it is worth noting that the findings in this chapter, although avowedly describing Springboard parents, are really a description of Springboard mothers. There is little reason to believe that the characteristics of fathers, both resident and non-resident, are dramatically different. The focus of Springboard on mothers - even in two-parent households - is not unusual in family support services and reflects a tendency among service providers to treat parenting as synonymous with mothering. At the same time, it is only fair to acknowledge that all of the projects in Springboard are taking extensive and creative measures to involve fathers in their work and this is beginning to bear fruit.

10 Springboard Interventions with Parents

10.1 Introduction

This chapter describes the interventions undertaken by Springboard with parents. The analysis begins by looking at the overall duration of interventions as measured by the total number of weeks during which the parent attended Springboard (section 10.2). This is followed by an overview of interventions undertaken with these parents (section 10.3). A more detailed description of each intervention is offered in sections 10.4 to 10.8. Since Springboard is typically only one of the agencies involved with each family, the chapter also details the number of other agencies involved with the parent (section 10.9). Finally there is a brief summary in section 10.10.

10.2 Duration of Intervention

Most of the parents (72%) have been attending Springboard for at least six months (Table A10.1). The average attendance is 48 weeks. This is similar to the mean number of weeks (46) attended by children (see Table A5.1).

10.3 Overview of Interventions

Table 10.1 summarises the total number of hours devoted to each type of intervention. This reveals that each parent received an average input of 82 hours from Springboard staff in the period up to May 2001; this is a good deal less than the average amount of time devoted to each child (103 hours). On a weekly basis, it is equivalent to 1.7 hours per parent per week, compared to 2.2 hours for children.

The main form of intervention with parents is individual work (28%); this contrasts with children where the main form of intervention is group work (41%). With parents, group work absorbed a relatively small proportion of time (15%), similar to the time devoted to family work (17%). Drop-in (12%) time is similar to that found among children (10%). The time devoted to administration (28%) is quite substantial and similar to that found in work with children (22%).

10.4 Individual Work

Individual work typically involves one-to-one sessions with the parent for the purpose of assessing needs and meeting therapeutic goals. This intervention absorbed 28% of total intervention time and amounted to an average of 23 hours per parent. The main types of individual work, according to staff, were one-to-one support and counselling, help with parenting issues and skills, as well as home visits (Table A10.8).

Table 10.1 Hours of Intervention with Each Parent

Interventions	Mean Hours	
	N	%
1. Individual Work	23	28
2. Group Work	12	15
3. Family Work	14	17
4. Drop-in	10	12
5. Administration	23	28
Total	82	100

Source: Compiled from Tables A10.2 (Individual Work), A10.3 (Group Work), A10.4 (Family Work), A10.5 (Drop-In Work), A10.6 (Administration) and A10.7 (Total). Total and Mean Hours were estimated by taking the mid-points of the categories 1-2 hours and 2-4 hours, and by assuming that a day workshop lasts for 6 hours and a weekend workshop for 12 hours.

10.5

Group Work

Group Work

Group work refers to interventions with groups and typically involves either focused sessions for the purpose of meeting therapeutic goals or activity-based programmes for the purpose of acquiring life skills and developing support networks. This intervention absorbed 15% of total intervention time and amounted to an average of 12 hours per parent. The main types of group work, according to staff, are group-based programmes and outings (Table A10.9).

10.6

Family Work

Family Work

Family work usually involves sessions with two or more members of the family for the purpose of assessing needs and meeting therapeutic goals. This intervention absorbed 17% of total intervention time and amounted to an average of 14 hours per parent. The main types of family work, according to staff, are family meetings to address family issues, child behaviour, or offer general support and encouragement (Table A10.10).

10.7

Drop-in

Drop-in

Drop-in is where the parent is visited by project staff at home, or alternatively where the parent visits the centre and engages in unstructured activities such as meeting others, participating in recreation activities, and generally having fun. This intervention absorbed 12% of total intervention time and amounted to an average of 10 hours per parent. The main types of drop-in, according to staff, are home visits to offer help and advice about the children, to monitor progress generally or at times of crisis (Table A10.11).

10.8 Administration

Administration

Administration is a crucial ingredient in the work of Springboard because it is the mechanism by which inter-agency responses and interventions are planned, organised and delivered. This typically absorbs time in organising meetings, writing notes, letters and reports, processing referrals, completing evaluation forms, etc. This work absorbed 28% of total intervention time and amounted to an average of 23 hours per parent.

10.9 Other Agencies Involved

Other Agencies Involved

It is a core objective of Springboard that it should provide a co-ordinated and integrated response to the needs of children, parents and families by drawing upon the resources of all relevant agencies. This approach requires sensitivity to ensure that families are not inundated by agencies, on the one hand, and that they receive all the agency support that they need, on the other. For Springboard parents, other agencies are involved in nearly nine out of ten cases (87%) (Table A10.13). The main agency involved is the Health Board, through its Social Workers (52%), hospitals (29%), Public Health Nurses (25%), child psychiatric services (19%), adult psychiatric services (14%), family support workers (6%) and community childcare workers (5%) (Table A10.12). Schools are also substantially involved in about six out of ten cases (61%). It is not possible, on the basis of this descriptive information alone, to draw any implications about the quality of inter-agency co-ordination between the Health Board and the schools or indeed about the level of intra-agency cooperation within the Health Board. These are issues which we address in Chapter 15 below.

10.10 Summary

Summary

This chapter described the interventions undertaken by Springboard staff with parents. The results show that, on average, parents have been attending Springboard for 48 weeks. Staff in Springboard spent an average of 82 hours on each parent in the period up to May 2001 which is equivalent to an average of 1.7 hours per parent per week. The main form of intervention with parents is individual work absorbed 28% of total intervention time; group work absorbed 15% of total intervention time; family work absorbed 17% of total intervention time; drop-in work absorbed 12% of total intervention time; and administration absorbed 28% of total intervention time. In addition to the input of Springboard, other agencies are involved with nearly nine out of ten parents, mainly Health Board services but also schools.

These results suggest that Springboard has worked intensively with the parents in its care. They also indicate that many Health Board services and schools are also involved with parents. The extent to which this is creating a more co-ordinated and integrated approach will be addressed in Chapter

Fifteen below. In the present context, the crucial question is whether the interventions of Springboard staff, as measured by the amount of time spent on each parent, makes any difference to the well-being of parents. In order to answer this question we must first identify the changes experienced by parents (which is the theme of Chapter Eleven - the next chapter) and then analyse the link between those changes and the amount of time spent by Springboard staff (which is the theme of Chapter Twelve - the following chapter).

11

Changes Experienced by Parents

11.1 Introduction

This chapter describes the changes experienced by parents who attended Springboard in the period between January 2000 and May 2001. We do this using three core measures. The first is change in stress levels as measured by the General Health Questionnaire (GHQ), which is described in section 11.2. The second is change in parenting capacity as measured by the Parent-Child Relationship Inventory (PCRI) and is detailed in section 11.3. The third is change in support networks which are described in section 11.4. We conclude the chapter with a brief synopsis of changes in the well-being of parents in section 11.5.

11.2 Changes in Stress

As already indicated in Chapter Two, stress levels were measured using the General Health Questionnaire (GHQ). The results indicate that stress levels among parents fell by 43%, this being the proportion of parents who moved from being above to being below the GHQ stress threshold (Table A11.1). At the time of first contact with Springboard, two thirds of parents (65%) were stressed and his fell to just over one third (37%) in May 2001. An encouraging aspect of the result is that those parents who were most stressed when they first came in contact with Springboard (those defined as "well above the threshold") were most likely to show signs of reduced stress[84]. Nevertheless, the overall level of stress within this group of parents remains rather high (37%) by comparison with most other sub-groups of the Irish population (see Table 9.1 above).

These changes in stress levels are impressive and are similar to the changes reported by a study of mothers who participated in a programme run by the Child and Family Centre in the Ballyfermot area of Dublin[85]. This study involved 48 mothers and their children who made an average of 2.3 visits to the clinic over a 3-4 month period to receive a broadly similar intervention to that offered by Springboard. A comparison of the proportions of parents above the GHQ before and after the intervention, as summarised in Table 11.1, reveals that the Child and Family Centre had a similar impact to Springboard, despite its shorter intervention period and fewer input hours. However, we do not have sufficient data to compare the level of stress above the GHQ threshold before and after the intervention, with the result that firm conclusions about effectiveness cannot be drawn. Other studies in Ireland have shown that interventions with mothers in the form of parenting programmes can significantly reduce stress, but strict comparison with Springboard is not possible because these studies compare only mean GHQ scores before and after intervention and do not make clear the GHQ scoring method employed[86].

[84] We are aware that some of the improvement in GHQ scores may be a statistical artefact, sometimes referred to as "regression to the mean", since parents with higher GHQ scores have more scope for improvement than parents with lower scores but we are unable to separate this from the true impact of Springboard's intervention due to the absence of a control group.

[85] Moukaddem, Fitzgerald and Barry, 1998.

[86] See for example, Mullin, Proudfoot and Glanville, 1990; Mullin, E., Quigley, K., and Glanville, B., 1994; Mullin, Oulton and James, 1995.

Table 11.2 Comparison of Parents Above GHQ Threshold Before & After Intervention in Two Programmes

Name of Project	> GHQ* Threshold at Baseline %	> GHQ* Threshold at Follow-up %	Change Between Baseline & Follow-up %
Springboard (n=191)	65	37	-28
Ballyfermot clinic (n=48)	62	29	-33

*The Ballyfermot clinic used the GHQ-28 (see Moukaddem, Fitzgerald and Barry, 1998) whereas Springboard used the GHQ-12 but various validity tests have shown that both variants of the GHQ are very similar in their ability to discriminate between clinical and non-clinical populations (see Goldberg and Williams, 1988, p.55)

11.3

Changes in Parenting Capacity

Changes in Parenting Capacity

Changes in parenting capacity were measured using the Parent-Child Relationship Inventory (PCRI), a US-based standardised measure created in the 1990s (Gerard, 1994). A comparison of PCRI scores between baseline and follow-up, as summarised in Table 11.2, shows that the parenting capacity of nearly one quarter of all parents (23%) improved while attending Springboard. This improvement affected three dimensions of parenting capacity (support, satisfaction and communication) in approximately equal manner while the fourth dimension (involvement) showed a much greater improvement. Statistically-significant changes were observed for support, communication and involvement. Improvements were least pronounced among those with the weakest parenting capacity when they first came into contact with Springboard and two thirds remain weak in terms of support and satisfaction (Tables A11.2, A11.3, A11.4, 11.5).

Table 11.2 Change in Parents' PCRI Scores Between Baseline and Follow-up

Type of Support	No Change %	Improvement %	Deterioration %
1. Support	73	18	9
2. Satisfaction	72	16	12
3. Involvement	49	34	17
4. Communication	63	23	14

Source: Tables A11.2, A11.2, A11.2, 11.5.

1. Support in the PCRI refers to "the practical help and emotional support which the client receives as a parent" (Gerard, 1994, p.9).
2. Satisfaction in the PCRI refers to "the enjoyment a client receives from being a parent" (Gerard, 1994, p.10).
3. Involvement in the PCRI refers to "the client's propensity to seek out his or her children and manifest an interest in their activities" (Gerard, 1994, p.10).
4. Communication in the PCRI refers to "the clients' awareness of how well they communicate with their children in a variety of situations including simple conversation" (Gerard, 1994, p.10).

We have already noted in Chapter Nine that more than half of all Springboard parents have weak parenting capacity which is twice the proportion of US parents who would be classified as weak.

Previous research suggests that improvements in parenting capacity tend to last for many years. This was comprehensively illustrated in the evaluation of the Eastern Health Board's Community Mothers Programme which has been running since 1983; community mothers are non-professional, experienced and successful mothers who volunteer to give support and encouragement to first-time parents in disadvantaged areas. In a seven-year follow-up of 38 first-time mothers who benefited from this programme, the authors found that, by comparison with a matched control group, "the Community Mothers programme has sustained beneficial effects on parenting skills and maternal self-esteem 7 years later with benefit extending to subsequent children".[87] Other studies have also found that parenting courses can have a beneficial effect on parenting capacity[88]. These findings suggest that the benefits of improved parenting capacity may last for many years, and our analysis in the next chapter also point to the downstream benefits which changes in parental well-being can bring to children.

11.4

Changes in Support Networks

Changes in Support Networks

As explained in Chapter Two, the term support network refers to the support which a parent receives in the form of practical help (such as baby sitting), emotional support (such as someone to talk to) and information/advice (such as how to access services) from any of the following: someone in the home, extended family, friends, neighbours, someone at work or in school, someone from a statutory agency, voluntary body or community organisation. Parents are classified as having weak, medium and strong support networks, depending on their scores (see Chapter Nine).

A comparison of the mean levels of support between baseline and follow-up, as summarised in Table 11.3, shows that the support networks of nearly four in ten parents (38%) improved while attending Springboard. This improvement affected all three forms of support - practical help, emotional support, information/advice - in approximately equal manner. As with the other indicators of well-being, the improvement was more pronounced among those who had the weakest support networks when they first came into contact with Springboard, with nearly half of these parents (48%) showing an improvement (Tables A11.6, A11.7 and A11.8).

There is no doubt that some of the improvement in parents' support networks is directly attributable to Springboard, if only because the measurement of support networks at follow-up in May 2001 included any support which the parent received from the Springboard project. This, of course, does not exclude the possibility that Springboard may also have contributed indirectly to the improvement of parents' support networks by establishing other sources of assistance, such as other parents or other agencies.

[87] Johnson, Molloy, Scallan, Fitzpatrick, Rooney, Keegan and Byrne, 2000, p.337; see also Johnson, Howell and Molloy, 1993; for a more general review of effectiveness studies, see McKeown, 2000, pp.20-23.

[88] See McKeown, 2000, pp.17-19 for a review.

Table 11.3 Change in Parents' Support Networks Between Baseline and Follow-up

Type of Support	No Change %	Improvement %	Deterioration %
Practical help	43	37	20
Emotional support	46	40	14
Information/advice	45	37	18

Source: Tables A11.6, A11.7, A11.8.

11.5 Summary

Summary

This chapter described the changes experienced by parents while attending Springboard between January 2000 and May 2001. The results in the three core areas of impact are:

- there was a reduction in the stress levels of more than four in ten (43%) parents.
- nearly one quarter of all parents (23%) recorded improved parenting capacity.
- the support networks of nearly four in ten parents (38%) improved.

These results indicate that decisive improvements in the well-being of parents took place while attending Springboard. It is difficult to find comparative data from other interventions but the reductions in stress are in line with those reported by a similar intervention in Ireland[89]. It is tempting to think of these changes in parental well-being as emanating entirely from Springboard given that they occurred while parents were attending it. That however would be unjustified since Springboard is only one of many influences on the lives of these parents. Equally, however, it is appropriate to determine the role which Springboard has played in bringing about the changes just described. That is the question which we address in the next chapter by focusing on our key measures of parental well-being, namely the GHQ and the PCRI.

[89] Moukaddem, Fitzgerald and Barry, 1998.

12

Impact of Springboard on Parents

12.1 Introduction

This chapter addresses three core questions which are central to Springboard and to family support services generally. The first question - what factors influence the stress levels of parents? - is addressed in section 12.2. The second question - what factors influence parenting capacity? - is addressed in section 12.3. The third question - what factors in the family system facilitate change in children and parents? - is addressed in section 12.4. Clearly, robust answers to these questions would help us to offer more effective support to vulnerable families. In Chapter Seven we outlined the method of statistical analysis - Structural Equation Modelling - used to answer these questions and there is no need to repeat it here (see section 7.2 above). In the final section (12.5) we draw together the answers to these questions and discuss some implications.

12.2 What Factors Influence Stress Levels in Parents?

Stress levels are measured using the General Health Questionnaire (GHQ) and, as we have seen in Chapter Eleven, between January 2000 and May 2001 there was a reduction of 43% in the proportion of parents who were stressed. In order to assess whether this reduction was due to Springboard, we carried out an extensive analysis of the factors which influence GHQ scores at baseline and the change between baseline and follow-up, using Structural Equation Modelling.

The Structural Equation Model which explains changes in GHQ is graphically summarised in the path diagram of Figure 12.1. The fit of the model to the data is excellent, since the CFI is .99 and the RMSEA is 0.02, these being very near to the optimal values that these coefficients can achieve. This gives us confidence that important relationships between variables in the model have not been omitted. Five key findings emerge from Figure 12.1.

12.2.1 Volatility of Stress

The GHQ measures a relatively volatile condition, in the sense that parents' scores at baseline in January 2000 have only a small influence on their scores at follow-up in May 2001; the standardised regression coefficient is +0.22. In this respect, parents' GHQ scores are much less stable than children's difficulties (see Chapter Seven), or indeed parenting capacity (see section 12.3 below). This is probably attributable to the relatively volatile and somewhat transient nature of the symptoms measured by the GHQ and the fact that the timeframe is "the past few weeks", unlike the SDQ, whose timeframe is "the past six months", and the PCRI, which has no specific time horizon.

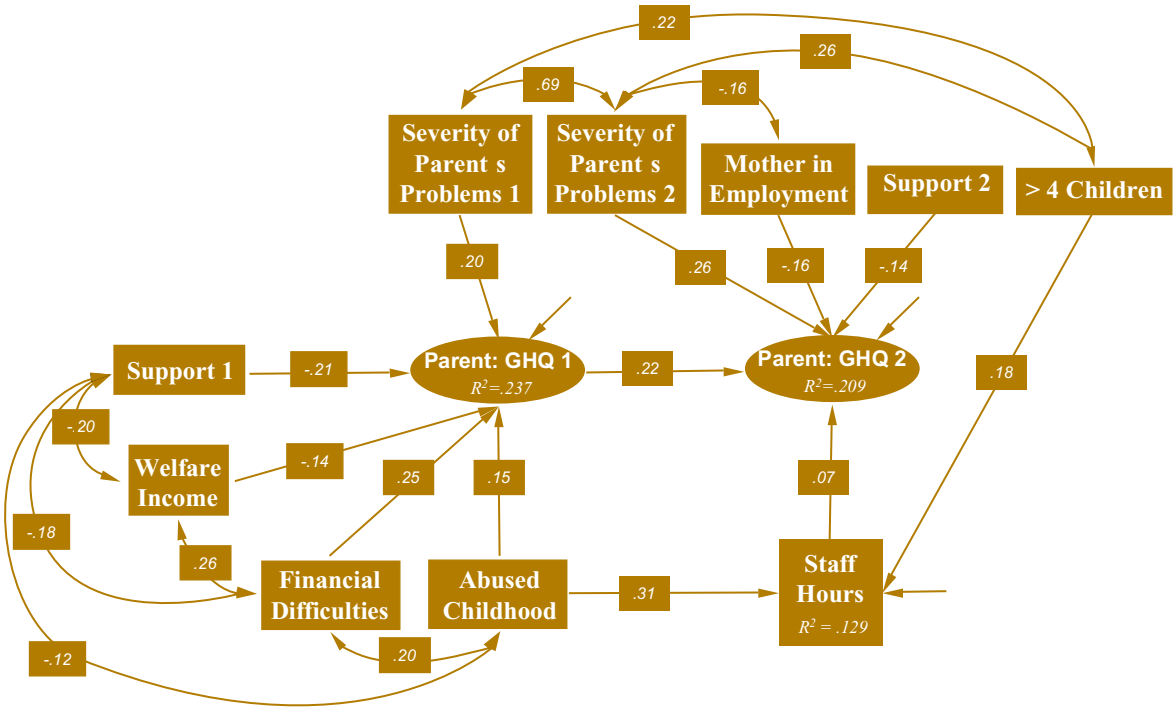
12.22

Influence of Springboard

Influence of Springboard

The amount of hours spent by Springboard staff on each parent had no influence on the changes which took place in the GHQ (i.e. on GHQ 2, controlling for GHQ 1). The regression coefficient indicates a very small effect (+0.07), which is not distinguishable from zero in statistical terms. In other words, the 1.7 hours per week which staff spent with each parent over an average of 48 weeks seem to have had no direct effect on their GHQ scores.

Figure 12.1 Path Diagram Showing Factors Which Influence the Impact of Springboard on the General Health Questionnaire (GHQ)



Notes:

1. All coefficients are standardised and all effects are statistically significant, with the exception of the effect of hours of intervention on the change in GHQ 2, which is not statistically significant.

12.23

Factors Causing Stress

Factors Causing Stress

The stress levels of parents at the time of their first contact with Springboard were influenced by four inter-related variables: (1) financial difficulties (2) abused childhood (3) support networks and (4) severity of current problems. Parents who have financial difficulties, as measured by the difficulty they experience in making ends meet, tend to have higher stress levels (+0.25); we saw in Chapter Three that 31% of parents had “great difficulty” making ends

meet. Interestingly, parents who have financial difficulties are also more likely to have experienced an abused childhood (+0.20) which, in turn, increases parental stress; parents with an abused childhood also have weaker support networks (-0.12) which increases their stress levels as well. These are extraordinary findings which testify to the lifetime consequences of child abuse and neglect. In Chapter Nine, we found that around 20% of parents were brought up in an "abusive alcoholic family" characterised by alcoholism, domestic violence, physical and emotional abuse. Parents who have financial difficulties also have weaker support networks (-0.18) which, in turn, increases their stress levels (-0.21), a finding which is consistent with other research showing the key role of social supports in promoting well-being[90]; we saw in Chapter Nine that one third of parents have weak support networks. Parents who depend solely on social welfare for their income are more likely to have financial difficulties (+0.26) and to have weaker support networks (-0.20), both of which increase their levels of stress. But when these two variables are taken into account, social welfare dependency alone does not increase the stress levels of parents (-0.14). Finally, parental stress is also influenced by the severity of the parent's current problems (+0.20); in Chapter Nine we saw that about half of all parents currently have relationship difficulties with their children and partners, one third of parents or their partners have problems with alcohol, and one quarter have psychiatric problems. The severity of these problems, in turn, tend to be greater when parents have more than four children (+0.22).

12.24

Factors Influencing Change in Stress

The factors which are responsible for changes in parental stress are: (1) the severity of parents' problems (2) the paid employment of mothers and (3) support networks. It is intuitively correct that parents with fewer current problems will tend to experience reductions in their stress levels (+0.26). Employment also helps to reduce stress among mothers (-0.16), a finding for which we also found evidence in Chapter Seven where, however, it was also associated with greater SDQ difficulties for children. The strengthening of support networks also helps to reduce stress (-0.14), which is in accord with the conclusion of other research projects that strong support networks tend to increase the effectiveness of therapeutic interventions[91].

12.25

Influences on Staff Time

The amount of time allocated by staff to each parent is influenced by whether a parent has had an abused childhood (+0.31) and whether the parent has four or more children (+0.18). This suggests an allocation of staff time on the basis of need.

12.26

Factors Having No Influence

Detailed statistical analyses were carried out to estimate the influence of a large range of variables on GHQ scores at baseline and follow-up and, apart from those in Figure 12.1, none were found to be statistically significant.

[90] See Leavy, 1983; Cutrona, 2000.
[91] Scovern, 1999, pp.272-273; Sprenkle, Blow and Dickey, 1999, p.334.

12.3

What Factors Influence Parenting?

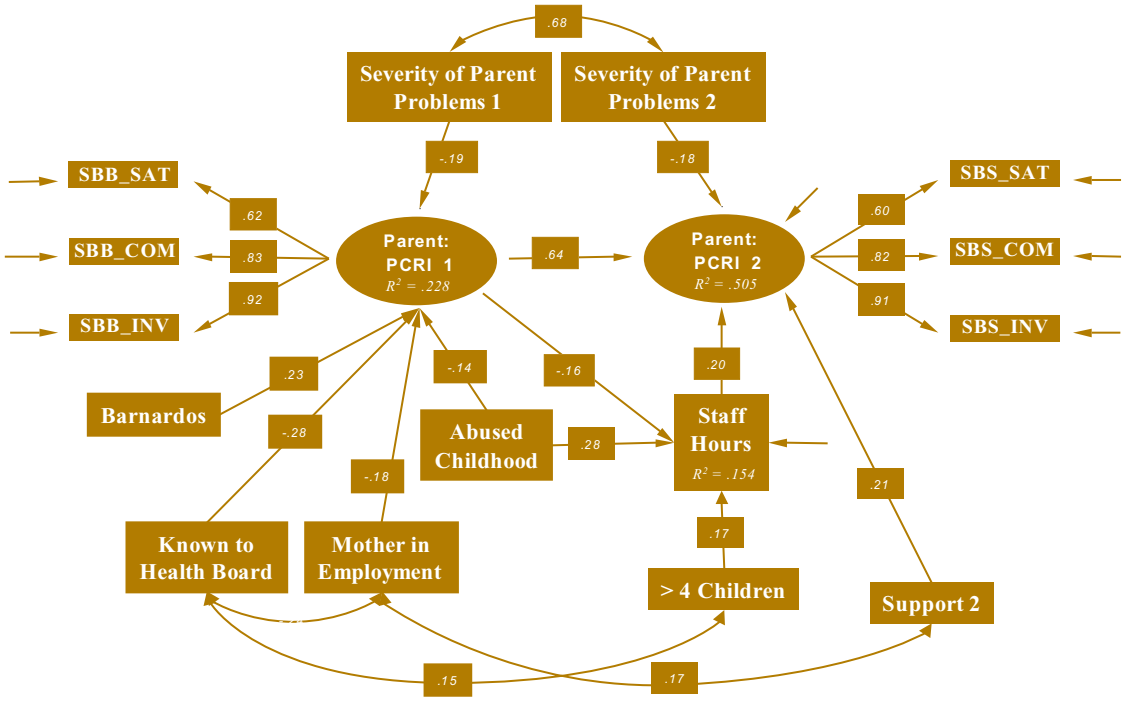
Specifically, the following variables were found to have no influence on GHQ at baseline (GHQ 1) or follow-up (GHQ 2): gender of parent, number of parents in household, father's employment, settled parent or Traveller, parent known to the Health Board, number of agencies involved, parent in a Barnardos or other project.

What Factors Influence Parenting?

Parenting is measured using the Parent Child Relationship Inventory (PCRI) and, as we have seen, the profile of Springboard parents is similar to US parents with one quarter presenting as "weak", half presenting as "modest" and one quarter presenting as "strong" (see Chapter Nine above). Over the course of the study period, one quarter of parents (27%) showed an improvement in parenting capacity, particularly those who were weakest at baseline (see Chapter Eleven above). We now examine the factors which contributed to this improvement, paying particular attention to the impact of Springboard as measured by the number of staff hours.

As part of the analysis, we carried out a Factor Analysis of the different dimensions of the PCRI and found that, as Figure 12.2a reveals, three of the four dimensions (satisfaction, communication and involvement) are highly related to each other; the other dimension (support) representing a different aspect of the parent-child relationship. It is these three dimensions that are used as indicators of the latent concept 'PCRI' in Figure 12.2a and 12.2b. At baseline ('PCRI' 1) these three dimensions had a mean factor loading of 0.79 and at follow-up ('PCRI' 2) the mean factor loading was 0.78, which implies that this measure has strong internal coherence. The fit of the model to the data is excellent since the CFI is 0.98 and the RMSEA is 0.04, these being close to their optimal values. This gives us confidence that important relationships between variables in the model have not been omitted.

Figure 12.2a Full Path Diagram Showing Factors Which Influence the Impact of Springboard on the Parent Child Relationship Inventory (PCRI)



Notes:

1. All coefficients are standardised and all effects are statistically significant.
2. Equality constraints were placed on the factor loadings of equivalent indicators of 'PCRI' over time to ensure that the meaning of the latent variable remained constant. The error variances associated with respective indicators were constrained to be equal and the error variances associated with specific indicator variables were allowed to correlate between the first and second time points.

We present the results of the model in more abbreviated form in Figure 12.2b for the purpose of highlighting the key relationships involved. From this, six key findings can be extrapolated.

Stability of Parenting Capacity

Parenting ability is a relatively stable attribute, and the stability coefficient for the latent 'PCRI' variable is 0.64. In this respect, parenting capacity behaves in a similar way to children's difficulties (see Chapter Seven), suggesting that these may not be amenable to rapid change.

12.3.1

Stability of Parenting Capacity

12.3.2

Influence of Springboard

Influence of Springboard

The number of hours spent by Springboard on each parent had a relatively small, but statistically-significant influence on change in parenting capacity (this may be seen in the diagram from the effect of staff intervention hours on 'PCRI' 2, controlling for 'PCRI' 1). Clearly, parenting capacity is influenced by a wide range of factors, many of them not captured by the Springboard evaluation system. Nevertheless, the fact that the number of staff intervention hours register an impact on parenting capacity suggests that staff input hours may provide an acceptable measure of the Springboard intervention as far as adults are concerned.

12.3.3

Influences on Parenting Capacity

Influences on Parenting Capacity

Parenting capacity is influenced by four main factors: (1) parent known to the Health Board (2) severity of parent problems (3) parent had an abused childhood and (4) mother is in paid employment. Our analysis also revealed that parents who attended Barnardos projects tended to be stronger in terms of parenting capacity (+0.23) than parents who attended other projects, a somewhat surprising finding given that a higher proportion of referrals to Barnardos are from the Health Boards (see section 3.10). Clearly, being known to the Health Board (-0.28) is indicative of deeper concerns about the protection and welfare of children and, for this reason, is probably a reasonably good indicator of weak parenting capacity. The severity of parent problems at the beginning of the study period (-0.19) exercises a similar influence on parenting capacity as it does on stress (+0.20). The long-term debilitating effects of having an abused childhood are also evident here in the reduced capacity of parents (-0.14), similar to the influence exercised by this variable on the stress of parents (+0.15). The fact that the employment of mothers has a negative influence on parenting capacity (-0.16) whilst being positively correlated with support networks (+0.17) is significant and draws attention to the trade-offs entailed by maternal employment discussed in Chapter Seven above. We return to this issue at the end of the chapter.

12.3.4

Influences on Change in Parenting Capacity

Influences on Change in Parenting Capacity

Changes in parenting capacity are influenced by changes in the parent's support network (+0.21) and by the severity of their problems (-0.18). Each of these factors exercises a similar influence to Springboard staff (+0.20) on changes in parenting capacity ('PCRI' 2).

12.3.5

Influences on Staff Time

Influences on Staff Time

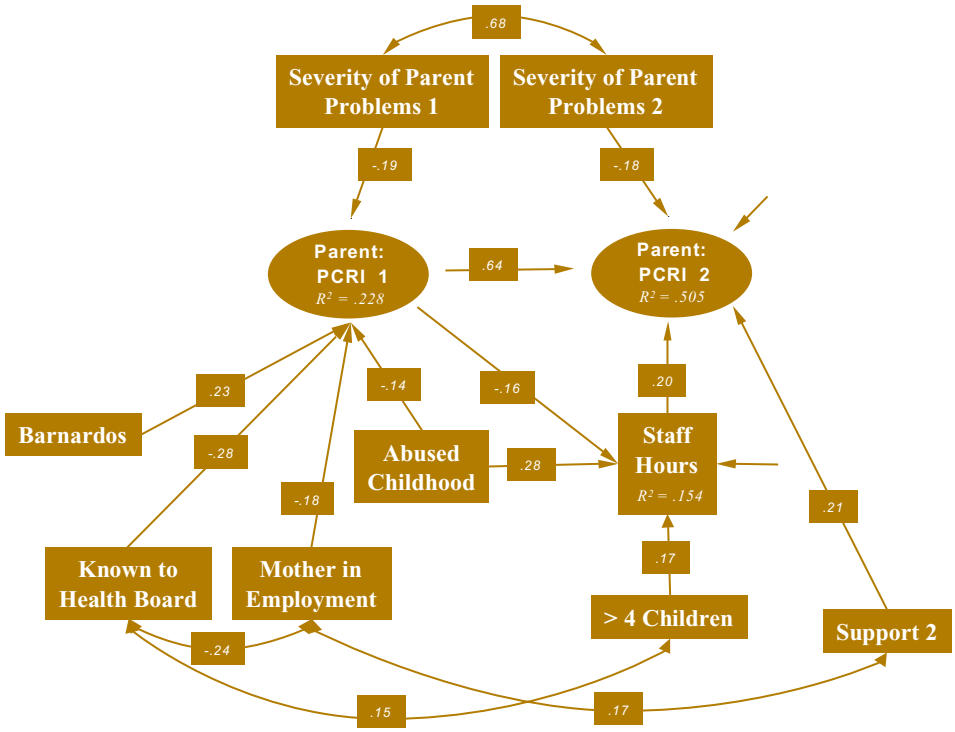
The amount of time allocated by staff to each parent is influenced by whether a parent has had an abused childhood (+0.28) and whether the parent has four or more children (+0.17), which again suggests an allocation of staff time on the basis of need.

12.3.6 Factors Having No Influence

Factors Having No Influence

Detailed statistical analyses were carried out to estimate the influence of a range of other variables on parenting capacity at baseline and on the change between baseline and follow-up. None of these - gender of parent, number of parents in household, settled or Traveller, source of household income, financial difficulties, number of agencies involved with the family - were found to be significant.

Figure 12.2b Abbreviated Path Diagram Showing Factors Which Influence the Impact of Springboard on the Parent Child Relationship Inventory (PCRI)



12.4 What Influences the Family System?

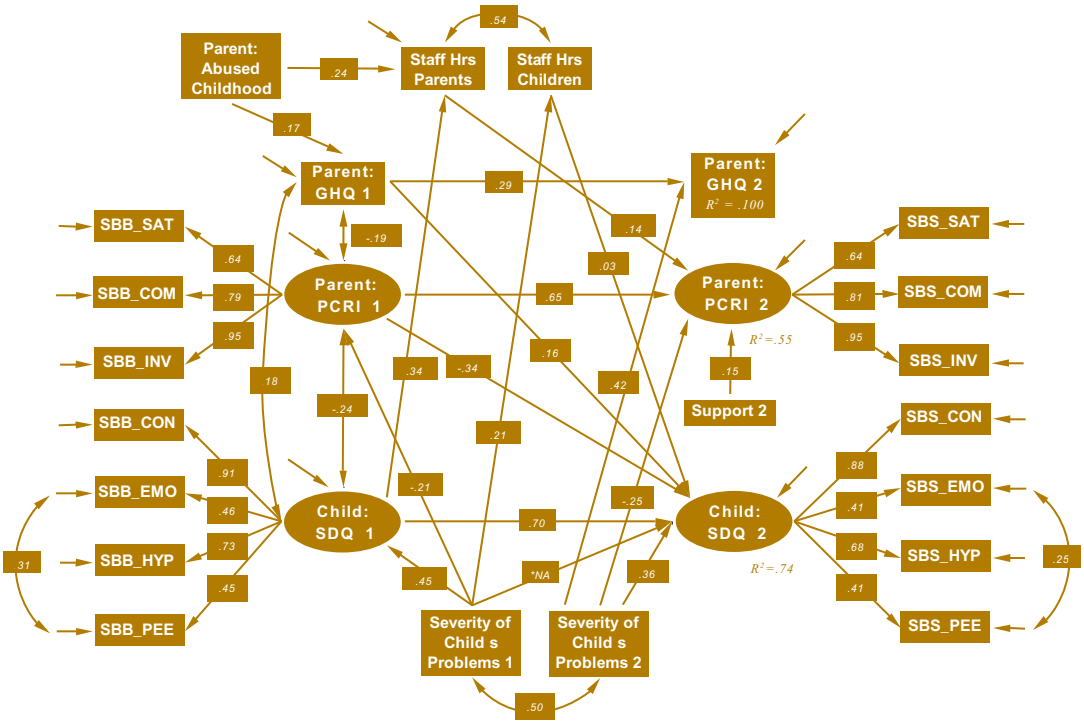
What Influences the Family System?

We have so far provided separate analyses of the factors which influence children's difficulties/well-being ('SDQ'), parental stress (GHQ) and parenting capacity ('PCRI'), the main impact variables by which the performance of Springboard is assessed. This inevitably involved analysing children and parents separately. However, in reality, every family is a system, where changes in one aspect are likely, other things being equal, to have repercussions for the rest of the family system. For this reason we decided to use Structural Equation Modelling to examine how all three impact variables are inter-related. All variables already found to be significant predictors of change in SDQ, GHQ and PCRI are included in the family system model.

As we shall see, many of these variables are no longer significant in the family system model due to the smaller sample size (this inevitably reduced the overall statistical power of the model) and due to the fact that (for technical reasons) we had to limit the analysis to just one child per family (we included the child with the highest SDQ score).

The results of our analysis are summarised in Figures 12.4a and 12.4b. The fit of the model is excellent, with a CFI of 0.97 and a RMSEA of 0.037. This gives us confidence that important relationships between variables in the model have not been omitted. Examining Figure 12.4b, we can identify four key findings, which are discussed in the following paragraphs.

Figure 12.4a Path Diagram Showing Factors Which Influence the Impact of Springboard on the Family System



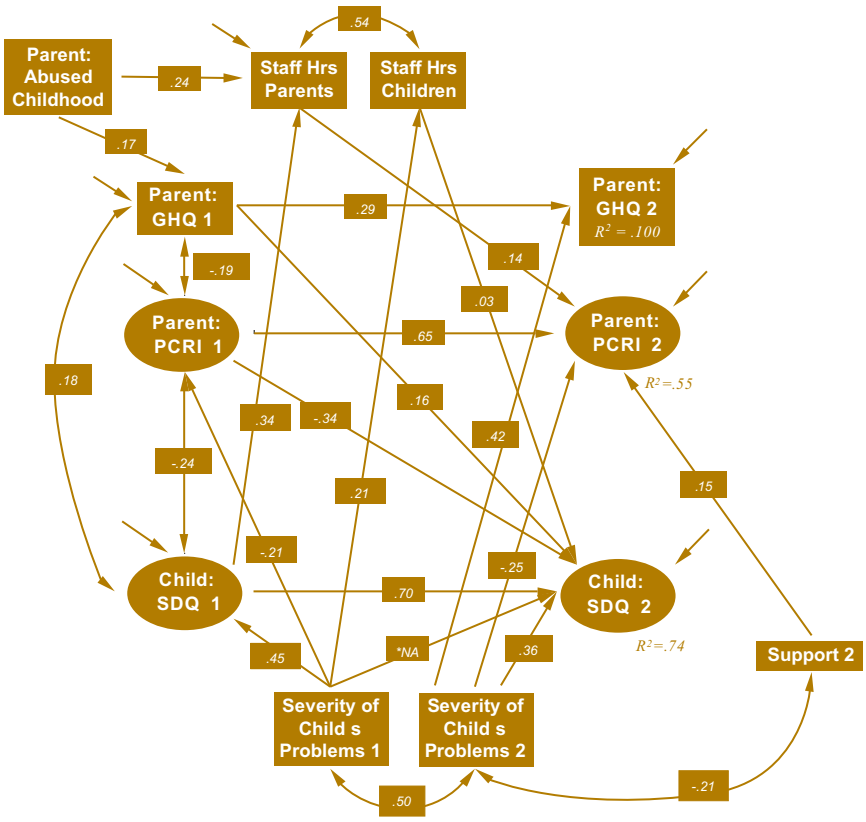
Notes:

1. All coefficients are standardised and all effects are statistically significant, with the exception of the effect of input hours with children on the 'SDQ' 2.
2. Equality constraints were placed on the factor loadings for the latent variables 'PCRI' and 'SDQ' at both time points in order to ensure comparability, and the error variances associated with respective indicators were also constrained to be equal.
3. The error variances associated with specific indicator variables were allowed to correlate between the first and second time points. In addition, correlations were specified between the 'Peer Relations' and

'Emotional Symptoms' subscales of the SDQ, as these were found to have a particularly close association during the analysis of data from the first follow-up. Only two of these correlations are shown in the diagram.

4. The correlations between 'PCRI' 1, 'SDQ' 1 and GHQ 1 should, strictly speaking, be drawn between the disturbance terms of these latent variables. However, for ease of interpretation, these have been drawn between the latent variables themselves.
5. The coefficient marked "*NA" was not reported because it is not directly interpretable, and functions within the model as a statistical control which enables us to assess the effect of changes in the severity of children's problems on the 'SDQ'.

Figure 12.4b Abbreviated Path Diagram Showing Factors Which Influence the Impact of Springboard on the Family System



Stability and Volatility in the Family System

The model shows, as before, that children's difficulties and parenting capacity are quite stable over time, suggesting that they may not be amenable to quick, short-term changes. This is not very surprising, given that these conditions are likely to be in place for some time. By contrast, the GHQ is more volatile, partly because of the symptoms which it measures and partly because of the relatively short time frame within which the symptoms are measured.

12.4.1

Stability and Volatility in the Family System

12.4.2

Influences on the Well-being of Children

Influences on the Well-being of Children

We will begin by looking at the factors which lead to changes in children's difficulties (i.e. those which have an effect on 'SDQ' 2, controlling for 'SDQ' 1). Children's difficulties diminish when their problems of neglect and abuse become less severe (+0.36), when parenting capacity is stronger (-0.34) and when parents are less stressed (+0.16). A particularly interesting feature of these results is that the likelihood of amelioration in a child's difficulties is shaped by the attributes of parents at the time they first came in contact with Springboard ('PCRI' 1 and GHQ 1), which suggests that the well-being of parents - or lack of it - has an impact on the well-being of their children over an extended period of time. This suggests, in turn, that the improvements in parental well-being observed between January 2000 and May 2001, which were the direct consequence of staff input hours with parents, are likely to bring about downstream benefits in the future. In this sense, it is true to say that improvements in the well-being of parents have both immediate and long-term effects for the well-being of children. Equally, it is clear that reducing the risk to the child of neglect and abuse directly increases the child's well-being. A clear implication of this finding is that the promotion of well-being among children involves simultaneously addressing problems of child neglect and abuse in its various forms while simultaneously working to improve parenting capacity and reduce parental stress.

12.4.3

Influences of Springboard on the Well-being of Children

Influences of Springboard on the Well-being of Children

We have already seen that the amount of time spent by staff working with children has no influence on their difficulties as measured by SDQ (see Chapter Seven). This result is replicated here, as we can see from Figure 12.4b.

12.4.4

Influences on the Well-being of Parents

Influences on the Well-being of Parents

We will now examine the factors which bring about change in parental stress (GHQ) and parenting capacity ('PCRI'). In the case of parenting capacity, the main influences are: (1) the severity of child's problems at the second time point (-0.25) and the parent's support network (+0.15). The parents of children with fewer problems managed to improve their parenting capacity. In addition, the severity of children's problems was correlated with parental support networks, which also boost parenting capacity (+0.15). These findings underline the systemic nature of families by showing how improvements in the well-being of one family member can often have knock-on effects for the well-being of others, just as we saw earlier. Turning to the GHQ, we see that increases in the stress levels of parents are caused by children's problems (+0.42); parental stress is influenced by the childhood experiences of the parent. Indeed, the link between the (abusive) childhood experiences of parents, via the parent's stress (GHQ 1), to their child's current difficulties ('SDQ' 2) is a graphic illustration of how the neglect and abuse of children is intergenerational in its impact. This underlines the need

for interventions such as Springboard which can help to break this harmful cycle of family dysfunction.

Influences on Staff Time

12.4.5

Influences on Staff Time

The family system model sheds additional light on the criteria used by staff when allocating their time to individual parents and children. As Figure 12.4b shows, children's difficulties at baseline had a moderate influence on staff intervention hours with parents (+0.34), suggesting that staff members are aware of the need to provide support to the parents of children with severe difficulties, as well as to the children themselves. This was not the only influence on staff interventions with parents, as parents who experienced physical, emotional or sexual abuse as children also received more time. Secondly, staff intervention hours with children were influenced by the severity of children's problems when they first came into contact with Springboard (+0.21). In other words, staff members tended to focus their attention on children whose objective circumstances were especially problematic, regardless of whether this was associated with particular difficulties.

12.5 Summary and Conclusion

Summary and Conclusion

This chapter used Structural Equation Modelling to analyse the impact of Springboard on parents in terms of their stress levels (as measured by the GHQ) and their parenting capacity (as measured by the PCRI). We also analysed how Springboard influences the family system as a whole by looking at the factors which influence children's difficulties, parental stress and parenting capacity simultaneously. The following key findings emerged:

- the stress levels of parents at the time of their first contact with Springboard are shaped by four inter-related variables: (1) financial difficulties (2) abused childhood (3) support networks and (4) severity of current problems.
- parental stress, which fell by 41% while attending Springboard, bore no relation to the amount of staff time received by each parent. The main factor which caused a reduction in parental stress was the severity of the parent's problems.
- the main factor influencing changes in parenting capacity - which improved for more than one quarter (27%) of all parents while attending Springboard - is their support network. Significantly, the amount of time spent by Springboard staff with each parent - which averaged 1.7 hours per week over 48 weeks - had the effect of improving parenting capacity, and was similar in its influence to the effect of support networks and the severity of the parent's current problems.
- parents are likely to present with weaker parenting capacity if they are known to the Health Board, have severe problems, have had an abused childhood and if the mother is in employment.

The family system model provided further evidence of the stability of children's difficulties and parenting capacity over time and the contrasting volatility of the GHQ. It also showed that the input of Springboard staff had no impact on children's difficulties or the GHQ but had a small and statistically-significant effect on parenting capacity. The family system model also added new insights by showing that:

- changes in the well-being of children are influenced by two main factors: (1) changes in the severity of children's problems (particularly neglect and abuse) and (2) the well-being of parents as measured by their parenting capacity and their stress levels.
- the well-being of parents - or lack of it - has an impact on the well-being of their children over an extended period of time, suggesting, in turn, that the improvements in parental well-being achieved by Springboard between January 2000 and May 2001 are likely to have downstream benefits for children in the future.
- the factors which influence changes in parenting capacity ('PCRI') - in addition to staff intervention hours - are the severity of child's problems (-0.25) and the parent's support network (+0.15), a finding which underlines the systemic nature of families by showing how improvements in the well-being of children have knock-on effects for the well-being of parents.
- the stress levels of parents are influenced by the childhood experiences of the parent and changes in the severity of children's problems have an effect on changes in parental stress (GHQ) (+0.42). The impact of changes in children's problems on parental stress is even greater than for parenting capacity.

These findings prompt a number of reflections. First, our analysis of stress revealed that parents who experienced an abused childhood continue to experience its negative impacts into adulthood in the form of elevated stress levels, increased financial difficulties and weaker support networks. This is arguably the most compelling reason why family support initiatives like Springboard are of such vital importance in promoting the well-being of children, particularly those living in vulnerable families, so that the cycle of abuse which children experience is not repeated when they become parents. We have already noted a striking similarity between the family problems which parents themselves experienced as children and the family problems which are currently observed, particularly relationship difficulties with children and partners sometimes associated with alcohol dependence and psychiatric problems (see Chapter Nine).

Second, despite our limited understanding of how to reduce parental stress, our analysis indicates that reducing the severity of parents' problems is important. In effect, this means addressing the relationship difficulties which many parents have with their children and with their partners as well as addressing more specific issues such as alcohol abuse and psychiatric illness. These problems are much more prevalent among Springboard families than in the population in general and require sensitive and skilled intervention.

Third, our analysis of parental stress and parenting capacity produced the challenging finding that paid employment increases the well-being of

families by reducing their financial difficulties, alleviating maternal stress and improving support networks (see Chapter Seven) but increases the difficulties of children and reduces parenting capacity. The significance of these findings, as we have suggested above, may go far beyond the confines of Springboard. Given that of all women in the labour force, the group with the highest participation is that of lone mothers with child(ren) under 15 (52%), followed by married women with child(ren) under 15 (49%)[92]. This draws attention to the need to ensure that children are not adversely affected by their mother's entry into the labour market. The provision of high-quality affordable childcare combined with the greater involvement of fathers may help avoid this negative trade-off. From the perspective of staff in Springboard, these findings suggest that arrangements for the care and protection of children when mothers are at work cannot be taken for granted and the child's experience of their mother's employment should be taken into account, bearing in mind the "principles for best practice" enunciated in the National Guidelines for the Protection and Welfare of Children[93].

Fourth, the key indicators of family well-being, namely children's difficulties and parenting capacity, are highly stable and not amenable to quick change. This cannot be repeated too often, if only to discourage unrealistic expectations about what is achievable by interventions such as Springboard. Our analysis has shown that significant progress has been achieved in promoting the well-being of children and parents despite the stability of the underlying conditions, but more remains to be done.

Fifth, our analysis of the family system has underlined the systemic nature of family well-being in the sense that the well-being of children is heavily determined by the well-being of their parents and vice versa. A clear implication of this finding is that strategies which do not fully engage with both parents and children are likely to be less effective.

Sixth, we have already acknowledged that the amount of time spent by staff working with children and parents is probably a rather crude measure of the therapeutic relationship between staff members and their clients. At the same time, our analysis has revealed two aspects of the family system that provide support for interventions such as Springboard. First, we have discovered that the well-being of parents affects children over a relatively long period of time - for example parental stress and parenting capacity influenced children's difficulties at follow-up - and this suggests that the improvements in parental well-being which occurred while attending Springboard will bring significant downstream benefits to children. Second, and possibly more significantly, our analysis clearly revealed one of the processes by which family dysfunction is transmitted inter-generationally. This was revealed in the link between a parent's abused childhood, the parent's current level of stress and their child's current difficulties, a graphic illustration of how the neglect and abuse of children has intergenerational impacts and serious implications as those children become parents themselves. Both of these findings provide powerful arguments in favour of intervening to support families through initiatives like Springboard in order to break the harmful cycle of family dysfunction.

[92] See McKeown and Sweeney, 2001:26, Box 15.
[93] Department of Health and Children, 1999a, pp.22-23.

13 Case Studies of Most Improved Parents

13.1 Introduction

As part of the evaluation, each project prepared a case study on the most improved parent. The purpose of the case studies, which are synthesised in this chapter, is to provide an insight into the life of each parent and the difficulties they encounter, and to illustrate the improvements which they experienced since attending Springboard. In this way it is hoped to deepen our understanding of the change process within Springboard and to throw further light on the statistical patterns identified in the previous chapters. Our analysis begins by comparing the most improved parents in the case studies with the general population of Springboard parents (section 13.2). We then discuss the key themes around which the case studies were written: the reasons why the cases were chosen (section 13.3), a brief description of parents and families (section 13.4), the objectives of intervention (section 13.5), a description of the intervention including ideas and models of practice used (section 13.6), outcomes (section 13.7), obstacles to change (section 13.8), project learning (section 13.9), time spent on each case (section 13.10), and case management (section 13.11). We conclude (section 13.12) by drawing out some of the general implications of the case studies.

13.2 Profile of Most Improved Parents

All of the parents are mothers, which accentuates their already dominant position within the total Springboard population (88%) (see section 9.2 above). This reflects the dual reality that mothers often have primary responsibility for the care of children while family support services are typically oriented towards supporting mothers rather than fathers. All but one of the most improved parents come from one-parent households which is also untypical of Springboard households generally, where nearly five out of ten households have two parents (see section 3.3 above). The average number of children per family in the case studies is 4.1, which is higher than among Springboard families generally (3.8).

In terms of their scores on the General Health Questionnaire (GHQ), the most improved parents experienced similar reductions in stress to the general population of parents. This is clear from a comparison of mean scores at baseline (both are 5) and second follow-up (both are 1). However the proportion of the most improved parents who are still stressed after the intervention (40%) is higher than among Springboard parents generally (28%).

The scores of the most improved parents on the Parent-Child Relationship Inventory (PCRI) indicate that they made significantly greater improvements on all PCRI dimensions; in fact, their margin of improvement was about six times greater than that of Springboard parents in general. Moreover, the most improved parents began from a lower base score although - like Springboard parents in general - they still fall somewhat below the US mean score on the PCRI, indicating that room for improvement still remains[94].

[94] We are aware that some of the improvement in GHQ and PCRI scores may be a statistical artefact, sometimes referred to as "regression to the mean", since parents with higher GHQ scores and lower PCRI scores have more scope for improvement than other parents.

Table 13.1 Baseline and Follow-up Scores on General Health Questionnaire: Comparison of All Springboard Parents and Most Improved Parents

GHQ Scores	Baseline		Follow-up		Change	
	>Threshold*	Mean**	>Threshold*	Mean**	>Threshold*	Mean**
1.All Springboard Parents	65	5	37	1	-28	-4
2.Most Improved Parents	100	5	60	1	-40	-4

1. Based on 191 cases for which there is baseline and follow-up data.
2. Based on 5 cases for which there is baseline and follow-up data.

*Threshold refers to the proportion of parents who are above the GHQ threshold which is a strong indicator of mental stress.
**Mean refers to the average score on the GHQ.

Table 13.2 Baseline and Follow-up Scores on Parent-Child Relationship Inventory (PCRI): Comparison of Mean Scores for All Springboard Parents and Most Improved Parents

PCRI	Baseline		Follow-up		Change		US Mean
	All Parents	Improved Parents	All Parents	Improved Parents	All Parents	Improved Parents	US Parents
1. Support	19.8	15.8	21.4	21.5	+1.6	+5.7	24
2. Satisfaction	31.4	25.8	31.8	30.5	+0.4	+4.7	34
3. Involvement	46.3	40.7	47.5	48.9	+1.2	+8.2	46
4. Communication	28.2	25.0	29.2	30.0	+1.0	+5.0	29
Total	126	107	130	131	+4	+24	133

1. Support in the PCRI refers to "the practical help and emotional support which the client receives as a parent" (Gerard, 1994, p.9).
2. Satisfaction in the PCRI refers to "the enjoyment a client receives from being a parent" (Gerard, 1994, p.10).
3. Involvement in the PCRI refers to "the client's propensity to seek out his or her children and manifest an interest in their activities" (Gerard, 1994, p.10).
4. Communication in the PCRI refers to "the clients' awareness of how well they communicate with their children in a variety of situations including simple conversation" (Gerard, 1994, p.10).

13.3 Reasons Why Cases Were Chosen

Reasons Why Cases Were Chosen

The reason why most parents were chosen is due to significant improvement in their PCRI and GHQ scores, a fact which points to the reliability of these instruments as indicators of well-being. In addition, cases were selected to illustrate how the project approaches its work and the issues and challenges posed when working with vulnerable parents.

13.4 Presenting Problems of Parent and Family

Presenting Problems of Parent and Family

The reality of parenting three or four children on one's own is made more difficult for virtually every mother by the fact that she is extremely isolated from extended family and community. This isolation is often related to the break-up of the relationship with the father of the children due to both an internalised sense of shame and to community disapproval at the break-up, particularly among Traveller families. Many mothers come from quite disturbed backgrounds themselves, characterised by alcohol abuse and domestic violence and this pattern is often repeated in adult relationships where they have experienced similar and further abuse. Some mothers suffer from depression and many are seriously impaired in their capacity to nurture and control their children. As a result, the children often show symptoms of behavioural problems at home and school and they too often experience isolation from peers; some appear undernourished, others unkempt. The powerful influence exercised by the negative childhood experiences of these mothers is consistent with the larger picture of Springboard parents which, as we have seen in Chapter Twelve, shows that parents who have experienced abused childhoods are more likely to have higher levels of stress (as measured by the GHQ) and a weaker parenting capacity (as measured by the PCRI).

13.5 Objectives of Intervention

Objectives of Intervention

Interventions with the most improved parents typically have a twofold aspect: one aspect involves increasing the mother's capacity to care and control her children and the second aspect involves reducing the behaviour and emotional problems of the children which are often a major source of stress. Increasing the mother's capacity to parent is done in a variety of ways including offering practical support in establishing family routines, addressing accommodation problems, managing finances, advising on specific parenting skills and generally building self-esteem and confidence through empathic and supportive listening. At least two of the projects used the Parents Plus Programme to developing the parenting capacity of the mother; this is a series of age-related parenting programmes devised by the Department of Child and Family Psychiatry at the Mater Hospital in Dublin. Some of the most improved parents were referred to Springboard as a result of problems presented by children and are typically working with other agencies such as schools and Health Boards. For some mothers, where Health Boards have child protection concerns, a key objective is to keep the children at home in the care of their mother and all have succeeded in doing this.

13.6 Interventions, Ideas and Models of Practice Used

Interventions, Ideas and Models of Practice Used

All interventions are informed by the philosophy of being "strengths-based" and "solution-focused". The key elements of the intervention in virtually every case involve:

- Individual work with the parent covering both practical and therapeutic issues. Many projects offer practical help such as transport to services, establishing family routines around getting up, eating breakfast, getting children to school, shopping, house cleaning, managing finances and debt, applying for social welfare entitlements, etc. Therapeutically, many parents are supported to feel better about themselves as persons and as parents and to feel better about their children as well; one mother received addiction counselling. Some projects use "modelling" by staff within the home to show parents how a child's difficult behaviour can be managed without causing unnecessary stress to either parent or child.
- Group work is mainly offered to children through breakfast clubs, after-school clubs, homework clubs, summer programmes, sport and leisure activities, outings, etc. for the purpose of promoting social skills, reducing isolation and creating fun. These interventions also have the benefit of giving respite to mothers, thereby helping to reduce their stress.
- Family work involves discussion of how the family functions as an entity. This is particularly important in situations where one child may be seen as "the cause of all the problems" and helps to create a shared sense of responsibility for the family.
- Inter-agency cooperation occurs, particularly where issues such as child protection or non-attendance at school are involved.

These interventions are tailored to the unique circumstances of each case and usually involve a combination of centre-based and home-based work.

13.7

Outcomes

Outcomes

We have already seen that these mothers have improved in terms of their GHQ and PCRI scores (section 13.2 above). The case studies add a qualitative dimension to this by highlighting how the intervention of Springboard typically results in parents feeling better and more self-confident about themselves. Mothers are less isolated not only as a result of the support obtained from Springboard but many also have re-established contact with their extended family and have become more integrated within their communities. Improvements are evident in practical ways such as paying off debts, keeping the house in a better state, establishing family routines, being more attentive to the needs of children in areas such as hygiene and school attendance and generally having more positive experiences as a family. The transformation in some mothers is evident from the fact that they have taken up a course of study while others have found a job; in a few instances, the most improved mothers have started to help other parents who are experiencing similar difficulties. Children too are benefiting from stronger support networks through their greater involvement in programmes of activities and appear to be more settled in school. Mothers about whom there were child protection concerns are deemed to be no longer at risk.

13.8 Obstacles

Obstacles

The main obstacle in many cases is the reluctance of parents to engage with the project. Many parents are slow to trust services and are fearful that their vulnerabilities may be exposed, having had previous negative experiences of services. All of the projects successfully overcame this obstacle by allowing trust and confidence to build up over time and by allowing the intervention to proceed at a pace that suited the parent. A second obstacle encountered by some projects arose from conflict between parents during and after separation and the related difficulty of engaging fathers; this was particularly the true in cases involving Travellers where marital breakdown can result in the woman being isolated if not ostracised from the rest of the community. In other cases, specific obstacles - inadequate accommodation, debts, depression, physical disability, too many agencies involved, etc. - posed a challenge. In all cases, however, the resourcefulness of staff and parents succeeded in overcoming these obstacles and ensured a positive outcome.

13.9 Lessons Learned

Lessons Learned

There is a wide degree of consensus about the key lessons which projects have learned from these case studies. These are similar to the lessons learned from the experience of the most improved children and include the following:

1. It is essential to build a trusting relationship with the parent. Typically that involves working at a pace which is comfortable for the parent, usually slow rather than fast, and being consistently available, often to meet very practical needs.
2. As with children, it is important to see the parent's problems from a family perspective and not just an individual perspective.
3. Vulnerable families can often be very isolated from the supports of extended family and community and this needs to be addressed.
4. It is important to work collaboratively with other members of staff and with other agencies to draw upon their skills and resources for the benefit of the family.
5. It is necessary to understand Traveller culture and the challenges which this can pose for women when marriages break down.

13.10 Time Spent On Case

Time Spent On Case

On average, as Table 13.2 shows, each of the most improved parents received an average of 422 hours from Springboard staff, five times more than parents more generally (82 hours) and four times more than children in general (102). The main focus of staff time with the most improved parents was on group work (45%) and individual work (36%), which is different to the general pattern of intervention with parents in Springboard, where the main focus is on individual work (28%) and administration (28%) (see Chapter Ten above). We know from Chapter Twelve that the amount of staff time is

directly related to improvements in parenting capacity (though not to GHQ scores) and this suggests that the substantial amount of time received by these parents is part of the reason why they improved so much relative to Springboard parents more generally. It is also consistent with the fact that GHQ scores of the most improved parents were similar to the Springboard parents as a whole.

Table 13.2 Staff Time Received by All Springboard Parents and by Most Improved Parents

Category Interventions	All Parents in Springboard Mean Hours N	Mean Hours %	Most Improved Parents* Mean Hours N	Mean Hours %
1. Individual Work	23	28	152	36
2. Group Work	12	15	189	45
3. Family Work	14	17	25	6
4. Drop-in	10	12	12	3
5. Administration	23	28	43	10
Total	82	100	422	100

* Based on 9 of the 15 case studies which supplied this information.

13.11

Case Management

Case Management

All projects seem to share a broadly similar template for the management of each case. This is similar for both the most improved parent and children and involves a number of elements:

- Team discussions where ideas and information are pooled and the key worker is supported;
- Case supervision where the project leader (usually) discusses the case in detail with the key worker;
- Ongoing discussion with the family to review and update goals in the light of what is working;
- Review and evaluation meetings involving all relevant agencies to share information and ensure that the family support plan is properly co-ordinated;
- Effective inter-agency communication and co-operation.

These different levels of management draw attention to the need for a creative and flexible approach to the needs of each child and family and for collaboration between staff in the project as well as with staff in other agencies. Above all, the management of each case requires sensitivity to the needs and strengths of each child and family by all of the professionals involved.

13.12

Summary and Conclusion

Summary and Conclusion

The key findings to emerge from the analysis and synthesis of these case studies show that all of the most improved parents are mothers and all but

one come from a one-parent household. On average, the amount of staff time received by each of the most improved parents was five times greater than other Springboard parents.

The most improved parents showed similar reductions in stress (GHQ scores) compared to the general population of parents but made significantly greater improvements in parenting capacity (PCRI scores). One of the main presenting problems for these parents was isolation from extended family and community. Many mothers come from quite disturbed family backgrounds, themselves characterised by alcohol abuse and domestic violence and this pattern is often repeated in adult relationships where they experience similar and further abuse.

Interventions with the most improved parents typically have a twofold aspect: one aspect involves increasing the mother's capacity to care for and control her children and the second aspect involves reducing the behavioural and emotional problems of the children, which are often a major source of stress for the mother as well as for the children themselves. All interventions are informed by the philosophy of being "strengths-based" and "solution-focused". The intervention of Springboard typically results in parents feeling better, more self-confident, less isolated and often brings about practical improvements such as paying off debts, keeping the house in a better state, establishing family routines, being more attentive to the needs of children in areas such as hygiene and school attendance, and generally having more positive experiences as a family. The main obstacle to change, which Springboard managed to overcome, is the reluctance of parents to engage with the project.

Some of the lessons which have been learned from these cases include: (1) it is essential to build up a trusting relationship with the parent; (2) it is important to see the parent's problems from a family perspective and not just an individual perspective; (3) vulnerable parents can often be very isolated from the supports of extended family and community; (4) it is important to work collaboratively with other members of staff and with other agencies; (5) it is necessary to understand Traveller culture and the challenges which this can pose for women when marriages breakdown. All projects share a broadly similar template for case management involving: (1) team discussions (2) case supervision (3) ongoing discussion with the family (4) review and evaluation meetings involving all relevant agencies, and (5) effective inter-agency communication and co-operation.

From the perspective of the evaluation, these findings highlight three important considerations in terms of working with vulnerable parents, and with mothers in particular. The first is that most vulnerable parents have themselves experienced abusive childhoods and often re-experience abusive relationships in adulthood with the result that their capacity to be a good parent is seriously impaired. This is a feature not only of the most improved parents in the case studies but is a more general feature of the parents who have come to the attention of Springboard. We have seen in Chapter Twelve that parents who experienced abused childhoods tend to have more severe problems as adults and to be more stressed. This shows how patterns of

abuse within families can have a strong inter-generational effect and why the work of Springboard is crucially important in breaking this cycle so that family life can provide positive experiences for children and parents alike.

Second, vulnerable families are often isolated from the supports of their extended family and their community. The case studies suggests that this is often exacerbated when relationships between parents break down, thereby adding to the family's vulnerability. We know from our analysis in Chapter Twelve that this is not just a feature of the case studies, since the strength of a parent's support network has a statistically-significant effect on their stress levels and their capacity to improve as parents. In this sense, the case studies draw attention to the importance of reducing a parent's vulnerability by strengthening their support networks.

Third, the most improved parents received a substantially larger amount of time from Springboard staff relative to that received by other parents and children, even the most improved children. We know from our analysis in Chapter Twelve that the amount of time received by parents is directly related to improvements in parenting capacity, although it is not related to changes in their level of stress. These findings suggest that while the amount of time received by parents is important, other factors are also responsible for changes in family well-being. This calls attention to the need for further research in order to explore the dynamics of the family system and the possibility of intervening to promote family well-being.

14 Perceptions of Parents and Children

14.1 Introduction

The core objective of Springboard is to improve the lives of parents and children in vulnerable families. For that reason, the evaluation has placed great emphasis on measuring the impact of Springboard on both parents and children. As we use the term, impact has two aspects, one objective and one subjective. The objective aspect refers to impacts which may be detected using independently-validated measures of the strengths and difficulties of children, the stress levels of parents and the parent-child relationship, as described in Chapter Two above. The subjective impact refers to the way in which Springboard is perceived by parents and children, and this is the theme of the present chapter. Obviously, the objective and subjective aspects of impact are related in the sense that the objective impact is more likely to be positive if clients also have positive perceptions and experiences of Springboard; however there is no necessary relationship since clients may have positive subjective experiences but there may be little change in the more objective indicators of well-being. For this reason, it is necessary to measure both objective and subjective impacts separately.

This chapter is based on interviews with a random sample of parents and children in each project[95], resulting in a total sample of 64 parents and 61 children; this is approximately five parents and five children per project. We chose a random sample from lists of clients supplied by Springboard staff in order to ensure that every parent and child had an equal chance of being interviewed with the result that the picture emerging from the survey is truly representative of the broader population of service users in Springboard. A similar questionnaire was used by our independent interviewers in their interviews with both parents and children.

The results of these interviews are presented in ten sections covering the characteristics of parents and children (section 14.2), the quality of springboard services (section 14.3), the personal and family impacts of Springboard (section 14.4), the qualities of Springboard staff (section 14.5), a profile of Springboard in the community (section 14.6), perceptions of Springboard compared to other services (section 14.7), the activities which are most helpful in Springboard (section 14.8) and suggestions for making Springboard more effective (section 14.9). We conclude the chapter with a summary of findings (section 14.10).

For ease of presentation, we have included all of the tables in the Appendix to this report. The survey results for each project are available in a separate report.

14.2 Characteristics of Parents and Children

Most of the parents are mothers (88%) due to the fact that many parents coming to Springboard are lone mothers, although it also reflects some selectivity by projects in working with mothers rather than fathers. Most of the parents (82%) are in their 30s or over (Table A14.1a) and all but three

[95] All Springboard projects are included with the exception of Tullamore which has only been fully operational since the beginning of November 2000.

have at least one child attending Springboard (Table A14.2).

Children are divided evenly between boys and girls with most (75%) aged nine and over (Table A14.1b). Approximately half of all parents and children have been attending Springboard for over 12 months; the other half have been attending for less than 12 months (Table A14.3).

14.3

Quality of Springboard Services

Quality of Springboard Services

We use the term "quality" to refer to the way in which Springboard services are experienced by parents and children. We measured this experience using seven statements about the service and asking respondents for their level of agreement or disagreement. The seven statements are:

- I was made to feel welcome by the project
- I was listened to by the project
- I was understood by the project
- I enjoy coming to the project
- The project gave me help just when I needed it
- The project gave me very good advice
- The project is always there to support you

We measured the level of agreement or disagreement by asking respondents how frequently each statement is true about their experience of the project; the response categories are: always, often, sometimes, rarely, and never.

The results of the survey indicate that virtually every parent and child had a very positive experience of Springboard (Table A14.4). The most frequent response (80% or more) to each statement was that it was "always true" and, with few exceptions, all of the responses were either "always true" or "often true". In other words, Springboard is seen and experienced as an excellent service.

14.4

Personal and Family Impacts of Springboard

Personal and Family Impacts of Springboard

One of the proofs of any family service is whether clients find it helpful in their personal or family life. With this in mind, we used the same response scale to measure respondents' agreement with the following statements:

- The project has been a big help to me
- The project has been a big help to my family

The results show that more than eight out of ten parents and children believe that both these statements are "always true" (Table A14.5a). In other words, they experience Springboard as being a "big help" to them and their families.

We also measured impact by asking parents and children "if your life has changed since coming to the project". The response categories are: much better, better, same, worse, much worse. The results indicate that more than

four in ten (42%) believe that life is "much better" and nearly five out of ten (47%) believe it to be "better", with only one tenth (11%) believing their lives are still the same; only one respondent experienced life as worse since coming to Springboard (Table A14.5b).

When asked to explain the changes they have experienced since coming to Springboard, many children refer to their relatively new experiences of "friends", "fun" and "feeling happier" as well as "not being bored", "not being bullied" and "not getting into trouble". A number of children also mentioned the importance of getting on better at school as a result of receiving help with their homework. For parents, the change since coming to Springboard is typically expressed in the following ways: (1) personal benefits such as feeling more supported, more confident and more happy (2) benefits to children in the form of improved behaviour and progress at school and (3) improved family relationships between parents as well as between parents and children. All of these comments seem to underline the important role which Springboard has played in promoting individual and family well-being.

14.5 Qualities of Springboard Staff

Qualities of Springboard Staff

The effectiveness of family support, like any personal service, is crucially dependent on the qualities of staff since these strongly influence the therapeutic relationship, itself a crucial determinant of change in the lives of clients[96]. We measured this by asking parents and children to express their level of agreement or disagreement with the following statements about staff:

- Staff in the project genuinely care about you
- Staff in the project know how to respect people
- Staff in the project are fair
- Staff in the project are very good at what they do

The response categories are: always, often, sometimes, rarely, and never.

The answers to these questions indicate that more than nine out of ten parents (93%) and more than eight out of ten children (86%) believe that these statements are "always true" (Table A14.6). This is an extremely high approval rating for staff and suggests that the key ingredients for an effective therapeutic relationship are in place within Springboard. It is also a strong endorsement of the personal and professional qualities of staff.

14.6 Profile of Springboard in the Community

Profile of Springboard in the Community

A key requirement of Springboard is that it should be accepted by the community in which it is located. In other words, Springboard needs the support of the community in order to support the families of that community. One of the strengths of Springboard, as perceived by other professionals, is that it is "non-stigmatising, non-threatening, non-judgemental, and non-clinical". In order to assess the community aspect of

[96] See McKeown, 2000, p.13.

Springboard, we asked parents and children to express their level of agreement with the following statements using the same response categories as before (always true, often true, sometimes true, rarely true, and never true):

- The project is respected in the area
- The project has given a boost to the area
- The project is needed in the area

The results indicate that over nine out of ten (91%) believe it is "always true" that the project is needed in the area although this falls to seven out of ten (70%) who believe it is "always true" that the project has given a boost to the area; this in turn falls to five out of ten (50%) who believe that it is "always true" that the project is respected in the area (Table A14.7). The apparent inconsistency in this pattern of response is due to the fact - explained by respondents in more detail during the interviews - that communities are often suspicious of agencies which intervene in the life of families due to fears of being judged inadequate or even losing custody of children. The sensitivity of working with families in vulnerable communities has also been underlined by staff in Springboard who, as we have seen in Chapter One, are well aware of the difficulties in gaining and sustaining confidence and credibility in communities which may themselves be quite divided and suspicious. In view of this, the scale of goodwill shown by clients towards Springboard and its staff is itself a considerable achievement and suggests that a strong foundation has been built for further work in those communities.

14.7

Springboard Compared to Other Services

Springboard Compared to Other Services

Some insight into the issue of quality can be gained by comparing clients' perceptions of Springboard with their perceptions of other services. With this in mind, we asked parents how their experience of Springboard compared with their experience of 12 other services, using the following scoring scale: much better, better, same, worse, and much worse. The results indicate that Springboard is experienced as being superior to all other services, with a much higher level of satisfaction than Social Workers (Health Board), Local Authorities, Community Welfare Officers, Secondary Schools, the Garda Síochána, the Department of Social, Community and Family Affairs, Primary Schools, and Public Health Nurses (Table A14.8). The four services which are viewed as being more similar to Springboard (albeit less satisfactory) are Probation and Welfare Services, FÁS, MABS and the Society of St. Vincent de Paul. These results show how, within a relatively short space of time, Springboard has managed to position itself favourably within the community and is regarded by parents as more acceptable than any other service.

14.8 Activities Which Are Most Helpful in Springboard

Activities Which Are Most Helpful in Springboard

The perceptions which parents and children have of Springboard derive essentially from their experience of its services. In practice, these services are delivered through four main forms of activity:

- Individual work, which typically involves one-to-one sessions with the child or parent for the purpose of assessing needs and meeting therapeutic goals.
- Group work, which typically involves sharing experiences or activities such as sports, recreation, courses, etc. for the purpose of meeting therapeutic goals.
- Family work, which usually involves sessions with two or more members of the family for the purpose of assessing needs and meeting therapeutic goals.
- Drop-in, which is where the child or parent visits the centre and engages in unstructured activities such as meeting others, participating in activities and relaxing/having fun.

Our survey revealed that more than seven out of ten parents (72%) underwent individual work and over six out of ten (64%) participated in family work (Table A14.9a). Similarly, the vast majority of children (78%) also took part in individual work, although children were much more likely than parents to experience group work (73% compared to 38%). Our main aim in this section is to see how parents and children perceive the relative effectiveness of these different forms of interventions. To measure this we asked respondents to select the activity which they found most helpful. The results suggest that parents and children experience the various activities in quite a different way. For parents, the two activities which are most helpful are individual work (36%) and family work (36%), while for children the most helpful activity is group work (64%) (Table A14.9b). This may shed light on the finding that staff intervention hours with children did not lead to improvements in their difficulties. Due to their age, children may benefit primarily from unstructured 'play' activities, contact with other children and from their informal interactions with staff members, whereas parents may benefit from structured interventions and conversations. This suggests that future evaluations should include more multifaceted measures of the interactions between children and projects/staff members.

14.9 Suggestions for Making Springboard More Effective

Suggestions for Making Springboard More Effective

All respondents were invited to make suggestions about how their dealings with the project could be improved. This yielded relatively few suggestions, since most parents and children are satisfied with the service they receive from Springboard. However, a small number of suggestions were made including: (1) larger premises (2) larger playgrounds (3) more activities and services (4) more staff (5) more male staff members and greater involvement of fathers (6) and more involvement by local people. These suggestions are not unlike those put forward by professionals (see Chapter One) and seem to be informed by a desire to see Springboard expand.

14.10

Summary and Conclusion

Summary and Conclusion

This chapter was based on survey results from a random sample of 64 parents and 61 children which aimed to measure their perceptions and experiences of Springboard. The results, which can be taken as broadly representative of Springboard clients, indicate that:

- virtually every parent and child has had a very positive experience of Springboard.
- most clients experience Springboard as being a "big help" to them and their families.
- since coming to Springboard, more than four in ten (42%) believe that life is "much better" and nearly five out of ten (47%) believe that it is "better" with only one tenth (11%) believing that it has remained the same; only one respondent experienced life as worse since coming to Springboard.
- virtually every parent and child experiences Springboard staff as caring, respectful, fair and competent.
- most parents believe that Springboard is needed in their area but, like staff, they recognise that gaining respect for its work can sometimes be difficult where communities are divided and vulnerable.
- Springboard is perceived by parents as more acceptable than any other service in the community.
- parents experience individual work and family work as most helpful, while children find group work most helpful.
- parents and children made a small number of suggestions for improving Springboard including: (1) larger premises (2) larger playground (3) more activities and services (4) more staff (5) more male staff members and greater involvement of fathers and (6) more involvement of local people.

These results throw valuable light on the subjective impact of Springboard as seen through the eyes of parents and children and complement the conclusions of other chapters in this evaluation. They show that Springboard is experienced as having a very beneficial impact on the lives of parents and children. The fact that parents are unanimous in their view that Springboard is needed in the area and compare it favourably to all other services they experience is indicative of the credibility which these projects have created over a relatively short period of time. The extent of this achievement in terms of gaining and sustaining confidence in communities which may themselves be quite divided and suspicious should not be underestimated and represents a genuine improvement in the social capital of those communities. Overall, these results provide a strong endorsement of Springboard and indicate that its core objective of "supporting vulnerable families" has been realised.

15 Perceptions of Professionals

15.1 Introduction

Springboard, like a number of other initiatives such as the Integrated Services Process (ISP) and the Programme for Revitalising Areas by Planning, Investment & Development (RAPID), have a remit to improve co-ordination and integration between service providers. This was made explicit in the documentation sent to prospective Springboard projects in 1998, which indicated an expectation "To work in partnership with other agencies, key groups and individuals in the community and with families to develop programmes of family support services"[97]. It is appropriate therefore to examine how Springboard projects are perceived by the different organisations and agencies in their community and to gain some insight into how well they have worked together.

This chapter is based on 172 self-completed questionnaires as summarised in Table 15.1. These were completed by a wide range of professionals (including project staff) who are in regular contact with the Springboard project in their area. As such, the results reported in this chapter represent a diffuse and well-informed body of professional opinion on the overall operation of Springboard throughout the country.

We present our findings in 15 sections covering the following areas:

- project effectiveness in working with selected client groups (section 15.2)
- project effectiveness in working with selected organisations and agencies (section 15.3)
- staff competence in Springboard (section 15.4)
- the adequacy of physical facilities (section 15.5)
- the quality of the relationship between Springboard and Health Boards (section 15.6)
- the perceived strengths of Springboard (section 15.7)
- the perceived weaknesses of Springboard (section 15.8)
- the factors which facilitate inter-agency cooperation (section 15.9)
- the factors which hinder inter-agency cooperation (section 15.10)
- has Springboard lived up to expectations? (section 15.11)
- does Springboard represent good value for money? (section 15.12)
- should Springboard continue to be funded? (section 15.13)
- suggestions for making Springboard more effective (section 15.14)
- summary and conclusion (section 15.15)

15.2 Effectiveness of Springboard in Working with Selected Client Groups

All respondents were asked: "Could you please indicate how well you think the Springboard project has worked with the individuals and organisations who have come in contact with it". The response options were: very good, good, fair, poor, very poor. In this section, we report on how well Springboard has worked with individuals; in the next section, we report on how well it has worked with organisations.

[97] Department of Health and Children, 1998; see also 1999.

Table 15.1 Breakdown of Questionnaires Returned

	Project Staff	Health Board	Schools	Other	Total
Questionnaires Completed	42	46	27	57	172

The results of the survey indicate that over 90% of respondents think that Springboard is good or very good in dealing with families, mothers and young children, both pre-school and pre-teenage (Table A15.1). Given that this is the key target group of Springboard, this is a powerful endorsement of the work done by projects. Moreover, this perception is consistent across all categories of respondent including project staff, Health Board, schools and other organisations.

The results also show that Springboard is perceived to be a good deal less effective in working with teenagers and is least effective in working with fathers (Table A15.1). Project staff are more likely than any other respondent to describe Springboard as being weak in this area. These responses reflect the reality that projects tend to concentrate on children in the 7-12 age group and have relatively little contact with fathers, as we showed in the interim evaluation report. It is also worth pointing out that some projects are actively considering ways of being more supportive of the fathers of vulnerable families irrespective of their marital or residential status.

Effectiveness of Springboard in Working with Selected Agencies

The survey also shows that, in the opinion of over 90% of respondents, Springboard has built good or very good working relationships with both local Primary Schools and Health Boards (Table A15.2). Given that these are key players in working with vulnerable families this is a strong endorsement of the partnership approach adopted by Springboard projects. Moreover, there is a high level of agreement among all respondents on this issue.

It is also a measure of the high level of satisfaction with Springboard that the agencies with which projects work least well are still perceived to have a good or very good working relationship with Springboard, notably the Probation and Welfare Service, Secondary Schools and FÁS. Clearly this somewhat lower approval rating is itself a reflection of the lower degree of contact between Springboard and these agencies.

15.3 Effectiveness of Springboard in Working with Selected Agencies

15.4 Staff Competence in Springboard

Respondents were also asked for their views on how well-equipped Springboard is in terms of the ability of staff to deal with vulnerable families. Four aspects of staff competence were covered - the approach of the staff team, the skills of the team, project administration and the number of staff. Each of these aspects could be rated as very good, good, fair, poor or very poor.

15.4 Staff Competence in Springboard

The results indicate that virtually every respondent believes that the approach and skills of staff teams in Springboard are good or very good. In fact, twice as many people rated staff as "very good" rather than just "good" in terms of their approach and skills (Table A15.3). There was also a very high rating (94%) for project administration. As if to underline these very high approval ratings, the approval rating for the size of the staff team falls to 60% (in other words, three fifths of respondents describe this as good or very good). In the light of the high approval rating for staff competencies, this would seem to imply that some staff teams are perceived to be too small.

Respondents were also asked if staff in Springboard have been adequately supported. The results indicate that three quarters (75%) believe that staff are either "always" or "often" supported, with staff in Springboard and the Health Board being most likely to believe this (Table A15.4). However, some project staff believe that they could receive more support:

1. More frequent supervision meetings and meetings of staff from other projects.
2. More support, supervision and personal counselling for project managers.
3. Management committees could be more attentive to, and supportive of, the needs of staff.

15.5

Adequacy of Physical Facilities in Springboard

Adequacy of Physical Facilities in Springboard

All respondents were asked for their views on how well Springboard is equipped in terms of physical facilities to deal with vulnerable families. Four aspects of physical facilities were covered - the location of premises, facilities & equipment, the layout of premises and their size - and each could be rated as very good, good, fair, poor or very poor.

The results indicate that nearly 90% believe that the location of premises is good or very good (Table A15.5). This is consistent with the fact that 10 of the 13 projects in the survey[98] are based in Local Authority housing estates from where almost all of their clients are drawn. However the approval level drops considerably when it comes to the other aspects of physical facilities. For example, only 69% think that facilities and equipment are good or very good and this falls to 46% in relation to the layout of premises; the lowest approval rating of all is for the size of premises with only 34% stating that this is good or very good. There is very little variation between respondents on these issues although staff are least satisfied with the size of premises, presumably because it limits the range of activities and interventions which they can undertaken with families and children.

Respondents were also asked if the project has been adequately supported. The results indicate that nearly three quarters (74%) believe that the project is either "always" or "often" supported (Table A15.6) although staff in Springboard and the Health Board are least likely to believe this. Some of the reasons why some projects have not been adequately supported include the following:

[98] The project in Tullamore was not included since it has been up and running for a relatively short time, beginning in November 2000.

1. Management committees could be more supportive and creative.
2. Usage of Springboard by Health Boards and schools could be increased.
3. There is still uncertainty regarding the future of Springboard.
4. There have been major difficulties with premises.
5. There could be more communication from the Department of Health and Children.

Quality of Relationship Between Springboard and Health Boards

15.6

Quality of Relationship Between Springboard and Health Boards

The relationship between the projects and the Health Boards is a key dimension of Springboard's intervention, not just because of the Health Board's statutory responsibilities in the area of child protection but also because many families are clients of both. In the longer term, the widely recognised need of strengthening family support as a necessary correlate of child protection requires that models of family support such as Springboard demonstrate a capacity to work in consonance with the Health Boards, and vice versa. With these considerations in mind, we asked each respondent the following question: "How would you describe the relationship between the Springboard project and the Health Board?". In addition to offering pre-coded answers - very good, good, fair, poor, very poor - respondents were also invited to explain their answers.

The results show that 97% of respondents believe that the relationship between Springboard and the Health Boards is good or very good (Table A15.7). This is a very positive result. Of particular interest is the fact that Health Boards are more positive (95% approval rating) about this relationship than Springboard (84% approval rating) which suggests that one or two projects may be less than fully satisfied with their relationship with the Health Board; in view of the guarantee of confidentiality that was given to every respondent in the survey, it is not possible to identify these projects since this would almost certainly breach that assurance.

When invited to explain the quality of the Springboard-Health Board relationship, staff in the projects tended to emphasise the importance of openness, trust and respect where the roles of each were understood and cultivated. A number of projects seem to have cultivated very good relationships with certain key professionals in the Health Board (notably Social Workers) - particularly with those on its Management Committee - but this does not always extend to all departments within the Health Board. The comments of project staff suggest that the Springboard-Health Board relationship may be less effective when: (1) there are very few referrals from the Health Board (2) referrals are not accompanied by an adequate information briefing (3) there is a shortage and turnover of staff in the Health Board and (4) there is ignorance or disinterest in family support work.

Staff in the Health Boards attributed good relationships with Springboard to qualities such as openness and flexibility, warmth and friendliness, efficient staff who make noticeable changes to the lives of families, and staff who are supportive of the Health Board and keep it informed. Equally, staff in the Health Boards acknowledged that some of the impediments to the Springboard-Health Board relationship include (1) difficulties in reconciling the ethos and approach of child protection with family support; (2) a lack of understanding and appreciation of family support (3); a poor flow of information from the projects (4); a lack of staffing resources in the Health Board and (5) a lack of meetings with Springboard.

These qualitative insights complement the quantitative results and suggest that, although the Springboard-Health Board relationship is very good, there are no grounds for complacency. As in all relationships, there are a number of areas where the relationship could be improved and the comments yielded by the survey suggest a possible checklist of areas which might be used to assess the situation in each project.

15.7 Perceived Strengths of Springboard

Perceived Strengths of Springboard

All respondents were asked for their views on the strengths of Springboard as an approach to developing and delivering a community-based service to vulnerable families and their children. Their responses, based on the strengths which they have observed through contacts with the projects, reveal a high level of consensus about the six key strengths of Springboard:

1. A general attitude to the family which is strengths-based, implying being friendly, positive, customer-oriented, non-stigmatising, non-threatening, non-judgemental, non-clinical, and willing to act as an advocate for the family.
2. An orientation to family problems which is solution-focused implying that it is practical, down-to-earth, structured, skilful, holistic, flexible, non-bureaucratic, intensive, realistic and allays fears (particularly regarding custody of children) while building trust.
3. A disposition among staff which is positive, enthusiastic, genuine, available, dedicated, astute, observant, sensitive, informal, committed and approachable.
4. A partnership approach which builds relationships with the family and with all the key agencies and organisations in recognition of the multi-faceted nature of family needs, thereby placing a premium on good communication.
5. A community-based location and orientation which is accessible, responsive, knowledgeable about the local situation and about family histories, and places a premium on being accepted in the community.
6. A facility which is accessible, comfortable, informal, non-threatening and non-stigmatising.

15.8

Perceived Weaknesses of Springboard

Perceived Weaknesses of Springboard

All respondents were also asked for their views on the weaknesses of Springboard. Again, the responses reveal a strong consensus around six key weaknesses across the different Springboard projects, although not all of the weaknesses apply equally to all projects. The areas of weakness are:

1. Uncertainty about the long-term future of the project which is unsettling for existing staff and has led to some staffing problems.
2. Premises are too small to provide the full range of services required; thus the advantage of working from premises which are similar to other houses in the community has the disadvantage of smallness because it restricts the quantity and range of services offered.
3. Staffing levels cannot cope with the level of family need and must work with a small number of families, thereby creating a waiting list and this reduces options for the referral agencies. In this way, the advantage of working intensively with a small number of families has the disadvantage that one obviously cannot also work extensively with a larger number of families.
4. The service is limited with respect to both its opening hours (for example there is no evening or weekend service) and its target groups (for example there is little engagement with teenagers or fathers).
5. There is scope for both projects and agencies to improve their partnership approach through more support and sharing of information.
6. Being accepted by families and by the community is not always easy, especially where there are deep divisions between families and within the community.

15.9

Factors Which Facilitate Inter-Agency Cooperation

Factors Which Facilitate Inter-Agency Cooperation

Respondents were asked to draw upon their knowledge and experience of Springboard to identify the factors which facilitate inter-agency cooperation in working with vulnerable families. Their responses suggest that inter-agency cooperation is facilitated by six key factors:

1. Ensuring that all of the relevant agencies and organisations are involved in the partnership process and are aware of its benefits.
2. Having regular contact and communication, both formal and informal, through meetings, phone calls, etc for the purpose of sharing information about each other's services and promoting clarity about the respective roles of each in working with families, thereby avoiding duplication, overlap and misunderstandings. Shared training events could also contribute to this objective.
3. Keeping in mind that the first priority is meeting the needs of vulnerable families.
4. Cultivating professional attitudes which place a premium on respect, openness, flexibility, clarity, networking, trust, cooperation, constructive challenge, prompt replies, clear boundaries and good communication.
5. Supporting the management committee in Springboard as a key instrument of inter-agency cooperation.
6. Ensuring that senior management, especially in the Health Board, show leadership and support for inter-agency cooperation.

15.10 Factors Which Hinder Inter-Agency Cooperation

Factors Which Hinder Inter-Agency Cooperation

Respondents were also asked to identify factors which hinder inter-agency cooperation in working with vulnerable families. Their responses suggest that inter-agency cooperation is hindered by seven key factors as follows:

1. Organisations and agencies having a rigidly "territorial" view of their role in family support services, leading to competition and "power struggles" over both funding and clients as well as a general devaluing of the contribution which others can offer.
2. Developing and maintaining negative stereotypes about organisations and agencies - and indeed "personalities" - possibly based on a previous negative experiences.
3. Failure to acknowledge and address the realities of fear, suspicion and misunderstanding that can arise because organisations and agencies have different objectives and orientations.
4. Staff shortages and turnover can make it more difficult to build relationships.
5. Failure to appreciate the value of inter-agency cooperation.
6. Failure to communicate regularly or make referrals.
7. Lack of training on the process of inter-agency cooperation, including lack of information on the respective roles of different organisations and agencies.

15.11 Has Springboard Lived Up to Expectations?

Has Springboard Lived Up to Expectations?

The vast majority of respondents (87%) believe that Springboard has lived up to their original expectations of it (see Table A15.8). This is particularly true of staff in both Springboard (92%) and the Health Board (92%); the corresponding proportion among schools is somewhat lower (77%).

In explaining their responses, many respondents reiterated their perception of the strengths of Springboard (see section 15.7 above) and the fact that all of the projects have succeeded in being accepted by families and by the various organisations and agencies in their communities, itself a tribute to the competence of staff (see section 15.4 above).

15.12 Does Springboard Represent Good Value for Money?

Does Springboard Represent Good Value for Money?

This is a difficult question, given that an accurate answer would require comparison of the costs and benefits of Springboard with the costs and benefits of alternative interventions in vulnerable families. None of the respondents could reasonably be expected to have this information - indeed such research has never been undertaken in Ireland - and in that sense it might be seen as a unfair question. Nevertheless, it is not wholly inappropriate to ask about this, if only because any decision on the future of Springboard will hinge on the assumptions which one makes about its value for money vis-à-vis other interventions. In other words, the question must

inevitably be confronted - and will be answered when the future of Springboard is decided - in the light of the available information. Indeed, the views of our respondents form part of the relevant information which should be taken into account in making that decision.

It is also appropriate to note here that the question of value for money is often considered in the relatively narrow context of the public or fiscal costs and benefits to the State. As we have argued elsewhere[99] this is quite a narrow subset of the total costs and benefits which also include the possibly much larger subset of personal costs and benefits as well as social and economic costs and benefits. Viewed within this broader frame of reference, the question then appears both more complex but also more real as one is forced to place a value on the well-being of families. As we shall now see, most respondents are quite willing and able to enter this complex domain of analysis and to offer an answer in the light of their experience and the evidence available to them.

The great majority of respondents (78%) believe that Springboard does indeed provide good value for money, while nearly all remaining respondents (21%) stated that they did not know, a response which is highly understandable in view of the lack of complete information (Table A15.9). It is interesting therefore to examine the reasons advanced by respondents for claiming that Springboard represents good value for money. In summary form, four different reasons were advanced to support this claim:

1. Springboard is cheaper than the fiscal cost of placing children in care, without even taking into account the present and future private and social costs of placing children in care[100].
2. Springboard is cheaper than other crisis-oriented forms of intervention with children and families because it reduces stress, reverses inter-generational cycles of family problems and dependency while strengthening the family's capacity to deal with its problems both now and in the future.
3. Springboard is cheaper than doing nothing because it helps families to solve their problems and therefore prevents crises at a later stage; this has a multiplier effect on all family members over both the short-term and long-term and helps reduce future public expenditure in a number of Government Departments.
4. Springboard reduces pressure on child protection services through reduced referrals and more effective interventions with existing referrals; this improves the overall quality of services and may reduce the fiscal costs of child protection in the longer term.

It is easy to become overwhelmed by measurement considerations when discussing value for money, because the measurement problems are enormous. Indeed, many are insurmountable, such as the full measurement of private and social costs and benefits. In the final instance, the decision on whether family support represents value for money depends ultimately on the value which one places on family well-being and the alleviation of suffering in those families which palpably do not experience well-being in either relational or economic terms.

[99] See McKeown and Sweeney, 2001.
[100] For example, the cost of keeping a child in residential care in Ireland in 2000 was between £50,000 and £55,000 a year (see McKeown and Sweeney, 2001, p.36).

15.13 Should Springboard Continue to be Funded?

Should Springboard Continue to be Funded?

The vast majority of respondents (95%) believe that Springboard should continue to be funded (Table A15.10). No respondent believes that it should not, while a small minority (5%) do not know if it should be. The following reasons were advanced for continuing to fund Springboard:

1. The importance of family support services has already been recognised in many other EU countries.
2. Springboard is working well; it is trusted and accepted in the communities and by other organisations and agencies. There would be great disappointment if it were to be withdrawn.
3. There has been a huge investment in setting up and gaining acceptance for Springboard in the different communities; all this expense and effort in creating a "community asset" would be lost if Springboard were to be discontinued.
4. Springboard has not yet achieved its full potential, although more people are becoming aware of it and accessing its services.
5. Springboard needs to continue because family support is essentially a long-term, preventative process.
6. If Springboard were discontinued, something similar would be needed to take its place.
7. There is a huge need for the work being done by Springboard.

15.14 Suggestions for Making Springboard More Effective?

Suggestions for Making Springboard More Effective?

Finally, respondents were asked if they had any suggestions for making Springboard more effective as a community-based service for vulnerable families and their children. The majority (87%) offered some suggestions although there is a good deal of overlap in what was suggested (Table A15.11). The core themes covered by the suggestions are:

1. Increase the local input to Springboard through training parents to act as support workers, home helps, community parents, etc; these parents could be involved as either volunteers or staff and could also be represented on the advisory/management committee. This would also increase community commitment to Springboard.
2. Expand Springboard to rural areas, either through centre-based services or outreach services or both.
3. Increase funding for staff and premises so that the service can expand to meet the need. Increased staffing could allow for more specialised roles in areas such working with teenagers and young adults, organising leisure activities, etc. Larger premises could allow crèche facilities and leisure facilities to be developed, for example.
4. Give the advisory/management committees a clearer and more realistic brief than at present.
5. Carry out an assessment to find out the different needs of families.
6. 'Mainstream' the projects.
7. Encourage schools to be more open and accepting of help from Springboard. Where appropriate, Gardaí could also become more involved.

8. Promote access to Springboard by raising awareness through local radio, local directories, posters & flyers in clinics, GP surgeries and hospitals, etc. as well as giving informal talks.
9. Improved supervision and staff supports, possibly through using professionals from the Health Boards.
10. Develop practical anti-poverty strategies in the Springboard areas such as money management, cooking on a limited budget, co-operatives for food, furniture, etc.
11. Develop staff competence, particularly in areas such as counselling.
12. Ensure that all services in the community are working together in the best interests of families; this includes not just health-related services but also community development projects and adult education programmes.

15.15

Summary and Conclusion

Summary and Conclusion

This chapter was based on the views of 172 professionals who are involved, directly or indirectly, in the work of Springboard. As such, the findings can be taken as a reliable indication of how Springboard is perceived by a wide range of well-informed professionals throughout the country. In view of this, the results are extremely encouraging for the work of Springboard while, at the same time, containing a number of challenges on how the initiative could be strengthened and expanded further. The key findings of the survey are:

- over 90% of professionals think that Springboard is good or very good in dealing with families, mothers and young children but is less effective in working with teenagers and especially fathers.
- over 90% of professionals believe that Springboard has built good or very good working relationships with both local Primary Schools and Health Boards.
- virtually every professional believes the approach and skills of staff teams in Springboard are good or very good.
- nearly 90% believe that the location of premises is good or very good. However only one third think that the size of premises is good or very good.
- most professionals (97%) believe that the relationship between Springboard and the Health Boards is good or very good. Despite, or possibly because of, this high rating, the qualitative comments of both staff in Springboard and Health Boards draw attention to areas where there is room for improvement.
- the key strengths of Springboard as perceived by professionals are: (1) a focus on strengths and solutions (2) a positive approach to working in partnership and (3) a facility which is family-friendly and community-based. The key weaknesses of Springboard as perceived by professionals are: (1) uncertainty about future funding (2) inadequate premises and insufficient staff (3) difficulties building partnerships with organisations, agencies and families.
- the factors which facilitate inter-agency working are: (1) awareness of its benefits (2) regular contacts between organisations and agencies and the cultivation of appropriate professional attitudes (3) ensuring that

families are always the first priority (4) supporting inter-agency working at all levels of the parent organisations. The key factors which hinder inter-agency cooperation are: (1) an excessive focus on power and territoriality (2) holding on to negative stereotypes about organisations and agencies (3) staff shortages and turnover (4) lack of contact and few referrals.

- the vast majority of professionals (87%) believe that Springboard has lived up to their original expectations.
- the great majority of professionals (78%) believe that Springboard represents good value for money, mainly because (1) it is cheaper than the fiscal cost of placing children in care or indeed other crisis-oriented forms of intervention (2) it is cheaper than doing nothing which can end up being very costly in terms of the long-term private, social and fiscal costs involved (3) it reduces pressure on child protection services which may, in turn, reduce fiscal costs.
- the vast majority of professionals (95%) believe that Springboard should continue to be funded mainly because: (1) it is working well (2) there is a huge need for it (3) there has already been a huge investment in setting up the projects and (4) family support is essentially a long-term, preventative process.
- a substantial number of suggestions were made for making Springboard more effective including: (1) 'mainstreaming' the initiative (2) expanding Springboard to rural areas (3) increasing funding for staff and premises (4) increasing local input through training for parents to act as support workers, home helps, community parents, etc. (5) strengthening the role of advisory/management committees (6) encouraging other organisations and agencies to use Springboard (7) improving supports for project managers and staff (8) developing a coherent approach within each community to all services for families.

These findings contain a wealth of information and show the high esteem in which Springboard is held by other professionals, essentially because the service is needed and is being delivered in a way which is seen as meeting that need very effectively. It is hard to imagine how a service could achieve a much higher approval rating from other professionals in the field. At the same time, the results openly acknowledge that there is still room for improvement.

16 Summary, Conclusions and Recommend-ations

16.1 Introduction

Springboard is a family support initiative designed to improve the well-being of families, parents and children and to improve the organisation and delivery of services generally. In September 2001, Springboard comprised 17 projects, 14 of which are the subject of this evaluation[101]. Each project is in receipt of an average annual budget of under IR£200,000. All Springboard projects have a general strategy of being open and available to all families in their communities as well as a more specific strategy of working intensively with those who are most vulnerable. In the evaluation period between January 2000 and May 2001, Springboard worked intensively with 207 families, 319 children and 191 parents - equivalent to about one third of all those who have come into contact with Springboard - and these clients are the subject of this evaluation.

The total number of persons employed through Springboard is 111[102], and these are almost equally divided between those who are full-time (58, 52%) and part-time (53, 48%). All projects are engaged in a wide range of family support activities including: (1) individual work involving one-to-one sessions with clients to assess needs and offer advice, counselling and support; (2) group work and activities such as parenting and personal development groups, homework and after-school activities, classes in arts, crafts, swimming, etc; (3) family work involving counselling and therapy, family evenings and outings, or accompanying families on visits to hospital, court, school, the Health Board, etc; (4) drop-in facilities for information, advice, recreation, coffee-breaks, etc. In addition to direct service provision, projects also spend time building up inter-agency networks with other services in the community, both statutory and voluntary. This work is motivated by the importance which Springboard attaches to a co-ordinated inter-agency approach to service delivery.

This evaluation was designed to answer the following questions: has Springboard improved the well-being of children and parents and how have its services been received? In answering these questions, we used a range of valid and reliable measurement instruments to assess the objective well-being of children and parents both before and after the intervention of Springboard. This research design, in conjunction with relatively sophisticated statistical analyses, allowed us to draw reasonably robust inferences about the impact of Springboard. For both ethical and economic reasons, it was not possible to use an "ideal" research design in which the impact of Springboard on children and parents is compared with the impact of "doing nothing" on a "control group" of children and parents.

In this chapter we draw together the key findings of the evaluation and present them in the sequence in which they appear in the report (section 16.2 to 16.14). We then build upon these findings to draw our conclusions and make our recommendations (sections 16.15).

[101] Three Springboard projects were set up in 2000 but have not been included in the evaluation due to their later starting date.
[102] This is based on the 14 projects included in the evaluation. The data includes staff on schemes such as Community Employment and the Jobs Initiative.

16.2 Profile of Families

Profile of Families

The key characteristics of the 207 families who received intensive assistance from Springboard between January 2000 and May 2001 are as follows:

- the majority (54%) of families have only one parent living in the family home.
- the average number of children per family is 3.8, higher than in Ireland (2.6).
- six out of ten mothers are full-time parents while four out of ten are in employment, mainly part-time; information on fathers is scarce but the data available suggest an unemployment rate of 37%, ten times the rate in Ireland in August 2001. There was a slight increase in the employment rate of mothers and fathers (about 5%) between baseline and follow-up in May 2001.
- the vast majority (90%) of families derive their income, either partly or wholly, from social welfare and the majority (78%) indicated that they have difficulty making ends meet. There was a slight reduction in social welfare dependency between baseline and follow-up in May 2001.
- the majority of fathers (82%) and mothers (77%) who live in the family home are in semi-skilled or unskilled manual jobs, about four times higher than in Ireland.
- the vast majority (77%) of households live in accommodation which is rented from the Local Authority.
- the vast majority (86%) of families come from the settled community but a significant minority (14%) come from the Travelling community.
- two thirds of families (66%) are known to the Health Boards who, in turn, are a significant source of referrals to Springboard.

From these findings it can be concluded that Springboard families differ from families in Ireland in that one parent households are over-represented by a factor of nearly four while two parent households are under-represented by a factor of nearly two; fathers who reside with their children are also under-represented by a factor of nearly four. The employment status of mothers is similar to that of mothers generally while the unemployment rate of fathers is ten times higher than the national average.

The vulnerability of these families is indicated by their high levels of dependency on social welfare, their weak socio-economic status, their difficulty in making ends meet, and the fact that many have already come to the attention of the Health Board. Although most are settled, Travellers are over-represented by a factor of 20 relative to their size in the national population. All of the signs are that these are relatively poor families and in need of family support services. Overall these results provide clear evidence that Springboard, as intended, is well targeted at vulnerable children and families.

Our analysis revealed that a modest improvement of about 5% took place in the employment status of mothers and fathers between baseline and the follow-up in May 2001, primarily due to a rise in part-time employment. This in turn had a modest impact in terms of reducing social welfare dependency. Overall, however, the employment situation of most families has remained unchanged since coming in contact with Springboard which implies that any substantial improvements in family well-being during this period are unlikely to be attributable to economic factors alone.

16.3

Profile of Children

Profile of Children

We analysed the background characteristics of 319 children who also received an intensive service from Springboard between January 2000 and May 2001. The data was collected when the children first made contact with Springboard and shows that:

- Springboard sees more boys (55%) than girls (45%).
- the majority of children (61%) are in the 7-12 age group with one quarter (25%) aged 2-6 years.
- the vast majority of children (94%) were living in their family home when they first came in contact with Springboard. However nearly a fifth (17%) have lived away from home at some time in the past.
- just over half (53%) of all children are living in one-parent households; correspondingly, just under half (47%) are living in two-parent households.
- roughly half of the children (55%) are not living with their biological father. Nearly two thirds of these children (62%) see their biological father, but more than one third (35%) have no contact.
- approximately half of all children, according to the scores of parents and teachers on the Strengths and Difficulties Questionnaire (SDQ) 103, have serious difficulties; this is five times higher than in the population of all children. Boys are more likely to have serious problems than girls. Parents experience older children as having less problems than younger children.
- in the opinion of staff, roughly half of all children have emotional or behaviour problems and, perhaps related to this, nearly four in ten experience emotional abuse. Around one quarter experience neglect and/or witness domestic violence.
- the vast majority of children (82%) are at school and most of these (84%) are at Primary School; a significant minority of children (21, 7%) have dropped out of school.
- the majority of children (66%) do not participate in organised out-of-school activities.
- the vast majority of children (93%) are cooperative with Springboard.

These results indicate that children using Springboard are mainly of Primary School age. Notwithstanding their young age, there is already a 7% drop-out rate from school. Despite the high level of non-resident fathers, two thirds of these fathers maintain some level of contact with their children. Children involved with Springboard are five times more likely than the population of all children to have serious difficulties, especially boys. A significant proportion of children are perceived by staff to experience emotional abuse and/or neglect and this, in conjunction with a low level of participation in out-of-school leisure activities, suggests that many Springboard children have relatively few fun activities in their lives. The vast majority of children are very cooperative with the work of Springboard. Despite their small numbers, Traveller children are significantly over-represented in Springboard. Once again, these results indicate that Springboard is a well-targeted initiative.

16.4 Interventions with Children

Interventions with Children

On average, children have been attending Springboard for 46 weeks. Staff in Springboard spent an average of [103] hours on each child in the period up to May 2001 which is equivalent to an average of 2.2 hours per child per week. The main form of intervention with children is group work, which absorbed 41% of total intervention time. Other forms of intervention included individual work (which absorbed 11% of total intervention time), family work (which absorbed 16%), drop-in work (10%) and administration (22%). In addition to Springboard, other agencies were involved with nearly eight out of ten children, the two main ones being schools (53% of cases) and Health Board Social Workers (41% of cases).

These results indicate that Springboard has worked intensively with children and has involved other agencies in that work. Projects devoted more time to children (averaging 2.2 hours per week) than to parents (averaging 1.7 hours per week) and the preferred style of intervention with children was group work compared to individual work with parents. Of course, the crucial question is whether the amount of time spent by staff on each child makes any difference to their well-being and we address that question later in the chapter.

16.5 Changes Experienced by Children

Changes Experienced by Children

We measured changes in selected attributes and behaviours of children who participated in Springboard in the period between January 2000 and May 2001. This was done by comparing the baseline situation when contact was first made with Springboard with the follow-up situation in May 2001 on a number of key variables, most notably the Strengths and Difficulties Questionnaire (SDQ) and variables such as school attendance, risks to the child as perceived by Health Boards and keeping out of trouble with the law. The main changes were as follows:

- One quarter of all children (25%) showed clinically-significant improvements in their SDQ symptoms while attending Springboard.
- More than half the children (55%) and more than four in ten parents (44%) believe the child's problems are "much better" since coming to Springboard.
- Springboard is perceived as being helpful by more than eight out of ten children and parents.
- one quarter of parents and teachers believe the children are less burdened by their SDQ symptoms while about one third of them see the child as less burdensome to others.
- The average school attendance of children is 84% and has changed little since coming in contact with Springboard. In aggregate terms, there has been no change in the proportion of children coming late to school (at around 30%) or without lunch (at around 8%) although there has been an improvement in the number of children coming to school hungry (now at 7%).
- In the opinion of Health Boards, the proportion of children deemed to be at moderate-to-high risk of abuse or going into care was halved while attending Springboard, reflecting both objective changes in the well-being of children and the Health Board's confidence in Springboard's ability to manage these cases successfully.

[103] See Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

Given that the SDQ is our core measure of child well-being, it is appropriate to ask how changes in children's difficulties compare with the impact of similar interventions elsewhere. That question is not so easy to answer given the diversity of interventions that come under the rubric of family support services and the fact that all interventions with vulnerable families and children tend to be slower in making an impact when compared to interventions with the "average" child or family. This is clear from our review of research on the effectiveness of a wide range of interventions with vulnerable families[104]: "intervention is less effective where problems are severe (such as addiction, personality disorder), of long duration (such as prolonged abuse or neglect in childhood) and multiple (such as marital and parenting difficulties compounded by addiction)[105]. Other studies have shown that interventions in families where parents have difficulty managing difficult or aggressive behaviour in children tend to be less successful with families who are socially disadvantaged, socially isolated or face other forms of adversity such as problems experienced by the mother[106]". Clearly, all of these factors are relevant in assessing the relative performance of Springboard. We have not been able to identify evaluations of interventions that are directly comparable to Springboard in terms of their scope and standardised measurements, and are led to the view that Springboard itself might best be regarded as a benchmark against which the performance of other interventions with vulnerable children could be judged, particularly in an Irish context. Viewed from that perspective, Springboard appears in a quite favourable light when compared to the outcomes of interventions like the Early Start Pre-School Programme[107]. We are safe in concluding therefore that Springboard has had a positive impact on children and its achievements will serve as a benchmark against which the performance of other interventions with vulnerable children and families can subsequently be judged.

16.6

Impact of Springboard on Children

Impact of Springboard on Children

We used Structural Equation Modelling to analyse the factors which influence children's difficulties (SDQ), the main impact variable for measuring change in the well-being of Springboard children. The results of the analysis show that SDQ is a robust measure in terms of validity and reliability and that it is a strong measure of child functioning and well-being. This adds to the confidence generated by other studies using this measure[108]. The key findings to emerge from the analysis are as follows:

- children's difficulties are highly stable and do not appear to change easily or quickly.
- the amount of hours spent by Springboard staff on each child did not have a statistically-significant influence on children's difficulties.
- the severity of problems experienced by the child - notably neglect, abuse, family violence, anti-social behaviour, not attending school, etc. -

[104] McKeown, 2000:10
[105] See Bergin and Garfiled, 1994
[106] See Gough, 1999, 115; Vetere, 1999:153-155
[107] Educational Research Centre, 1998; see also Kellaghan, 1977; Kellaghan and Greaney, 1992; Kellaghan, Weir, O'hUallachain and Morgan, 1995. Another Irish study of interventions with vulnerable families (see Moukaddem, Fitzgerald and Barry, 1998), albeit based on a very small population compared to that used in either Springboard or the Early Start Pre-School Programme, showed a more favourable performance than either of these interventions but this could not be regarded as a reliable benchmark in view of the small number of cases involved and the possibility of bias through the self-selection of those cases.
[108] See Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

influences children's difficulties. Deteriorations in children's problems tend to lead to an exacerbation of their difficulties. Children who experience severe problems are more likely to have parents with financial difficulties and who are wholly dependent on social welfare income, a finding which suggests that deficits in the family's relational and material well-being diminish children's well-being[109].

- the children of employed mothers tend to have greater difficulties than the children of full-time mothers, although employed mothers also have less financial difficulties.
- the amount of staff time received by each child is influenced by the severity of the child's problems. Children whose parents are wholly dependent on social welfare tend to receive more staff time than other children.

One of the most challenging findings to emerge from this analysis is that the amount of time spent by Springboard staff on each child had no impact in bringing about improvements in child well-being. This does not imply that staff had no impact but it does imply that time is a poor indicator of the process by which Springboard impacts on the well-being of children. As a result of this finding, we are required to look elsewhere to see if there is evidence which might link improvements in child well-being to the intervention of Springboard. We take up that challenge later in the chapter and discuss other implications of these findings.

16.7 Case Studies of Most Improved Children

Case Studies of Most Improved Children

In order to throw further light on the process of improving well-being among children we invited each of the 14 projects to prepare a case study on their most improved child. The key findings to emerge from the analysis of those case studies show that the most improved children were more likely to be boys than girls and to have received twice as much staff time as children in Springboard generally. In terms of scores on the Strengths and Difficulties Questionnaire (SDQ), children in the case studies began with much greater difficulties than the average child in Springboard but also made much more progress between the baseline and follow-up[110].

Most of the children in the case studies exhibit a pattern of behaviour problems at home and at school involving angry outbursts and, perhaps because of this, they have difficulty making and sustaining friends. They often appear unhappy and lacking in confidence and self-esteem; many of the children are under-performing at school due to poor concentration and hyperactivity. Many of the parents are unable to cope with the problems which their children are presenting. Many also have, or have had, damaging relationships with the fathers of the children and this inhibits their parenting capacity, particularly when compounded by financial difficulties and overcrowding.

The key elements which constitute the intervention of Springboard in virtually every case involve: (1) individual work with the child through the

[109] For a discussion of relational and economic well-being, see McKeown and Sweeney, 2001, Chapter Six.

[110] We are aware that some of the improvement in SDQ scores may be a statistical artefact, sometimes referred to as "regression to the mean", since children with higher SDQ scores have more scope for improvement than children with lower scores.

medium of some activity (art, crafts, sensory work, etc) to address emotional and behaviour problems; (2) group work such as after school clubs, summer programmes, sport and leisure activities, outings, etc. for the purpose of promoting social skills, reducing isolation and creating fun; (3) parent support through one-to-one discussion, home visits, practical help in setting family routines or home maintenance, as well as inclusion in group programmes for parents; (4) including other professionals in the overall plan to support the child and parent(s), notably Social Workers, Psychologists and Teachers; (5) holding review meetings with professionals and the parent(s) to assess progress and adapt to changing needs.

The intervention of Springboard typically results in children being happier, more self-confident, having more friends, attending and performing better at school, being more involved in leisure activities and having a better relationship with their parent(s). The main obstacle to change in virtually every case was the reluctance of parents, and to a lesser extent children, to engage with the project, an obstacle which all of the projects successfully overcame.

The key lessons learned by staff from their case studies are: (1) it is essential to build a trusting relationship with the family; (2) when working with a child, always work with the parents as well as other family members, including the extended family if appropriate; (3) children need the support networks that come with school, clubs, leisure activities, etc. but are often excluded from these because of their behaviour or emotional problems; (4) work collaboratively with other members of the staff and seek team and management supervision to ensure that one is working effectively and is supported in one's work; (5) work in collaboration with other agencies and draw upon their skills and resources to help the child and family; (6) hold regular reviews with the family to evaluate progress and assess what further interventions are needed.

All projects seem to share a broadly-similar template for case management involving: (1) team discussions; (2) case supervision; (3) ongoing discussion with the family; (4) review and evaluation meetings involving all relevant agencies; (5) effective inter-agency communication and co-operation.

These findings provide a useful insight into the way in which Springboard works with children and the type of interventions that seem to work best. In particular, they complement one of the key findings of the evaluation, which is that, within the family system, the well-being of children and parents are highly interdependent. This implies that interventions to promote the well-being of one typically require parallel interventions to promote the well-being of the other. The case studies graphically illustrate that this already forms part of good practice within Springboard.

16.8 Profile of Parents

Profile of Parents

We analysed the characteristics of 191 parents who attended Springboard between January 2000 and May 2001 and found that:

- nine out of ten parents in Springboard are mothers.
- more than one quarter (28%) of parents experienced emotional abuse as children, while one fifth (22%) had parents with an alcohol problem and experienced domestic violence (20%) or physical abuse (20%).
- the main problems currently experienced by parents are managing the children (53%) and couple/marital problems (46%) as well as debt problems (36%) and bad housing (27%). Beyond these, the levels of alcoholism (34%) and psychiatric illness (25%) are much higher than among the general population.
- two thirds of parents showed signs of stress, as measured by the General Health Questionnaire (GHQ)[111], when they first contacted Springboard.
- in terms of parenting capacity, as measured by the Parent-Child Relationship Inventory (PCRI)[112], more than half of Springboard parents are "weak", twice the proportion of US parents, the only comparative norm available.
- one third of parents have weak support networks, one third have medium support networks and one third have strong support networks.
- the vast majority of parents (94%) are experienced by staff as cooperative or very cooperative.

These findings indicate that a majority of Springboard parents present with high levels of stress and weak parenting capacity and have at least two serious problems in their lives while also coping with a history of abusive childhood experiences. On the other hand, the majority have medium to strong support networks which may help them cope with these adversities.

The prevalence of alcohol problems in the lives of at least one third of Springboard families mirrors the childhood experiences of some of these parents, where we found a strong association between alcoholism, domestic violence, physical abuse and emotional abuse. This draws attention to the way in which family problems are transmitted over the generations which, in turn, underlines the importance of interventions like Springboard to break the cycle of dysfunctional behaviours in families.

16.9 Interventions with Parents

Interventions with Parents

On average, parents have been attending Springboard for 48 weeks. Staff in Springboard spent an average of 82 hours on each parent in the period up to May 2001, which is equivalent to an average of 1.7 hours per parent per week. The main form of intervention with parents is individual work, and this absorbed 28% of total intervention time; group work absorbed 15% of total intervention time, family work 17%, drop-in work 12% and administration 28%. In addition to the input of Springboard, other agencies are involved with nearly nine out of ten parents, mainly Health Board professionals but also schools.

These results indicate that Springboard has worked intensively with parents and has involved other agencies in that work. Projects devoted less time to

[111] Goldberg, 1972; Goldberg and Williams, 1988.

[112] See Gerard, 1994. The two dimensions of the PCRI which are not included are limit setting and autonomy.

parents (averaging 1.7 hours per week) than to children (averaging 2.2 hours per week) and the preferred style of intervention with parents was individual work compared to group work with children. Of course, we must now address the question of whether the amount of time spent by staff on each parent made any difference to their well-being.

16.10

Changes Experienced by Parents

Changes Experienced by Parents

We analysed changes in three aspects of parental well-being: (1) change in stress levels as measured by the General Health Questionnaire (GHQ), (2) change in parenting capacity as measured by the Parent-Child Relationship Inventory (PCRI) and (3) change in support networks using an adapted form of the social network map[113]. In the period between January 2000 and May 2001 we identified the following changes in the well-being of parents:

- there was a reduction in the stress levels of more than four in ten (43%) parents.
- nearly one quarter of all parents (23%) recorded improved parenting capacity.
- the support networks of nearly four in ten parents (38%) improved.

These results indicate that decisive improvements in the well-being of parents took place while attending Springboard. It is difficult to find comparative data with other interventions but the reductions in stress are in line with that reported by another intervention in Ireland[114].

16.11

Changes Experienced by Parents

Impact of Springboard on Parents

We used Structural Equation Modelling to analyse the impact of Springboard on parental well-being in terms of their stress levels (as measured by the GHQ) and their parenting capacity (as measured by the PCRI). This yielded the following key findings:

- the stress levels of parents at the time of first contact with Springboard are shaped by four inter-related variables: (1) financial difficulties (2) abused childhood (3) support networks and (4) severity of current problems.
- parental stress, which fell by 41% while attending Springboard, was not influenced by the amount of staff time received by each parent. The main factor which caused a reduction in parental stress was changes in the severity of the parent's current problems.
- parenting capacity - which improved for nearly one quarter (23%) of all parents while attending Springboard - is rather stable over time. Significantly, the amount of time spent by Springboard staff with each parent had the effect of improving parenting capacity and was similar in its influence to the effect of parental support networks and the severity of the parent's current problems.
- parents are likely to present with weaker parenting capacity if they are known to the Health Board, have severe problems, have had an abused childhood and if the mother is in employment.

[113] See Tracy and Whittaker, 1990; Kinney, Haapala, Booth and Leavitt, 1990; see also Saleeby, 1992; 1999; Gilligan, 1991; 1999.
[114] Moukaddem, Fitzgerald and Barry, 1998.

We also analysed how Springboard influences the family system as a whole by looking at the factors which influence children's difficulties, parental stress and parenting capacity simultaneously. This analysis further confirmed the stability of children's difficulties and parenting capacity over time and the contrasting volatility of the GHQ. It also showed that the input of Springboard staff had no impact on children's difficulties or parents' stress, but had a statistically-significant effect on parenting capacity. The family system model also added new insights by showing that:

- the well-being of children ('SDQ') is influenced by two main factors: (1) the severity of the child's problems, particularly neglect and abuse and (2) the well-being of parents as measured by their parenting capacity ('PCRI') and their stress levels (GHQ).
- the well-being of parents has an impact on the well-being of their children over an extended period of time suggesting, in turn, that improvements in parental well-being while attending Springboard between January 2000 and May 2001 are likely to have downstream benefits for children.
- the factors influencing parenting capacity ('PCRI') are the severity of children's problems and parents' support network, a finding which underlines the systemic nature of families by showing how improvements in the well-being of children have knock-on effects for the well-being of parents, and vice versa.
- changes in the stress levels of parents are influenced by the severity of child's problems, and this effect is even greater than the effect of parental well-being on children's difficulties. Parental stress levels are also influenced by the childhood experiences of the parent.

These findings provide direct evidence that the amount of time spent by Springboard staff had a statistically-significant beneficial influence on parenting capacity. Nevertheless, this effect is relatively small and covers only one aspect of family well-being. Once again, this suggests that staff time is probably a poor indicator of Springboard's intervention and that unstructured and informal contacts between the projects and their clients were also important.

16.12

Case Studies of Most Improved Parents

Case Studies of Most Improved Parents

In order to throw further light on the process of improving parental well-being we invited each of the 14 projects to prepare a case study on their most improved parent, similar to the one prepared on the most improved child. The key findings to emerge from the analysis of these case studies show that all of the most improved parents are mothers and all but one come from a one-parent household. On average, the amount of staff time received by each of the most improved parents was five times greater than other Springboard parents.

The most improved parents showed similar reductions in stress (GHQ scores) compared to the general population of parents but made significantly greater improvements in parenting capacity (PCRI scores). One of the main presenting problems for these parents was isolation from the extended family and the community. Many mothers come from quite disturbed family

backgrounds, themselves characterised by alcohol abuse and domestic violence and this pattern is often repeated in adult relationships where they experience similar and further abuse.

Interventions with the most improved parents typically involved increasing the mother's capacity to care for and control her children and reducing the behavioural and emotional problems of the children. These problems were often a major source of stress for the mother as well as the children. All interventions were informed by the philosophy of being "strengths-based" and "solution-focused". The intervention of Springboard typically resulted in parents feeling better, more self-confident, less isolated and often brought about practical improvements such as paying off debts, keeping the house better, establishing family routines, being more attentive to the needs of children in areas such as hygiene and school attendance, and generally having more positive experiences as a family. The main obstacle to change, which Springboard managed to overcome, was the reluctance of parents to engage with the project.

Some of the lessons which have been learned from these cases include: (1) it is essential to build a trusting relationship with the parent; (2) it is important to see the parent's problems from a family perspective and not just an individual perspective; (3) vulnerable parents can often be very isolated from the supports of extended family and community; (4) it is important to work collaboratively with other members of staff and with other agencies; (5) it is necessary to understand Traveller culture and the challenges which this can pose for women when marriages breakdown. All projects share a broadly similar template for case management involving: (1) team discussions (2) case supervision (3) ongoing discussion with the family (4) review and evaluation meetings involving all relevant agencies, and (5) effective inter-agency communication and co-operation.

The case studies on parents complement the key findings which have emerged from the statistical analysis in the evaluation, highlighting the importance of a family system perspective and a related awareness of the intergenerational consequences of family dysfunction. Many of the case studies show that vulnerable parents have experienced abusive childhoods and re-experienced abusive relationships in adulthood, with the result that their capacity to parent children is seriously impaired, often leading to isolation from the supports of extended family and community. Effective interventions require that all of these aspects of the family system be addressed.

16.13

Perceptions of Springboard by Parents and Children

Perceptions of Springboard by Parents and Children

A key objective of Springboard is to improve the co-ordination and delivery of services to vulnerable families. We assessed the performance of Springboard in terms of this objective by surveying a random sample of 64 parents and 61 children in early 2001 to find out about their perceptions and experiences of Springboard[115]. The results, which can be taken as broadly representative of Springboard clients generally, indicate that:

[115] All Springboard projects were included with the exception of Tullamore and the three additional Springboard projects set up in 2000.

- virtually every parent and child has had very positive experiences of Springboard services.
- most clients experience Springboard as being a "big help" to them and their families.
- since coming to Springboard, more than four in ten (42%) believe that life is "much better" and nearly five out of ten (47%) believe that it is "better", with only one tenth (11%) believing that their life has remained the same; only one respondent experienced life as worse since coming to Springboard.
- virtually every parent and child experiences Springboard staff as caring, respectful, fair and competent.
- most parents believe that Springboard is needed in their area but, like staff, they recognise that gaining respect for its work can sometimes be difficult where communities are divided and vulnerable.
- Springboard is perceived by parents as more acceptable than any other service in the community.
- parents experience individual work and family work as most helpful while children find group work most helpful.
- parents and children made a number of suggestions for improving Springboard, including: (1) larger premises (2) larger playgrounds (3) more activities and services (4) more staff (5) more involvement of male staff and fathers (6) and more involvement of local people.

These results throw valuable light on the subjective impact of Springboard as seen through the eyes of parents and children and serve to complement and confirm the results of this evaluation. They show that Springboard is experienced as having a significantly beneficial impact on the lives of parents and children. The fact that parents are unanimous in the view that Springboard is needed in the area and compare it favourably to every other service they have experienced is indicative of the credibility which these projects have created over a relatively short period of time. The extent of this achievement in terms of gaining and sustaining confidence in communities which may themselves be quite divided and suspicious should not be underestimated and represents a genuine improvement in the social capital of those communities. Overall these results provide a strong endorsement of Springboard and indicate that its core objective of "supporting vulnerable families" has been realised.

16.14

Perceptions of Springboard by Professionals

Perceptions of Springboard by Professionals

In the early part of 2001 we also surveyed 172 professionals who are involved, directly or indirectly, in the work of Springboard in order to get an indication of how Springboard is perceived by a wide range of professionals throughout the country. The results are extremely encouraging for the work of Springboard while, at the same time, containing a number of challenges on how the initiative could be strengthened and expanded. The key findings of the survey are as follows:

- over 90% of professionals think that Springboard is good or very good in dealing with families, mothers and young children but is less effective in working with teenagers and especially fathers.

- over 90% of professionals believe that Springboard has built good or very good working relationships with local Primary Schools and Health Boards.
- virtually every professional believes the approach and skills of staff teams in Springboard are good or very good.
- nearly 90% believe that the location of premises is good or very good. However, only one third think the size of premises is good or very good.
- most professionals (97%) believe that the relationship between Springboard and the Health Boards is good or very good. Despite, or possibly because of, this high rating, the qualitative comments of interviewees draw attention to areas where there is room for improvement.
- the key strengths of Springboard as perceived by professionals are: (1) a focus on strengths and solutions (2) a positive approach to working in partnership and (3) a facility which is family-friendly and community-based. The key weaknesses of Springboard as perceived by professionals are: (1) uncertainty about future funding (2) inadequate premises and insufficient staff (3) difficulties building partnerships with organisations, agencies and families.
- the factors which facilitate inter-agency working are: (1) awareness of its benefits (2) regular contacts between organisations and agencies and the cultivation of appropriate professional attitudes (3) ensuring that families are always the first priority (4) supporting inter-agency working at all levels of the parent organisations. The key factors which hinder inter-agency cooperation are: (1) an excessive focus on power and territoriality (2) holding on to negative stereotypes about organisations and agencies (3) staff shortages and turnover (4) lack of contact and few referrals.
- the vast majority of professionals (87%) believe that Springboard has lived up to their original expectations.
- the great majority of professionals (78%) believe that Springboard provides value for money mainly because (1) it is cheaper than the fiscal cost of placing children in care or indeed other crisis-oriented forms of intervention (2) it is cheaper than doing nothing which can end up being very costly in terms of the long-term private, social and fiscal costs involved (3) it reduces pressure on child protection services which may, in turn, reduce fiscal costs.
- the vast majority of professionals (95%) believe that Springboard should continue to be funded mainly because: (1) it is working well (2) there is a huge need for it (3) there has already been a large investment in setting up the projects and (4) family support is essentially a long-term, preventative process.
- a substantial number of suggestions were made for making Springboard more effective including: (1) 'mainstreaming' the initiative (2) expanding Springboard to rural areas (3) increasing funding for staff and premises (4) increasing local input through training for parents to act as support workers, home helps, community parents, etc. (5) strengthening the role of advisory/management committees (6) encouraging other organisations and agencies to use Springboard (7) improving supports for project managers and staff and (8) developing a coherent approach within each community to all services for families.

These findings contain a wealth of information and show the high esteem in which Springboard is held by other professionals, because it is a service which is needed and is being delivered in a way which is seen as meeting that need very effectively. It is hard to imagine how a service could achieve a higher approval rating from other professionals in the field. At the same time, the results openly acknowledge that there is room for improvement.

16.15 Conclusions and Recommendations

In this final section of this report we assess the overall impact of Springboard and examine the case for 'mainstreaming' the programme. We also address a number of specific issues which emerged forcefully during the evaluation: (1) the importance of a family system perspective (2) the seriousness of non-attendance at school (3) the trade-offs implicit in maternal employment and (4) the need for realistic expectations about family support services.

16.15.1 Mainstreaming Springboard

Our evaluation has shown that parents and children experienced considerable improvements in well-being while attending Springboard between January 2000 and May 2001. In the case of children, this included a clinically-significant reduction in difficulties among one quarter of all children and a five-fold reduction in their perceived risk of abuse. For parents, roughly four in ten experienced a reduction in stress and a strengthening of their support networks while nearly one quarter improved their parenting capacity. At the same time, we were not able to find a strong association between these improvements in well-being and the time devoted by Springboard staff to each child essentially because time seems to be a poor indicator of the process by which Springboard impacts on the well-being of children. In contrast, staff hours had a significant influence on parenting capacity. This is clearly a challenging finding given that, on average, each child received approximately 2.2 hours per week over the course of a year, while parents received 1.7 hours per week over the same period. It is necessary therefore to search the evaluation for other evidence which could shed light on the link between improvements in well-being and the intervention of Springboard. Our review of the evaluation findings suggests four reasons why improvements in family well-being were probably due to the intervention of Springboard.

First, it is unlike that changes in the socio-economic situation of families were responsible for improvements in their well-being. It is true that a modest improvement of around 5% took place in the employment status of mothers and fathers between baseline and follow-up in May 2001 and that this had a modest impact in terms of reducing social welfare dependency. Overall, however, the employment situation of these families has been quite stable over the evaluation period.

Second, virtually every parent and child attributed their improved well-being to the intervention of Springboard. This emerged during the survey of a

random sample of parents and children in early 2001, with 90% believing that life is "better" or "much better" since coming into contact with Springboard. Most parents and children have had very positive experiences of Springboard and describe it as a "big help" to them and their families. Similarly, in the measurement of each child's difficulties (SDQ), around half the parents and children believe that the child is "much better" since coming to Springboard and more than eight out of ten experience Springboard as helpful.

Third, Health Boards estimate that Springboard has been successful in halving the number of children at moderate-to-high risk of being abused or going into care. This is a very significant achievement for a programme designed to shift the emphasis of intervention with vulnerable families from child protection to family support. In this sense, therefore, the strategy of addressing child protection concerns through the family support approach of Springboard is working well and points the way towards more effective and holistic forms of intervention with vulnerable families. It is true that risk may not always be a good indicator of well-being and is difficult to assess in a standardised way due to the organisational, professional and personal factors which influence its definition[116]. Nevertheless, from the perspective of the evaluation, it is significant that Health Boards see Springboard as making decisive impacts on children and their families.

Fourth, our survey of 172 professionals who are involved, directly or indirectly, with the work of Springboard indicates that projects are perceived as being good or very good in dealing with families, mothers and young children. The majority of professionals (78%) believe that Springboard represents value for money because: (1) it is cheaper than the fiscal cost of placing children in care or indeed other crisis-oriented forms of intervention (2) it is cheaper than doing nothing which can end up being very costly in terms of the long-term private, social and fiscal costs involved (3) it reduces pressure on child protection services which may, in turn, reduce fiscal costs. The vast majority of these professionals (95%) also believe that Springboard should continue to be funded mainly because: (1) it is working well (2) there is a huge need for it (3) there has already been a huge investment in setting up the projects and (4) family support is essentially a long-term, preventative process.

The weight of evidence cited above suggests that Springboard has made significant improvements in the well-being of parents and children. Before making our recommendation, however, it is also worth referring to two additional findings which underline the central importance of family support interventions like Springboard. First, we have seen in stark statistical terms that the consequences of growing up in a dysfunctional family tend to repeat themselves as children become parents. This cycle will probably continue its inter-generational movement without external intervention such as that provided by Springboard. Second, the evaluation showed that improvements in the well-being of parents have long-term benefits for their children and vice versa, which suggests, in turn, that further improvements in family well-being, over and above those documented here, are likely to accrue from the intervention of Springboard in the future.

[116] See for example, Jacobs, Williams and Kapuscik, 1997; Whittaker, 1997; Rossi, 1992a; 1992b.

All of these considerations lead us to the conclusion that Springboard has made a significant contribution to the well-being of families which, in turn, has positive consequences for their communities and for society in general, including the State. The evidence from this evaluation suggests that vulnerable families do not tend to experience "spontaneous remission" in their problems and the option of "doing nothing" is often tantamount to permitting further deteriorations in their well-being. The average cost of the benefits to each client in Springboard, both children and parents, is around IR£5,500[117] - excluding the benefits to those clients who receive a less intensive service - and compares very favourably to the cost of keeping a child in institutional care (IR£55,000)[118] or the cost of keeping a child in foster care (IR£11,000)[119] - and this suggests that Springboard is a cost effective programme. Accordingly, we recommend that Springboard should be established as a mainstream family support programme and should be expanded on a phased basis to meet the ultimate target that every community in Ireland in which there is a significant concentration of vulnerable families will have a family support service reflecting the model and ethos of Springboard. In terms of phasing, resources might initially be targeted at families where children are deemed by Health Boards to be at risk and then expanded to other families where there are clear deficits in the well-being of parents and children, particularly where these are geographically concentrated. In expanding Springboard, improvements in well-being should continue to be carefully monitored and evaluated to ensure its continued cost effectiveness. Given that other Government Departments are also involved in family support services, notably the Department of Social, Community and Family Affairs, the proposed expansion of Springboard will require consultation and co-ordination to ensure that it is shaped by the elements of good practice which have been developed through the Springboard model while at the same time being flexible and responsive to the diverse need of vulnerable families in the different communities.

16.15.2

Importance of a Family System Perspective

Importance of a Family System Perspective

The Springboard model, as seen by professionals, is characterised by: (1) a focus on strengths and solutions (2) a positive approach to working in partnership and (3) a facility which is family-friendly and community-based. The evaluation adds a fourth element to this model by emphasising the importance of a family system perspective. Our analysis provided clear statistical evidence for the systemic nature of family well-being in the sense that the well-being of children is heavily determined by the well-being of their parents and vice versa. A clear implication of this finding is that strategies which do not fully engage with both parents and children are less likely to be effective.

Beyond the immediate family, we have also seen that families are embedded in a larger network of relationships from which they draw practical and emotional support. As a result, parental support networks have a clear influence on parental stress and parenting capacity which, in turn, influences the well-being of children. These finding are consistent with a growing body of research on the benefits of social capital for well-being generally[120].

[117] This is estimated on the basis that the annual average budget of each of the 14 Springboard projects in the evaluation is around IR£200,000 and these have worked intensively with 319 children and 191 parents.
[118] See McKeown and Sweeney, 2001, p.36.
[119] Ibid.
[120] OECD, 2001.

In the light of these considerations it is a little paradoxical to find that one element of the family system that is routinely ignored by most family services is fathers. Despite the best efforts of Springboard to engage fathers, we have seen that the vast majority of Springboard time, even in two parent households, is devoted to mothers and children, although we have no reason to believe that fathers, both resident and non-resident, are any less in need of support services or are any less affected by the well-being of the family system. The pattern by which family services tend to ignore fathers reflects a tendency among service providers to treat parenting as synonymous with mothering[121]. It is doubtful if such selectivity between parents - which no doubt is reinforced by a process of self-selection by some fathers themselves - is consistent with a family support service in the fullest sense of the word family. Accordingly, we recommend that services to families - which should not be treated as synonymous with services to households - should give careful consideration to all elements of the family system and offer supports in a holistic and inclusive manner.

16.15.3

Seriousness of Non-Attendance At School

Seriousness of Non-Attendance At School

The evaluation has shown that the average school attendance of Springboard children in May 2001 was 84% and has changed little since coming into contact with Springboard. In aggregate terms, there has been no change in the proportion of children coming late to school (at around 30%) or without lunch (at around 8%), although there has been a marginal improvement in the number of children coming to school hungry (now at 7%). In other words, there has been very little improvement in the school-related aspects of these children's lives according to the indicators that we have used. Many of the creative initiatives being used by Springboard to promote educational participation and attainment - breakfast clubs, homework clubs and other out-of-school activities - are likely to have beneficial effects but these have not so far been detected in the evaluation, possibly due to the limited number of indicators used.

The level of absenteeism from school is alarming, bearing in mind that the average age of the children concerned is under nine (8.8 years). It should also be recalled that the parents of these children are often early school leavers themselves and the experience of many projects in Springboard is that some parents do not place a high value on their children's education. As a result, children are losing an average of 30 school days each year which, even without other forms of adversity in their lives, will be difficult to make up and will impair them in a cumulative fashion as they move into adult life. Similarly, there has been no change in the proportion of children coming late to school or even in the proportion of children coming to school without lunch. These findings indicate that the school-related aspects of children's lives cannot be left solely to the pioneering interventions of Springboard but require a more focused approach by the schools themselves, working in tandem with the parents and other agencies. Accordingly, we recommend that the Department of Health and Children and the Department of Education and Science give urgent consideration to measures which will address all school-related issues which affect the well-being of children.

[121] Roberts and Macdonald, 1999:63; see also French, 1998:187-188; Rylands, 1995; Murphy, 1996:95; McKeown, 2001, Chapter Eight; Buckley, 1998, p.7.

16.15.4

Trade-Offs Entailed by Maternal Employment

Trade-Offs Entailed by Maternal Employment

The evaluation revealed that maternal employment creates a trade-off between the well-being of mothers and the well-being of their children because, on the one hand, mothers' employment increases the well-being of families by reducing their financial difficulties, alleviating their stress and improving their support networks while, on the other hand, it increases the difficulties of children and reduces parenting capacity (see Chapters Seven and Twelve). It may well be that the overall net effect of mother's employment on the well-being of children is positive but this cannot be automatically assumed in the light of this finding. It is significant that a similar finding emerged from a recent longitudinal study, based on data from the British Household Panel Survey, which found that, after controlling for factors such as parents' education, occupation and family type, the longer mothers spent in employment while their children were aged one to five years, the poorer those children's subsequent educational attainment and the higher their risk of unemployment and psychological stress when they reached the age of 20 years and over; interestingly, the same study also found that father's employment during this stage of their children's lives had much less impact and it tended to be in the opposite direction to mothers with longer periods of father's employment being associated with reduced risk of economic inactivity and psychological stress although also associated with reduced educational outcomes[122]. Another recent British study has come up with the same result[123] although there is less consensus from the findings of American studies[124]. The significance of our finding may well go far beyond the confines of Springboard, given that of all women in the labour force (42%), the group with the highest participation is that of lone mothers with child(ren) under 15 (52%), followed by married women with child(ren) under 15 (49%)[125]. This draws attention to the need to ensure that children are not adversely affected by their mother's entry into the labour market, particularly when the children are of pre-school age. This is an issue which merits careful consideration given that the emphasis in public policy on increasing the participation of mothers (and fathers) in the workforce is not always matched by an equal emphasis on safeguarding the well-being of children while their parents are at work. The provision of high-quality affordable childcare combined with the greater involvement of fathers may help to avoid this negative trade-off for children. From the perspective of staff in Springboard, these findings suggest that arrangements for the care and protection of children when mothers are out at work cannot be taken for granted and the child's experience of their mother's employment should be taken into account, bearing in mind the "principles for best practice" enunciated in the National Guidelines for the Protection and Welfare of Children[126]. Accordingly, we recommend that the impact of parental employment on the well-being of children be given serious consideration at all levels of the Springboard programme.

[122] Ermisch and Francesconi, 2001.
[123] Joshi and Verropoulou, 2000.
[124] Haveman and Wolfe, 1995; Baydar and Brooks-Gunn, 1991; Belsky and Eggebeen, 1991.
[125] See McKeown and Sweeney, 2001:26, Box 15.
[126] Department of Health and Children, 1999a, pp.22-23.

Realistic Expectations of Springboard

16.15.5

Realistic Expectations of Springboard

The evaluation has shown that the problems in vulnerable families tend to be entrenched for many years and to have an inter-generational dimension. We saw this in the striking similarity between the family problems which parents experienced as children and the problems which they currently experience, particularly relationship difficulties with children and partners which are sometimes associated with alcohol dependence and psychiatric problems. These problems are much more prevalent among Springboard families than in the Irish population[127] and require sensitive and skilled intervention.

Our evaluation has shown that the key indicators of family well-being are highly stable and not amenable to quick change. In other words, the forces for stability - even when the stable condition in question may not be indicative of well-being - are often greater than the forces for change. This is probably obvious to most people, but there is often a presumption that initiatives like Springboard can solve problems that others have found intractable. It is clear from the evaluation that families with serious problems cannot expect a 'miracle cure' and this is in line with the known impacts of other interventions both in Ireland[128] and elsewhere[129]. This is worth repeating if only to discourage unrealistic expectations about what is achievable by interventions such as Springboard. Our analysis has shown that significant progress has been achieved in promoting the well-being of children and parents despite the stability of the underlying conditions, but more remains to be done.

[127] See Webb, 1991, p.107; Study Group on the Development of Psychiatric Services, 1984:7 and 153; Commission on the Status of People with Disabilities, 1996:284-289, Appendix A.
[128] Kellaghan, 1977; Kellaghan and Greaney, 1992; Educational Research Centre, 1998; see also Kellaghan, Weir, O'hUallachain and Morgan, 1995.
[129] Hill, 1999; Hellinckz, Colton, and Williams, 1997.

Bibliography

American Psychiatric Association, 1994. Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), Washington DC: American Psychiatric Association.

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

Bayder, N., and Brooks-Gunn, J., 1991. "Effects of Maternal Employment and Childcare Arrangements on Preschoolers' Cognitive and Behavioural Outcomes: Evidence from the NLS of Youth", Developmental Psychology, Volume 27, pp.932-945.

Behaviour and Attitudes, 1999. A Survey of 18-30 Year Olds, July, Dublin: Wilson Hartnell Public Relations.

Belsky, J., and Eggebeen, DJ., 1991. "Early and Extensive Maternal Employment and Young Children's Socio-emotional Development: Children of the NLS of Youth"" Journal of Marriage and the Family, Volume 53, pp.1083-1110.

Bradbury, TN., and Fincham, FD., 1990. "Preventing Marital Dysfunction: Review and Analysis", in Fincham, FD., and Bradbury, TN., (Editors), The Psychology of Marriage: Basic Issues and Applications, New York: The Guilford Press, Chapter 13, pp. 375-401.

Bradshaw, J., Stimson, C., Skinner, C., and Williams, J., 1999a. Absent Fathers?, London: Routledge.

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

Brugha, TS., 1995. "Social Support and Psychiatric Disorder: Recommendations for Clinical Practice and Research", in Brugha, TS., (Editor), Social Support and Psychiatric Disorder: Research Findings and Guidelines for Clinical Practice, Cambridge: Cambridge University Press.

Buckley, H., 1998. "Filtering Out Fathers: The Gendered Nature of Social Work in Child Protection", Irish Social Worker, Volume 16, Number 3, pp.7-11.

Buckley, H., 2000. "Working Together to Protect Children: An Evaluation of an Inter-Agency Training Programme", Administration: Journal of the Institute of Public Administration, Volume 48, Number 2, Summer, pp.24-42.

Cade, B., and O'Hanlon, WH., 1993. A Brief Guide to Brief Therapy, London: Norton Publishers.

Callan, T., Layte, R., Nolan, B., Watson, D., Whelan, CT., Williams, J., and Maitre, B., 1999. Monitoring Poverty Trends: Data from the 1997 Living in Ireland Survey, June, Dublin: Stationery Office and Combat Poverty Agency.

Canavan, J., 1998. The North Mayo Schools Project: A Blueprint for Supporting Young People in School, Dublin: Foróige, National Youth Development Organisation.

Canavan, J., and Dolan, P., 2000. "Refocusing Project with Adolescents towards a Family Support paradigm", in Canavan, J., Dolan, P., and Pinkerton, J., (Editors), Family Support: Direction from Diversity, London: Jessica Kingsley Publishers, pp. 123-144.

Census of Population, 1991. Volume 10, Housing, Dublin: Stationery Office.

Census of Population, 1996. Volume 7, Occupations, Dublin: Stationery Office.

Coulton, M., and Williams, M., 1997. "Supporting Children in Need and their Families through a Change in Legislation: A Case Study based on the Impact of the Children Act in England and Wales", in Hellinckz, W., Colton, MJ., and Williams, M., (Editors), International Perspectives on Family Support, Arena: Aldershot, Chapter Nine, pp.140-152.

Commission on the Family, 1998. Strengthening Families for Life, Final Report, July, Dublin: Stationery Office.

Commission on the Status of People with Disabilities, 1996. Report, November, Dublin: Department of Justice, Equality and Law Reform.

Cowen, E., Pedro-Carroll, J., and Alpert-Gillis, L., 1990. "Relationships between Support and Adjustment Among Children of Divorce", Journal of Child Psychology and Psychiatry, Volume 31, pp.727-735.

Cutrona, C., 2000. "Social Support Principles for Strengthening Families: Messages from the USA", in Canavan, J., Dolan, P., and Pinkerton, J., (Editors), Family Support: Direction from Diversity, London: Jessica Kingsley Publishers, pp. 103-122.

De Panfilis, 1996. "Social Isolation of Neglectful Families: A Review of Social Support Assessment and Intervention Models", Child Maltreatment, Volume 1, Number 1, pp.37-52.

Department of Education, 1994. School Attendance / Truancy Report, Issued by Niamh Bhreathnach, TD, Minister of Education, April, Dublin: Department of Education.

Department of Education and Health Promotion Unit, 1996. A National Survey of Involvement in Sport and Physical Activity, Dublin: Department of Education and Health Promotion Unit.

Department of Environment and Local Government, 1999. Annual Housing Statistics Bulletin 1998, Dublin: Stationery Office.

Department of Health and Children, 1998. Pilot Projects for Children at Risk: Guidelines for Preparation of Proposals, Dublin: Department of Health and Children.

Department of Health and Children, 1999a. Children First: National Guidelines for the Protection and Welfare of Children, Dublin: The Stationery Office.

Department of Health and Children, 1999b. Springboard Initiatives: Family Support Projects for Children at Risk; Request for Proposals for Evaluation of Springboard Initiatives, Dublin: Department of Health and Children.

Department of Health and Children, 2000. Report on Vital Statistics, Compiled by the Central Statistics Office, Dublin: Stationery Office.

Educational Research Centre, 1998. Early Start Pre-School Programme: Final Evaluation Report, Saint Patrick's College, Drumcondra, Dublin: Educational Research Centre.

Ermish, J., and Francesconi, M., 2001. The Effects of Parents' Employment on Children's Lives, March, London: Family Policy Studies Centre.

Fianna Fáil and the Progressive Democrats, 1997. An Action Programme for the Millennium, 1997, July, Dublin: Government Information Services.

Fianna Fáil and the Progressive Democrats, 1999. An Action Programme for the Millennium An Action Programme for the Millennium, As Reviewed by Fianna Fáil and the Progressive Democrats in Government, November, Dublin: Government Information Services.

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

Fortin, A., and Chamberland, C., 1995. "Preventing the Psychological Maltreatment of Children", Journal of Interpersonal Violence, Volume 10, Number 3, pp.275-295.

French, G., 1998. Enhancing Our Future: A Profile of Parenting Programmes in Ireland, Dublin: Barnardos and the Department of Health & Children.

George, E., Iveson, C., and Ratner, H., 1997. Problem to Solution, London: Brief Therapy Press.

Gerard, AB., 1994. Parent-Child Relationship Inventory (PCRI): Manual, Los Angeles: Western Psychological Services.

Gilligan, R., 1991. "Family Support and Child Welfare: Realising the Promise of the Child Care Act 1991", in Ferguson, H., and Kenny, P., (Editors), Child Welfare, Child Protection and the Child Care Act 1991, Dublin: A&A Farmar.

Gilligan, R., 1995. "Family Support and Child Welfare: Realising the Promise of the Child Care Act 1991", in Ferguson, H., and Kenny, P., (Editors), On Behalf of the Child: Child Welfare, Child Protection and the Child Care Act 1991, Dublin: A&A Farmer, pp.60-83.

Gilligan, R., 1999. "Working with Social Networks: Key Resources in Working with Children at Risk", in Hill, M., (Editor), Effective Ways of Working with Children and their Families, Research Highlights in Social Work 35, London: Jessica Kingsley Publishers, Chapter Three, pp.70-91.

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

Goldberg, DP., and Williams, P., 1988. A Users Guide to the General Health Questionnaire, Nfer-Nelson.

Goodman, R., 1997. "The Strengths and Difficulties Questionnaire: A Research Note", Journal of Child Psychology and Psychiatry, Volume 38, Number 5, pp. 581-586.

Goodman, R., Meltzer, H., and Bailey, V., 1998. "The Strengths and Difficulties Questionnaire: A Pilot Study on the Validity of the Self-Report Version", European Child and Adolescent Psychiatry, Volume 7, pp. 125-130.

Goodman, R., and Scott, S., 1999. "Comparing the Strengths and Difficulties Questionnaire and the Child Behaviour Checklist: Is Small Beautiful?", Journal of Abnormal Child Psychology, Volume 27, Number 1, pp. 17-24.

Goodman, R., 1999. "The Extended Version of the Strengths and Difficulties Questionnaires a Guide to Psychiatric Caseness and Consequent Burden", Journal of Child Psychology and Psychiatry, Volume 40, Number 5, pp. 791-799.

Guterman, N., 1997. "Early Prevention of Physical Child Abuse and Neglect: Existing Evidence and Future Directions", Child Maltreatment, Volume 2, Number 1, pp.12-34.

Haveman, R., and Wolfe, B., 1995. "The Determinants of Children's Attainments: A Review of Methods and Findings", Journal of Economic Literature, Volume 33, December.

Hellinckz, W., Colton, MJ., and Williams, M., (Editors), 1997. International Perspectives on Family Support, Arena: Aldershot.

Herbert, M., 1988. Working with Children and Their Families, London: Routledge.

Herbert, M., 2000. "Children in Control: Helping Parents to Restore Balance", in Canavan, J., Dolan, P., and Pinkerton, J., (Editors), Family Support: Direction from Diversity, London: Jessica Kingsley Publishers, pp. 79-102.

Hill, M., (Editor), 1999. Effective Ways of Working with Children and their Families, Research Highlights in Social Work 35, London: Jessica Kingsley Publishers.

Jacobs, FH., Williams, PH., and Kapusick, JL., 1997. "Evaluating Family Preservation Services: Asking the Right Questions", in Hellinckz, W., Colton, MJ., and Williams, M., (Editors), International Perspectives on Family Support, Arena: Aldershot, Chapter Thirteen, pp.206-223.

Johnson, Z., Howell, F., and Molloy, B., 1993. "Community Mothers Programme: Randomised Controlled Trial of Non-Professional Intervention in Parenting", British Medical Journal, Volume 306, pp. 1449-1452.

Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T., and Byrne, P., 2000. "Community Mothers Programme - Seven Year Follow-Up of a Randomised Control Trial of Non-Professional Intervention in Parenting", Journal of Public Health Medicine, Volume 22, Number 3, pp.337-342.

Joshi, H., and Verropoulou, G., 2000. Maternal Employment and Child Outcomes, Smith Institute Report.

Ireland, 1999. National Development Plan 2000-2006, November, Dublin: Stationery Office.

Kaplan, D., 2000. Structural Equation Modelling: Advanced Methods and Applications, London: Sage Publications.

Kazdin, AE., 1997. "A Model for Developing Effective Treatments: Progression and Interplay of Theory, Research and Practice", Journal of Clinical Child Psychology, Volume 26, pp.114-129.

Kellaghan, T., 1977. The Evaluation of an Intervention Programme for Disadvantaged Children, Windsor, Berks: NFER Publishing Company.

Kellaghan, T., and Greaney, BJ., 1993. The Educational Development of Students Following Participation in a Preschool Programme in a Disadvantaged Area, Dublin: Educational Research Centre.

Kellaghan, T., Weir, S., O'hUallachain, S., and Morgan, M., 1995. Educational Disadvantage in Ireland, Dublin: Combat Poverty Agency.

Kinney, JD., Haapala, D., Booth, C., and Leavitt, S., 1990. "The Homebuilders Model", in Whittaker, JK., Kinney, J., Tracy, EM., and Booth, C., (Editors), Reaching High Risk Families: Intensive Family Preservation in Human Services, Washington DC: Centre for Social Welfare Research, University of Washington, School of Social Work.

Labour Force Survey, 1997. Dublin: Stationery Office.

Lambert, MJ., 1992. "Implications of Outcome Research for Psychotherapy Integration", in Norcross, JC., and Goldstein, MR., (Editors), Handbook of Psychotherapy Integration, New York: Basic, pp.94-129.

Lawlor, M., and James, D., 2000. "Prevalence of Psychological Problems in Irish School Going Adolescents", Irish Journal of Psychological Medicine, Volume 17, Number 4, December, pp.117-122.

Leavy, RL., 1983. "Social Support and Psychological Disorder: A Review", Journal of Community Psychology, Volume 11, pp.3-21.

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

McKeown, K., 2001. Fathers and Families: Research and Reflection on Key Questions, December, Dublin: Stationery Office.

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

McKeown, K., Haase, T., Pratschke, J., Rock, R., and Kidd, P., 2001. Unhappy Marriages: Does Counselling Help? A Report to ACCORD, March, Dublin: ACCORD.

McKeown, K., Haase, T., and Pratschke, J., 2001. Distressed Relationships: Does Counselling Help? A Report to MRCS - Marriage and Relationship Counselling Services, April, Dublin: ACCORD.

McNicholas, F., 2000. "Good Practice in Attention Deficit Hyperactivity Disorder", Irish Journal of Psychological Medicine, Volume 17, Number 2, June, pp.62-66.

McSorley, C., 1997. School Absenteeism in Clondalkin: Causes and Responses, November, Dublin: Clondalkin Partnership.

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

Moukaddem, S., Fitzgerald, M., and Barry, M., 1998. "Evaluation of a Child and Family Centre", Child Psychology and Psychiatry Review, Volume 3, Number 4, pp. 161-168.

Mullin, E., Proudfoot, R., and Glanville, B., 1990. "Group Parent Training in the Eastern Health Board: Programme Description and Evaluation", Irish Journal of Psychology, Volume 11, Number 4, pp. 342-353.

Mullin, E., Quigley, K., and Glanville, B., 1994. "A Controlled Evaluation of the Impact of a Parent Training Programme on Child Behaviour and Mothers' General Well-Being", Counselling Psychology Quarterly, Volume 7, Number 2, pp. 167-179.

Mullin, E., Oulton, K., and James, T., 1995. "Skills Training with Parents of Physically Disabled Persons", International Journal of Rehabilitation Research, Volume 18, pp. 142-145.

Murphy, M., 1996. "From Prevention to 'Family Support' and Beyond: Promoting the Welfare of Irish Children", Administration, Volume 44, Number 2, Summer, pp.73-101.

National Children's Strategy, 2000. Report of the Public Consultation, September, Dublin: Department of Health and Children.

NSPCC Practice Development Unit and University of Central Lancashire, 2000. Social Inclusion and Family Support, A Report to DG5 of the European Commission, London: NSPCC National Centre.

OECD, 2001. The Well-being of Nations: The Role of Human and Social Capital, Paris: Organisation for Economic Co-Operation and Development.

Pinkerton, J., Higgins, K., and Devine, P., 2000. Family Support - Linking Project Evaluation to Policy Analysis, Aldershot, England: Ashgate.

Programme for Prosperity and Fairness, 2000. January, Dublin: Government Information Service.

Quarterly National Household Survey, 2001. Statistical Release, Second Quarter, 29 August, Dublin: Central Statistics Office.

Richardson, V., 1999. "Children and Social Policy", in Quin, S., Kennedy, P., O'Donnell, A., and Kiely, G., (Editors), Contemporary Irish Social Policy, Dublin: University college Dublin Press, pp. 170-199.

Roberts, H., and MacDonald, G., 1999. "Working with Families in the Early Years", in Hill, M., (Editor), Effective Ways of Working with Children and their Families, Research Highlights in Social Work 35, London: Jessica Kingsley Publishers, Chapter Two, pp.79-69.

Rossi, PH., 1992a. "Assessing Family Preservation Programs", Children and Youth Services Review, Volume 14, pp.77-97.

Rossi, PH., 1992b. "Strategies for Evaluation", Children and Youth Services Review, Volume 14, pp.167-191.

Runyan, D., Hunter, W., Socolar, R., Amaya-Jackson, D., English, D., Landsverk, J., Dubowitz, H., Browne, D., Bangdiwala, S., and Matthew, R., 1998. "Children who Prosper in Unfavourable Environments: The Relationship to Social Capital", Pediatrics, Volume 101, Number 1, pp.12-18.

Rylands, J., 1995. A Study of Parenting Programmes in Ireland: Exploration of Needs and Current Provision, Dublin: Barnardos and the Department of Health & Children.

Saleeby, D., 1992. (Editor), The Strengths Perspective in Social Work Practice, New York: Longman.

Saleeby, D., 1996. "The Strengths Perspective in Social Work Practice: Extensions and Cautions", Social Work, Volume 41, Number 3, May, pp.296-305.

Saleeby, D., 2000. "Behind the Label: Discovering the Promise in Individuals and Families 'At Risk'", Irish Social Worker, Volume 18, Number 1, Summer, pp.4-10.

Scovern, AW., 1999. "From Placebo to Alliance: the Role of Common Factors in Medicine", in Hubble, MA., Duncan, BL., and Miller, SD., (Editors), The Heart and Soul of Change: What Works in Therapy, Washington: American Psychological Association, pp. 259-295.

Smedje, H., Broman, JE., Hetta, J., and von Knorring, AL., 1999. "Psychometric Properties of the Strengths and Difficulties Questionnaire", European Child and Adolescent Psychiatry, Volume 8, pp. 63-70.

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

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

Study Group on the Development of the Psychiatric Services, 1984. The Psychiatric Services: Planning for the Future, Dublin: Stationery Office.

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

Taoiseach, 1998. "Implementation of the Integrated Services Project", Dublin Castle, 4 December, Dublin: Government Information Services.

Tracy, EM., and Whittaker, JK., 1990. "The Social Network Map: Assessing Social Support in Clinical Practice", Families in Society: The Journal of Contemporary Human Services, October, pp. 461-770.

Verhulst, FC., and Koot, HM., 1992. Child Psychiatric Epidemiology: Concepts, Methods and Findings, Volume 3, Developmental Clinical Psychology and Psychiatry, London: Sage Publications.

Wall, E., and Burke, K., 1990. Micra-T Reading Attainment Tests: Level 1, Level 23, Level 3, Teacher's manual, Dublin: CJ Fallon.

Webb, M., 1991. "Alcohol Excess - The Curse of the Drinking Classes", in Keane, C. (Editor), Mental Health in Ireland, Dublin: Gill and Macmillan and Radio Telefís Éireann, pp.99-111.

Whelan, C., Hannan, D., Creighton, S., 1991. Unemployment, Poverty and Psychological Distress, January, Dublin: Economic and Social Research Institute.

Whittaker, JK., 1997. "Intensive Family Preservation work with High risk Families: Critical Challenges for Research, Clinical Intervention and Policy", in Hellinckz, W., Colton, MJ., and Williams, M., (Editors), International Perspectives on Family Support, Arena: Aldershot, Chapter Thirteen, pp.124-139.

World Health Organisation, 1994. The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research, Geneva: World Health Organisation.

Technical Appendix

List of Figures and Tables

A2: Methodology

Table A2.1 Valid Baseline and Follow-up Questionnaires Returned by Projects *

					Baseline						Follow-up					
		Included in Analysis			Strength & Difficulties Questionnaire			Staff on Child	Parent on Parent	Staff on Parent	Strength & Difficulties Questionnaire			Staff on Child	Parent on Parent	Staff on Parent
ID	Project	Children	Parents	Families	Child	Parent	Teacher				Child	Parent	Teacher			
01	Athlone	24	19	20	5	24	23	17	21	21	4	20	12	17	20	21
02	Tullamore	16	20	20	1	16	13	13	20	20	1	16	13	13	20	20
03	Thurles	12	11	16	1	12	4	11	13	11	1	11	2	10	13	10
04	Limerick	20	11	11	6	20	15	10	12	12	5	19	14	10	12	12
05	Cork	13	12	11	2	13	8	9	14	13	2	13	6	10	13	14
06	Waterford	22	7	7	1	22	13	7	9	8	4	22	19	7	8	9
07	Dublin	13	11	10	7	12	12	10	13	14	7	11	12	10	14	14
	Barnardos	**120**	**91**	**95**	**23**	**119**	**88**	**77**	**102**	**99**	**24**	**112**	**78**	**77**	**100**	**100**
12	Sligo	42	12	17	16	42	34	17	15	15	12	34	32	16	13	14
13	Galway Westside	20	11	8	7	20	13	8	12	12	6	20	12	8	11	11
14	Galway Ballybane	39	19	19	9	39	25	18	19	20	4	36	22	18	19	20
15	Galway Ballinfoyle	34	21	27	34	34	34	27	27	27	31	32	29	27	27	27
16	Dundalk	34	19	19	27	33	25	17	21	21	30	30	25	17	21	21
17	Navan	14	7	11	14	13	12	11	8	11	13	12	13	11	11	11
18	Naas	16	11	11	5	13	12	11	12	14	5	12	12	11	13	13
	Other	**199**	**100**	**112**	**112**	**194**	**155**	**109**	**114**	**120**	**101**	**176**	**145**	**108**	**115**	**117**
	Total	**319**	**191**	**207**	**135**	**313**	**243**	**186**	**216**	**219**	**125**	**288**	**223**	**185**	**215**	**217**

* The term ‘valid’ denotes cases for which a matching set of data was available both for the baseline and follow-up.

A3: Profile of Families

Table A3.1: Number of Parents in Family Home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	112	54.1	54.1	54.1
	2	95	45.9	45.9	100.0
	Total	207	100.0	100.0	

Table A3.2: Parents in Family Home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Biological mother and father	67	32.4	32.5	32.5
	Biological mother only	103	49.8	50.0	82.5
	Biological father only	9	4.3	4.4	86.9
	Biological mother and partner	11	5.3	5.3	92.2
	Other	3	1.4	1.5	93.7
	Relationship not known	13	6.3	6.3	100.0
	Total	206	99.5	100.0	
Missing	System	1	.5		
Total		207	100.0		

Table A3.3: Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married to each other	57	27.5	27.5	27.5
	Divorced / separated	6	2.9	2.9	30.4
	Not married to each other	42	20.3	20.3	50.7
	Single	102	49.3	49.3	100.0
	Total	207	100.0	100.0	

Table A3.4: Number of Children in the Family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	15	7.2	8.4	8.4
	2	30	14.5	16.8	25.1
	3	40	19.3	22.3	47.5
	4	35	16.9	19.6	67.0
	5	25	12.1	14.0	81.0
	6	19	9.2	10.6	91.6
	7	12	5.8	6.7	98.3
	9	2	1.0	1.1	99.4
	10	1	.5	.6	100.0
	Total	179	86.5	100.0	
Missing	System	28	13.5		
Total		207	100.0		

Table A3.5: Number of Full-siblings in the Family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	10	4.8	5.6	5.6
	1	22	10.6	12.3	17.9
	2	34	16.4	19.0	36.9
	3	36	17.4	20.1	57.0
	4	28	13.5	15.6	72.6
	5	22	10.6	12.3	84.9
	6	18	8.7	10.1	95.0
	7	7	3.4	3.9	98.9
	9	1	.5	.6	99.4
	10	1	.5	.6	100.0
	Total	179	86.5	100.0	
Missing	System	28	13.5		
Total		207	100.0		

Table A3.6: Number of Half-siblings in the Family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	143	69.1	79.9	79.9
	1	13	6.3	7.3	87.2
	2	12	5.8	6.7	93.9
	3	5	2.4	2.8	96.6
	4	5	2.4	2.8	99.4
	6	1	.5	.6	100.0
	Total	179	86.5	100.0	
Missing	System	28	13.5		
Total		207	100.0		

Table A3.7: Number of Grandchildren in the Family Home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	173	83.6	96.6	96.6
	1	4	1.9	2.2	98.9
	3	2	1.0	1.1	100.0
	Total	179	86.5	100.0	
Missing	System	28	13.5		
Total		207	100.0		

Note: Tables A3.4 to A3.7 have a significant number of missing data (28 families). This is due to projects working increasingly with parents without participation of their children. Unfortunately, in such circumstances no data had been collected on some family characteristics, as this formed part of the staff-on-child questionnaire.

Table A3.8: Employment Status of Male Partner Follow up

			other	full-time employee	part-time employee	un-employed	full-time parent	Total
Baseline	other	Count	126	3	1	1		131
		%	99.2%	10.0%	5.3%	3.4%		63.3%
	full-time employee	Count	1	26	1	1		29
		%	0.8%	86.7%	5.3%	3.4%		14.0%
	part-time employee	Count			12	2		14
		%			63.2%	6.9%		6.8%
	unemployed	Count		1	5	25		31
		%		3.3%	26.3%	86.2%		15.0%
	full-time parent	Count					2	2
		%					100.0%	1.0%
	Total	Count	127	30	19	29	2	207
		%	100%	100%	100%	100%	100%	100%

Table A3.9: Employment Status of Female Partner Follow up

			other	full-time employee	part-time employee	un-employed	full-time parent	Total
Baseline	other	Count	17	1				18
		%	65.4%	7.1%				8.7%
	full-time employee	Count		9	1			10
		%		64.3%	1.6%			4.8%
	part-time employee	Count	4		45	5	5	59
		%	15.4%		73.8%	14.3%	7.0%	28.5%
	unemployed	Count	3	3	8	28	1	43
		%	11.5%	21.4%	13.1%	80.0%	1.4%	20.8%
	full-time parent	Count	2	1	7	2	65	77
		%	7.7%	7.1%	11.5%	5.7%	91.5%	37.2%
	Total	Count	26	14	61	35	71	207
		%	100%	100%	100%	100%	100%	100%

Table A3.10: Duration of Unemployment of Male Partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than a year	3	1.4	10.3	10.3
	More than a year	26	12.6	89.7	100.0
	Total	29	14.0	100.0	
Missing	System	178	86.0		
Total		207	100.0		

Table A3.11: Duration of Unemployment of Female Partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than a year	10	4.8	24.4	24.4
	More than a year	31	15.0	75.6	100.0
	Total	41	19.8	100.0	
Missing	System	166	80.2		
Total		207	100.0		

Table A3.12: Main Source of Household Income Second Follow up

		social welfare only	employment only	social welfare and employment	Total
Baseline social welfare only	Count	72	1	21	94
	%	86.7%	4.8%	21.2%	46.3%
employment only	Count	1	20		21
	%	1.2%	95.2%		10.3%
social welfare and employment	Count	10		78	88
	%	12.0%		78.8%	43.3%
Total	Count	83	21	99	203
	%	100%	100%	100%	100%

Table A3.13: Households' Ability to Make Ends Meet

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Great difficulty	59	28.5	30.7	30.7
	Difficulty	32	15.5	16.7	47.4
	Some difficulty	59	28.5	30.7	78.1
	Fairly easy	27	13.0	14.1	92.2
	Easily	9	4.3	4.7	96.9
	Very easily	6	2.9	3.1	100.0
	Total	192	92.8	100.0	
Missing	System	15	7.2		
Total		207	100.0		

Table A3.14: Occupational Status of Male Partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Lower professional	3	1.4	1.4	1.4
	Skilled manual	7	3.4	3.4	4.8
	Semi-skilled manual	10	4.8	4.8	9.7
	Unskilled manual	36	17.4	17.4	27.1
	Parent not present	108	52.2	52.2	79.2
	Don't know	43	20.8	20.8	100.0
	Total	207	100.0	100.0	

Table A3.15: Occupational Status of Female Partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Higher professional	1	.5	.5	.5
	Lower professional	6	2.9	2.9	3.4
	Other non-manual	8	3.9	3.9	7.2
	Skilled manual	14	6.8	6.8	14.0
	Semi-skilled manual	13	6.3	6.3	20.3
	Unskilled manual	85	41.1	41.1	61.4
	Parent not present	9	4.3	4.3	65.7
	Don't know	71	34.3	34.3	100.0
	Total	207	100.0	100.0	

Table A3.16: Type of Accommodation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Owner occupied	22	10.6	11.4	11.4
	Rented from Local Authority	148	71.5	76.7	88.1
	Rented from private landlord	16	7.7	8.3	96.4
	Halting site	1	.5	.5	96.9
	Other	6	2.9	3.1	100.0
	Total	193	93.2	100.0	
Missing	System	14	6.8		
Total		207	100.0		

Table A3.17: Length of Time in Present Accommodation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-5 years	89	43.0	63.1	63.1
	6-10 years	25	12.1	17.7	80.9
	more than 10 years	27	13.0	19.1	100.0
	Total	141	68.1	100.0	
Missing	System	66	31.9		
Total		207	100.0		

Table A3.18: Expectation to Live in House in One Year's Time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	136	65.7	70.5	70.5
	No	32	15.5	16.6	87.0
	Don't know	25	12.1	13.0	100.0
	Total	193	93.2	100.0	
Missing	System	14	6.8		
Total		207	100.0		

Table A3.19: Member of Settled or Travelling Community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Settled community	166	80.2	85.6	85.6
	Traveller community	27	13.0	13.9	99.5
	Refugee	1	.5	.5	100.0
	Total	194	93.7	100.0	
Missing	System	13	6.3		
Total		207	100.0		

Table A3.20: Family Known to Health Board Team

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	59	28.5	33.9	33.9
	Yes	115	55.6	66.1	100.0
	Total	174	84.1	100.0	
Missing	System	33	15.9		
Total		207	100.0		

Table A3.21: Sources of Referral

	Barnardos		Other Projects		All Projects	
	N	%	N	%	N	%
Health Board Social Worker	43	38.7	25	15.6	68	25.1
Health Board Community Childcare Worker	0	0.0	4	2.5	4	1.5
Health Board Family Support Worker	2	1.8	0	0.0	2	0.7
Public Health Nurse	5	4.5	3	1.9	8	3.0
Child Psychiatric Services	1	0.9	0	0.0	1	0.4
Adult Psychiatric Services	0	0.0	0	0.0	0	0.0
Hospital	0	0.0	0	0.0	0	0.0
Self	35	31.5	35	21.9	70	25.8
School	15	13.5	41	25.6	56	20.7
Garda Siochana	0	0.0	6	3.8	6	2.2
Youth Services	1	0.9	5	3.1	6	2.2
Neighbourhood Youth Project	0	0.0	5	3.1	5	1.8
Community Mothers Programme	0	0.0	0	0.0	0	0.0
Community Development Project	0	0.0	1	0.6	1	0.4
Neighbours of Family	1	0.9	8	5.0	9	3.3
Other	8	7.2	27	16.9	35	12.9
Total Number of Referrals	111	100.0	160	100.0	271	100.0
Number of Families	95		112		207	

Note: Referrals are possible by more than one agent

A4: Background Characteristics of Children

Table A4.1: Gender of Children

			Project Group		Total
			Barnardos	Other projects	
Gender	Female	Count	58	87	145
		% within Project Group	48.3%	43.7%	45.5%
	Male	Count	62	112	174
		% within Project Group	51.7%	56.3%	54.5%
Total		Count	120	199	319
		% within Project Group	100.0%	100.0%	100.0%

Table A4.2: Age of Children

			Project Group		Total
			Barnardos	Other projects	
AGE_GRP	2-6	Count	38	40	78
		% within Project Group	31.7%	20.1%	24.5%
	7-12	Count	71	125	196
		% within Project Group	59.2%	62.8%	61.4%
	13-16	Count	11	33	44
		% within Project Group	9.2%	16.6%	13.8%
	17-18	Count		1	1
		% within Project Group		.5%	.3%
Total		Count	120	199	319
		% within Project Group	100.0%	100.0%	100.0%

Table A4.3: Does Child Live in Family Home?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	291	91.2	94.2	94.2
	No	18	5.6	5.8	100.0
	Total	309	96.9	100.0	
Missing	System	10	3.1		
Total		319	100.0		

Table A4.4: Place where Child Lives Away from Family Home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Family/friends	7	2.2	38.9	38.9
	Foster care	4	1.3	22.2	61.1
	Other	7	2.2	38.9	100.0
	Total	18	5.6	100.0	
Missing	System	301	94.4		
Total		319	100.0		

Table A4.5: Has Child Ever Lived Outside the Family Home

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	49	15.4	17.6	17.6
	No	230	72.1	82.4	100.0
	Total	279	87.5	100.0	
Missing	System	40	12.5		
Total		319	100.0		

Table A4.6: Number of Parents in Household

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	168	52.7	52.7	52.7
	2	151	47.3	47.3	100.0
	Total	319	100.0	100.0	

Table A4.7: How Frequent does Child See Non-resident Father?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Every day	6	1.9	4.0	4.0
	A few times a week	9	2.8	6.0	10.0
	Once a week or less	26	8.2	17.3	27.3
	About once a month	16	5.0	10.7	38.0
	Less than once a month	36	11.3	24.0	62.0
	Never	52	16.3	34.7	96.7
	n/a	5	1.6	3.3	100.0
	Total	150	47.0	100.0	
Missing	System	169	53.0		
Total		319	100.0		

Table A4.8: Is Child from Settled or Travelling Community?

			Project Group		Total
			Barnardos	Other projects	
Travellers	Settled community	Count	99	145	244
		% within Project Group	92.5%	76.3%	82.2%
	Traveller community	Count	8	44	52
		% within Project Group	7.5%	23.2%	17.5%
	Ethnic group	Count		1	1
		% within Project Group		.5%	.3%
Total		Count	107	190	297
		% within Project Group	100.0%	100.0%	100.0%

Table A4.9: Children being Classified as having Difficulties (Subscales)

	Number of Children classified by			Proportion of Children classified by		
Conduct Problems	**Child**	**Parent**	**Teacher**	**Child**	**Parent**	**Teacher**
None	68	115	116	50.4%	36.7%	47.7%
Some	21	36	32	15.6%	11.5%	13.2%
Serious	46	162	95	34.1%	51.8%	39.1%
	135	313	243	100.0%	100.0%	100.0%
Hyperactivity	**Child**	**Parent**	**Teacher**	**Child**	**Parent**	**Teacher**
None	88	140	106	64.2%	44.7%	43.6%
Some	27	35	18	19.7%	11.2%	7.4%
Serious	22	138	119	16.1%	44.1%	49.0%
	137	313	243	100.0%	100.0%	100.0%
Emotional Problems	**Child**	**Parent**	**Teacher**	**Child**	**Parent**	**Teacher**
None	97	150	167	70.8%	47.9%	68.7%
Some	16	44	29	11.7%	14.1%	11.9%
Serious	24	119	47	17.5%	38.0%	19.3%
	137	313	243	100.0%	100.0%	100.0%
Peer Problems	**Child**	**Parent**	**Teacher**	**Child**	**Parent**	**Teacher**
None	99	150	146	72.3%	47.9%	60.1%
Some	27	46	33	19.7%	14.7%	13.6%
Serious	11	117	64	8.0%	37.4%	26.3%
	137	313	243	100.0%	100.0%	100.0%
Prosocial Behaviour	**Child**	**Parent**	**Teacher**	**Child**	**Parent**	**Teacher**
None	123	258	137	90.4%	82.4%	56.4%
Some	7	22	41	5.1%	7.0%	16.9%
Serious	6	33	65	4.4%	10.5%	26.7%
	136	313	243	100.0%	100.0%	100.0%
Total Difficulties	**Child**	**Parent**	**Teacher**	**Child**	**Parent**	**Teacher**
None	76	116	90	55.9%	37.1%	37.0%
Some	30	45	39	22.1%	14.4%	16.0%
Serious	29	152	114	21.3%	48.6%	46.9%
	135	313	243	99.3%	100.0%	100.0%

Table A4.10: Children with Serious Total Difficulties by Gender

Gender	Number of Children with serious difficulties identified by			Proportion of Children with serious difficulties identified by		
	Child	Parents	Teacher	Child	Parents	Teacher
Female	12	58	40	18%	41%	37%
Male	17	94	74	24%	55%	54%
Total	29	152	114	21%	49%	47%
Total Responses	135	313	243			

Table A4.11: Children with Serious Total Difficulties by Age Group

Age Group	Number of Children with serious difficulties identified by			Proportion of Children with serious difficulties identified by		
	Child	Parents	Teacher	Child	Parents	Teacher
2-6	1	41	19	13%	53%	39%
7-12	20	95	77	22%	49%	47%
13-16	8	16	18	22%	38%	60%
Total	**29**	**152**	**114**	**22%**	**49%**	**47%**
Total Responses	**134**	**312**	**243**			

Table A4.12: Problems Experienced by Children

	Not a problem	Not so serious	Fairly serious	Serious	Very serious
1 Experiencing neglect	32	68	43	18	12
2 Experiencing physical abuse	92	31	16	4	1
3 Experiencing emotional abuse	27	5	53	18	5
4 Experiencing sexual abuse	77	4	1	0	2
5 Experiencing emotional problems	60	77	82	43	16
6 Witnessing domestic violence	156	26	23	21	12
7 Violent towards parent(s)	216	25	7	2	1
8 Violent towards sibling(s)	181	49	12	10	1
9 Presenting behavioural problems	68	83	68	46	17
10 Not attending School	141	65	39	19	16
11 Involved in anti-social behaviour	171	44	32	21	5
12 Using alcohol	248	7	9	2	0
13 Using drugs	253	7	3	0	0
14 Solvent abuse	257	3	1	0	0
15 In trouble with the law	247	15	5	3	2
16 Physical or mental disability	223	25	12	5	3
17 Returning home from care	264	2	3	2	3
18 Expected to be carer at home	205	28	22	13	6
19 Experiencing homelessness	272	1	0	0	1
20 Other	103	1	15	8	13

	Not a problem %	Not so serious %	Fairly serious %	Serious %	Very serious %
1 Experiencing neglect	48.4	24.9	15.8	6.6	4.4
2 Experiencing physical abuse	78.7	12.7	6.6	1.6	0.4
3 Experiencing emotional abuse	61.1	2.4	25.5	8.7	2.4
4 Experiencing sexual abuse	96.2	2.2	0.5	0.0	1.1
5 Experiencing emotional problems	21.6	27.7	29.5	15.5	5.8
6 Witnessing domestic violence	65.5	10.9	9.7	8.8	5.0
7 Violent towards parent(s)	86.1	10.0	2.8	0.8	0.4
8 Violent towards sibling(s)	71.5	19.4	4.7	4.0	0.4
9 Presenting behavioural problems	24.1	29.4	24.1	16.3	6.0
10 Not attending School	50.4	23.2	13.9	6.8	5.7
11 Involved in anti-social behaviour	62.6	16.1	11.7	7.7	1.8
12 Using alcohol	93.2	2.6	3.4	0.8	0.0
13 Using drugs	96.2	2.7	1.1	0.0	0.0
14 Solvent abuse	98.5	1.1	0.4	0.0	0.0
15 In trouble with the law	90.8	5.5	1.8	1.1	0.7
16 Physical or mental disability	83.2	9.3	4.5	1.9	1.1
17 Returning home from care	96.4	0.7	1.1	0.7	1.1
18 Expected to be carer at home	74.8	10.2	8.0	4.7	2.2
19 Experiencing homelessness	99.3	0.4	0.0	0.0	0.4
20 Other	73.6	0.7	10.7	5.7	9.3

Table A4.13: Number of Serious Problems Experienced by Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	70	21.9	22.7	22.7
	1	48	15.0	15.5	38.2
	2	52	16.3	16.8	55.0
	3	50	15.7	16.2	71.2
	4	30	9.4	9.7	80.9
	5	20	6.3	6.5	87.4
	6	22	6.9	7.1	94.5
	7	7	2.2	2.3	96.8
	8	5	1.6	1.6	98.4
	9	2	.6	.6	99.0
	10	1	.3	.3	99.4
	13	2	.6	.6	100.0
	Total	309	96.9	100.0	
Missing	System	10	3.1		
Total		319	100.0		

Note: Table A4.13 refers to the Number of Children presenting none, 1, 2, 3, etc. problems at 'fairly serious', 'serious', or 'very serious' level.

Table A4.14: Child at School

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	262	82.1	91.0	91.0
	No	26	8.2	9.0	100.0
	Total	288	90.3	100.0	
Missing	System	31	9.7		
Total		319	100.0		

Table A4.15: Type of School Attended

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary school	222	69.6	84.4	84.4
	Secondary school	25	7.8	9.5	93.9
	Special school	13	4.1	4.9	98.9
	Other school	3	.9	1.1	100.0
	Total	263	82.4	100.0	
Missing	System	56	17.6		
Total		319	100.0		

Table A4.16: Reasons for Not Being at School

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reached age 15	1	.3	4.8	4.8
	Drop out	4	1.3	19.0	23.8
	Numerous suspensions	1	.3	4.8	28.6
	To avoid bullying	4	1.3	19.0	47.6
	Other	11	3.4	52.4	100.0
	Total	21	6.6	100.0	
Missing	System	298	93.4		
Total		319	100.0		

Table A4.17: Participation in Out-of-School Activities and Numbers Involved

	Yes	No	No suspended	No not available	No too young
1 Sports Club	24	206	2	2	26
2 Youth Club	32	201	3	0	26
3 Scouts Group	3	222	0	3	22
4 Dancing Class	4	221	0	7	17
5 Boxing Club	0	221	0	3	22
6 Other	64	140	0	1	17

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	210	65.8	65.8	65.8
	1	93	29.2	29.2	95.0
	2	15	4.7	4.7	99.7
	4	1	.3	.3	100.0
	Total	319	100.0	100.0	

Table A4.18: Co-operativeness of Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very co-operative	148	46.4	51.7	51.7
	co-operative	118	37.0	41.3	93.0
	unco-operative	19	6.0	6.6	99.7
	very unco-operative	1	.3	.3	100.0
	Total	286	89.7	100.0	
Missing	System	33	10.3		
Total		319	100.0		

A5: Interventions with Children

Table A5.1: Number of weeks Attended by Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than half a year	56	17.6	22.9	22.9
	between half and one year	103	32.3	42.0	64.9
	between one and one-and-a-half years	59	18.5	24.1	89.0
	over one-and-a-half years	27	8.5	11.0	100.0
	Total	245	76.8	100.0	
Missing	System	74	23.2		
Total		319	100.0		

Table A5.2: Individual Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	190	59.6	62.9	62.9
	5 to 20 Hours	63	19.7	20.9	83.8
	21 to 40 Hours	27	8.5	8.9	92.7
	over 40 Hours	22	6.9	7.3	100.0
	Total	302	94.7	100.0	
Missing	System	17	5.3		
Total		319	100.0		

Table A5.3: Group Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	92	28.8	30.5	30.5
	5 to 20 Hours	63	19.7	20.9	51.3
	21 to 40 Hours	54	16.9	17.9	69.2
	over 40 Hours	93	29.2	30.8	100.0
	Total	302	94.7	100.0	
Missing	System	17	5.3		
Total		319	100.0		

Table A5.4: Family Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	181	56.7	59.9	59.9
	5 to 20 Hours	70	21.9	23.2	83.1
	21 to 40 Hours	24	7.5	7.9	91.1
	over 40 Hours	27	8.5	8.9	100.0
	Total	302	94.7	100.0	
Missing	System	17	5.3		
Total		319	100.0		

Table A5.5: Drop-in Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	234	73.4	77.5	77.5
	5 to 20 Hours	45	14.1	14.9	92.4
	21 to 40 Hours	15	4.7	5.0	97.4
	over 40 Hours	8	2.5	2.6	100.0
	Total	302	94.7	100.0	
Missing	System	17	5.3		
Total		319	100.0		

Table A5.6: Administration Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	108	33.9	35.8	35.8
	5 to 20 Hours	100	31.3	33.1	68.9
	21 to 40 Hours	44	13.8	14.6	83.4
	over 40 Hours	50	15.7	16.6	100.0
	Total	302	94.7	100.0	
Missing	System	17	5.3		
Total		319	100.0		

Table A5.7: Total and Average Intervention Time with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 20 Hours	77	24.1	25.5	25.5
	21 to 60 Hours	75	23.5	24.8	50.3
	61 to 100 Hours	55	17.2	18.2	68.5
	101 to 140 Hours	24	7.5	7.9	76.5
	over 140 Hours	71	22.3	23.5	100.0
	Total	302	94.7	100.0	
Missing	System	17	5.3		
Total		319	100.0		

	N	Minimum	Maximum	Sum	Mean
Individual Work with Children	302	0	270	3551	11.8
Group Work with Children	302	0	361	12712	42.1
Family Work with Children	302	0	350	5026	16.6
Drop-in Work with Children	302	0	400	3036	10.1

	N	Minimum	Maximum	Sum	Mean
Intervention hours with child	302	0	1350	24325	80.6
Administration hours	302	0	200	6726	22.3
Total hours of intervention	302	0	1550	31051	102.8

Table A5.8: Examples of Individual Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	One to One	28	14.6	30.1	30.1
	Counselling, Talking and helping	24	12.5	25.8	55.9
	Arts, Crafts, Outings	17	8.9	18.3	74.2
	After school play/group	10	5.2	10.8	84.9
	Seasonal Work	6	3.1	6.5	91.4
	Reaching Goals and Achievements	4	2.1	4.3	95.7
	Assessing and monitoring	3	1.6	3.2	98.9
	Outings	1	.5	1.1	100.0
	Total	93	48.4	100.0	
Missing	System	99	51.6		
Total		192	100.0		

Table A5.9: Examples of Group Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Arts, Crafts, Outings	77	40.1	53.8	53.8
	After school play/group	40	20.8	28.0	81.8
	Personal development/social skills	26	13.5	18.2	100.0
	Total	143	74.5	100.0	
Missing	System	49	25.5		
Total		192	100.0		

Table A5.10: Examples of Family Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Family Meetings	48	25.0	44.9	44.9
	Outings	19	9.9	17.8	62.6
	Behaviour Problems	17	8.9	15.9	78.5
	Addressing Family Issues	11	5.7	10.3	88.8
	Support and Encouragement	8	4.2	7.5	96.3
	Attending Clinic/Psychologist	2	1.0	1.9	98.1
	Meeting with Schools, Hospitals etc.	2	1.0	1.9	100.0
	Total	107	55.7	100.0	
Missing	System	85	44.3		
Total		192	100.0		

Table A5.11: Examples of Drop-in Work with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Occational drop-in	46	24.0	50.0	50.0
	Talking, Info and Advice	18	9.4	19.6	69.6
	Playroom / Recreational Activities	15	7.8	16.3	85.9
	Call to Family Home	8	4.2	8.7	94.6
	Assessing & Monitoring	3	1.6	3.3	97.8
	Crisis situation	1	.5	1.1	98.9
	Support	1	.5	1.1	100.0
	Total	92	47.9	100.0	
Missing	System	100	52.1		
Total		192	100.0		

Table A5.12: Other Agencies Involved with Children

	N	Sum
School	319	170
Health Board Social Worker	319	132
Youth Services	319	99
Other	319	62
Neighbourhood Youth Project	319	61
Child Psychiatric Services	319	43
Hospital	319	40
Garda Siochana	319	38
Neighbours of Family	319	34
Public Health Nurse	319	29
Health Board Family Support Worker	319	16
Health Board Community Childcare Worker	319	10
Adult Psychiatric Services	319	8
Community Mothers Programme	319	3
Community Development Project	319	1
Valid N (listwise)	319	

Table A5.13: Number of Agencies Involved with Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	71	22.3	22.3	22.3
	1	46	14.4	14.4	36.7
	2	76	23.8	23.8	60.5
	3	47	14.7	14.7	75.2
	4	25	7.8	7.8	83.1
	5	29	9.1	9.1	92.2
	6	16	5.0	5.0	97.2
	7	7	2.2	2.2	99.4
	8	1	.3	.3	99.7
	9	1	.3	.3	100.0
	Total	319	100.0	100.0	

Note: Contact may be to more than one agency with respect to any one child.

Table A5.14: Was Involvement of Other Agencies Initiated by Springboard?

	N	Sum
School	319	107
Youth Services	319	74
Other	319	46
Health Board Social Worker	319	44
Neighbourhood Youth Project	319	39
Child Psychiatric Services	319	24
Garda Siochana	319	12
Hospital	319	8
Public Health Nurse	319	6
Health Board Family Support Worker	319	6
Neighbours of Family	319	5
Community Development Project	319	5
Adult Psychiatric Services	319	4
Health Board Community Childcare Worker	319	3
Community Mothers Programme	319	1
Valid N (listwise)	319	

Note: Contact may have been initiated to more than one agency with respect to any one child.

A6: Changes Experienced by Children

Table A6.1: SDQ: Total Difficulties at Baseline and Follow Up (Child)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	55	17	10	82
		% of Total	47.8%	14.8%	8.7%	71.3%
	Some	Count	5	5	6	16
		% of Total	4.3%	4.3%	5.2%	13.9%
	Serious	Count	5	5	7	17
		% of Total	4.3%	4.3%	6.1%	14.8%
Total		Count	65	27	23	115
		% of Total	56.5%	23.5%	20.0%	100.0%

Table A6.2: SDQ: Total Difficulties at Baseline and Follow Up (Parents)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	88	20	30	138
		% of Total	31.2%	7.1%	10.6%	48.9%
	Some	Count	12	6	23	41
		% of Total	4.3%	2.1%	8.2%	14.5%
	Serious	Count	9	12	82	103
		% of Total	3.2%	4.3%	29.1%	36.5%
Total		Count	109	38	135	282
		% of Total	38.7%	13.5%	47.9%	100.0%

Table A6.3: SDQ: Total Difficulties at Baseline and Follow Up (Teacher)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	48	8	18	74
		% of Total	23.3%	3.9%	8.7%	35.9%
	Some	Count	13	13	15	41
		% of Total	6.3%	6.3%	7.3%	19.9%
	Serious	Count	17	12	62	91
		% of Total	8.3%	5.8%	30.1%	44.2%
Total		Count	78	33	95	206
		% of Total	37.9%	16.0%	46.1%	100.0%

Table A6.4: SDQ: Conduct Problems at Baseline and Follow Up (Child)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	47	12	7	66
		% of Total	40.9%	10.4%	6.1%	57.4%
	Some	Count	7	3	12	22
		% of Total	6.1%	2.6%	10.4%	19.1%
	Serious	Count	5	3	19	27
		% of Total	4.3%	2.6%	16.5%	23.5%
Total		Count	59	18	38	115
		% of Total	51.3%	15.7%	33.0%	100.0%

Table A6.5: SDQ: Conduct Problems at Baseline and Follow Up (Parents)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	74	20	30	124
		% of Total	26.2%	7.1%	10.6%	44.0%
	Some	Count	19	7	17	43
		% of Total	6.7%	2.5%	6.0%	15.2%
	Serious	Count	15	4	96	115
		% of Total	5.3%	1.4%	34.0%	40.8%
Total		Count	108	31	143	282
		% of Total	38.3%	11.0%	50.7%	100.0%

Table A6.6: SDQ: Conduct Problems at Baseline and Follow Up (Teacher)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	72	11	22	105
		% of Total	35.0%	5.3%	10.7%	51.0%
	Some	Count	10	4	6	20
		% of Total	4.9%	1.9%	2.9%	9.7%
	Serious	Count	17	11	53	81
		% of Total	8.3%	5.3%	25.7%	39.3%
Total		Count	99	26	81	206
		% of Total	48.1%	12.6%	39.3%	100.0%

Table A6.7: SDQ: Hyper Activity at Baseline and Follow Up (Child)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	67	13	5	85
		% of Total	57.3%	11.1%	4.3%	72.6%
	Some	Count	7	2	2	11
		% of Total	6.0%	1.7%	1.7%	9.4%
	Serious	Count	7	4	10	21
		% of Total	6.0%	3.4%	8.5%	17.9%
Total		Count	81	19	17	117
		% of Total	69.2%	16.2%	14.5%	100.0%

Table A6.8: SDQ: Hyper Activity at Baseline and Follow Up (Parents)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	108	17	39	164
		% of Total	38.3%	6.0%	13.8%	58.2%
	Some	Count	12	7	11	30
		% of Total	4.3%	2.5%	3.9%	10.6%
	Serious	Count	8	6	74	88
		% of Total	2.8%	2.1%	26.2%	31.2%
Total		Count	128	30	124	282
		% of Total	45.4%	10.6%	44.0%	100.0%

Table A6.9: SDQ: Hyper Activity at Baseline and Follow Up (Teacher)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	56	10	25	91
		% of Total	27.2%	4.9%	12.1%	44.2%
	Some	Count	9	1	10	20
		% of Total	4.4%	.5%	4.9%	9.7%
	Serious	Count	25	3	67	95
		% of Total	12.1%	1.5%	32.5%	46.1%
Total		Count	90	14	102	206
		% of Total	43.7%	6.8%	49.5%	100.0%

Table A6.10: SDQ: Emotional Problems at Baseline and Follow Up (Child)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	73	9	12	94
		% of Total	62.4%	7.7%	10.3%	80.3%
	Some	Count	5	2	2	9
		% of Total	4.3%	1.7%	1.7%	7.7%
	Serious	Count	7	2	5	14
		% of Total	6.0%	1.7%	4.3%	12.0%
Total		Count	85	13	19	117
		% of Total	72.6%	11.1%	16.2%	100.0%

Table A6.11: SDQ: Emotional Problems at Baseline and Follow Up (Parents)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	109	23	31	163
		% of Total	38.7%	8.2%	11.0%	57.8%
	Some	Count	13	3	22	38
		% of Total	4.6%	1.1%	7.8%	13.5%
	Serious	Count	12	14	55	81
		% of Total	4.3%	5.0%	19.5%	28.7%
Total		Count	134	40	108	282
		% of Total	47.5%	14.2%	38.3%	100.0%

Table A6.12: SDQ: Emotional Problems at Baseline and Follow Up (Teacher)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	116	15	26	157
		% of Total	56.3%	7.3%	12.6%	76.2%
	Some	Count	11	4	2	17
		% of Total	5.3%	1.9%	1.0%	8.3%
	Serious	Count	14	7	11	32
		% of Total	6.8%	3.4%	5.3%	15.5%
Total		Count	141	26	39	206
		% of Total	68.4%	12.6%	18.9%	100.0%

Table A6.13: SDQ: Peer Problems at Baseline and Follow Up (Child)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	71	17	3	91
		% of Total	60.7%	14.5%	2.6%	77.8%
	Some	Count	7	6	3	16
		% of Total	6.0%	5.1%	2.6%	13.7%
	Serious	Count	4	2	4	10
		% of Total	3.4%	1.7%	3.4%	8.5%
Total		Count	82	25	10	117
		% of Total	70.1%	21.4%	8.5%	100.0%

Table A6.14: SDQ: Peer Problems at Baseline and Follow Up (Parents)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	106	20	28	154
		% of Total	37.6%	7.1%	9.9%	54.6%
	Some	Count	17	5	23	45
		% of Total	6.0%	1.8%	8.2%	16.0%
	Serious	Count	12	17	54	83
		% of Total	4.3%	6.0%	19.1%	29.4%
Total		Count	135	42	105	282
		% of Total	47.9%	14.9%	37.2%	100.0%

Table A6.15: SDQ: Peer Problems at Baseline and Follow Up (Teacher)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	105	16	25	146
		% of Total	51.0%	7.8%	12.1%	70.9%
	Some	Count	13	2	7	22
		% of Total	6.3%	1.0%	3.4%	10.7%
	Serious	Count	11	8	19	38
		% of Total	5.3%	3.9%	9.2%	18.4%
Total		Count	129	26	51	206
		% of Total	62.6%	12.6%	24.8%	100.0%

Table A6.16: SDQ: Prosocial Behaviour at Baseline and Follow Up (Child)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	94	4	3	101
		% of Total	81.0%	3.4%	2.6%	87.1%
	Some	Count	8	1	1	10
		% of Total	6.9%	.9%	.9%	8.6%
	Serious	Count	3	1	1	5
		% of Total	2.6%	.9%	.9%	4.3%
Total		Count	105	6	5	116
		% of Total	90.5%	5.2%	4.3%	100.0%

Table A6.17: SDQ: Prosocial Behaviour at Baseline and Follow Up (Parents)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	214	15	16	245
		% of Total	75.9%	5.3%	5.7%	86.9%
	Some	Count	8	3	6	17
		% of Total	2.8%	1.1%	2.1%	6.0%
	Serious	Count	8	3	9	20
		% of Total	2.8%	1.1%	3.2%	7.1%
Total		Count	230	21	31	282
		% of Total	81.6%	7.4%	11.0%	100.0%

Table A6.18: SDQ: Prosocial Behaviour at Baseline and Follow Up (Teacher)

			Baseline			Total
			None	Some	Serious	
Second Follow-up	None	Count	93	17	19	129
		% of Total	45.1%	8.3%	9.2%	62.6%
	Some	Count	11	9	6	26
		% of Total	5.3%	4.4%	2.9%	12.6%
	Serious	Count	16	9	26	51
		% of Total	7.8%	4.4%	12.6%	24.8%
Total		Count	120	35	51	206
		% of Total	58.3%	17.0%	24.8%	100.0%

Table A6.19: SDQ: Ameliorations of Problems (Child)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much better	68	21.3	56.7	56.7
	A bit better	39	12.2	32.5	89.2
	About the same	11	3.4	9.2	98.3
	A bit worse	1	.3	.8	99.2
	Much worse	1	.3	.8	100.0
	Total	120	37.6	100.0	
Missing	System	199	62.4		
Total		319	100.0		

Table A6.20: SDQ: Ameliorations of Problems (Parents)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much better	124	38.9	43.8	43.8
	A bit better	94	29.5	33.2	77.0
	About the same	60	18.8	21.2	98.2
	A bit worse	2	.6	.7	98.9
	Much worse	3	.9	1.1	100.0
	Total	283	88.7	100.0	
Missing	System	36	11.3		
Total		319	100.0		

Table A6.21: SDQ: Ameliorations of Problems (Teacher)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much better	33	10.3	17.8	17.8
	A bit better	64	20.1	34.6	52.4
	About the same	76	23.8	41.1	93.5
	A bit worse	9	2.8	4.9	98.4
	Much worse	3	.9	1.6	100.0
	Total	185	58.0	100.0	
Missing	System	134	42.0		
Total		319	100.0		

Table A6.22: SDQ: Experience of Ameliorations by Severity of Problems (Child)

			Child has difficulties				Total
			No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties	
Change in difficulties	Much better	Count	19	26	9	3	57
		% within Child has difficulties	55.9%	52.0%	75.0%	37.5%	54.8%
	A bit better	Count	11	19	3	4	37
		% within Child has difficulties	32.4%	38.0%	25.0%	50.0%	35.6%
	About the same	Count	3	5		1	9
		% within Child has difficulties	8.8%	10.0%		12.5%	8.7%
	A bit worse	Count	1				1
		% within Child has difficulties	2.9%				1.0%
Total		Count	34	50	12	8	104
		% within Child has difficulties	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.23: SDQ: Experience of Amelioration's by Severity of Problems (Parents)

			Child has difficulties				Total
			No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties	
Change in difficulties	Much better	Count	46	35	30	7	118
		% within Child has difficulties	54.1%	41.2%	39.0%	25.9%	43.1%
	A bit better	Count	26	30	26	10	92
		% within Child has difficulties	30.6%	35.3%	33.8%	37.0%	33.6%
	About the same	Count	13	19	18	9	59
		% within Child has difficulties	15.3%	22.4%	23.4%	33.3%	21.5%
	A bit worse	Count		1	1		2
		% within Child has difficulties		1.2%	1.3%		.7%
	Much worse	Count			2	1	3
		% within Child has difficulties			2.6%	3.7%	1.1%
Total		Count	85	85	77	27	274
		% within Child has difficulties	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.24: SDQ: Experience of Ameliorations by Severity of Problems (Teacher)

			Child has difficulties				Total
			No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties	
Change in difficulties	Much better	Count	5	8	12	7	32
		% within Child has difficulties	25.0%	19.0%	18.5%	16.7%	18.9%
	A bit better	Count	2	12	30	16	60
		% within Child has difficulties	10.0%	28.6%	46.2%	38.1%	35.5%
	About the same	Count	13	19	18	16	66
		% within Child has difficulties	65.0%	45.2%	27.7%	38.1%	39.1%
	A bit worse	Count		3	3	2	8
		% within Child has difficulties		7.1%	4.6%	4.8%	4.7%
	Much worse	Count			2	1	3
		% within Child has difficulties			3.1%	2.4%	1.8%
Total		Count	20	42	65	42	169
		% within Child has difficulties	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.25: SDQ: Has Project been Helpful (Child)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	5	1.6	4.1	4.1
	Only a little	18	5.6	14.8	18.9
	Quite a lot	46	14.4	37.7	56.6
	A great deal	53	16.6	43.4	100.0
	Total	122	38.2	100.0	
Missing	System	197	61.8		
Total		319	100.0		

Table A6.26: SDQ: Has Project been Helpful (Parents)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	11	3.4	3.9	3.9
	Only a little	44	13.8	15.6	19.5
	Quite a lot	119	37.3	42.2	61.7
	A great deal	108	33.9	38.3	100.0
	Total	282	88.4	100.0	
Missing	System	37	11.6		
Total		319	100.0		

Table A6.27: SDQ: Has Project been Helpful (Teacher)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	28	8.8	17.6	17.6
	Only a little	65	20.4	40.9	58.5
	Quite a lot	42	13.2	26.4	84.9
	A great deal	24	7.5	15.1	100.0
	Total	159	49.8	100.0	
Missing	System	160	50.2		
Total		319	100.0		

Table A6.28: SDQ: Helpfulness of Project by Severity of Difficulties (Child)

			Child has difficulties				Total
			No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties	
Participation in project helpful	Not at all	Count	1	3			4
		% within Child has difficulties	2.9%	6.0%			3.8%
	Only a little	Count	7	7	1	2	17
		% within Child has difficulties	20.0%	14.0%	7.7%	25.0%	16.0%
	Quite a lot	Count	8	21	6	4	39
		% within Child has difficulties	22.9%	42.0%	46.2%	50.0%	36.8%
	A great deal	Count	19	19	6	2	46
		% within Child has difficulties	54.3%	38.0%	46.2%	25.0%	43.4%
Total		Count	35	50	13	8	106
		% within Child has difficulties	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.29: SDQ: Helpfulness of Project by Severity of Difficulties (Parents)

			Child has difficulties				Total
			No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties	
Participation in project helpful	Not at all	Count	5	3	3		11
		% within Child has difficulties	5.9%	3.6%	3.9%		4.0%
	Only a little	Count	10	12	11	10	43
		% within Child has difficulties	11.8%	14.3%	14.3%	37.0%	15.8%
	Quite a lot	Count	39	33	34	10	116
		% within Child has difficulties	45.9%	39.3%	44.2%	37.0%	42.5%
	A great deal	Count	31	36	29	7	103
		% within Child has difficulties	36.5%	42.9%	37.7%	25.9%	37.7%
Total		Count	85	84	77	27	273
		% within Child has difficulties	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.30: SDQ: Helpfulness of Project by Severity of Difficulties (Teacher)

			Child has difficulties				Total
			No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties	
Participation in project helpful	Not at all	Count	5	8	8	5	26
		% within Child has difficulties	27.8%	21.1%	14.3%	15.6%	18.1%
	Only a little	Count	5	15	25	11	56
		% within Child has difficulties	27.8%	39.5%	44.6%	34.4%	38.9%
	Quite a lot	Count	5	11	11	12	39
		% within Child has difficulties	27.8%	28.9%	19.6%	37.5%	27.1%
	A great deal	Count	3	4	12	4	23
		% within Child has difficulties	16.7%	10.5%	21.4%	12.5%	16.0%
Total		Count	18	38	56	32	144
		% within Child has difficulties	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.31: SDQ: Burden to Child Experienced at Baseline and Follow Up (Child)

			Baseline			Total
			Small Burden	Medium Burden	Large Burden	
Second Follow-up	Small Burden	Count	287	18	1	306
		% of Total	90.0%	5.6%	.3%	95.9%
	Medium Burde	Count	6		2	8
		% of Total	1.9%		.6%	2.5%
	Large Burden	Count	2	3		5
		% of Total	.6%	.9%		1.6%
Total		Count	295	21	3	319
		% of Total	92.5%	6.6%	.9%	100.0%

Table A6.32: SDQ: Burden to Child Experienced at Baseline and Follow Up (Parents)

			Baseline			Total
			Small Burden	Medium Burden	Large Burden	
Second Follow-up	Small Burden	Count	177	66	14	257
		% of Total	55.5%	20.7%	4.4%	80.6%
	Medium Burde	Count	13	26	10	49
		% of Total	4.1%	8.2%	3.1%	15.4%
	Large Burden	Count	5	2	6	13
		% of Total	1.6%	.6%	1.9%	4.1%
Total		Count	195	94	30	319
		% of Total	61.1%	29.5%	9.4%	100.0%

Table A6.33: SDQ: Burden to Child Experienced at Baseline and Follow Up (Teacher)

			Baseline			Total
			Small Burden	Medium Burden	Large Burden	
Second Follow-up	Small Burden	Count	152	44	25	221
		% of Total	47.6%	13.8%	7.8%	69.3%
	Medium Burde	Count	25	32	22	79
		% of Total	7.8%	10.0%	6.9%	24.8%
	Large Burden	Count	6	6	7	19
		% of Total	1.9%	1.9%	2.2%	6.0%
Total		Count	183	82	54	319
		% of Total	57.4%	25.7%	16.9%	100.0%

Table A6.34: SDQ: Burden to Others Experienced at Baseline and Follow Up (Child)

			Baseline				Total
			Not at all	Only a little	Quite a lot	A great deal	
Second Follow-up	Not at all	Count	4	9	3		16
		% within Baseline	21.1%	26.5%	16.7%		21.1%
	Only a little	Count	2	11	6		19
		% within Baseline	10.5%	32.4%	33.3%		25.0%
	Quite a lot	Count	1	1	4	3	9
		% within Baseline	5.3%	2.9%	22.2%	60.0%	11.8%
	A great deal	Count	1	1	1	1	4
		% within Baseline	5.3%	2.9%	5.6%	20.0%	5.3%
	missing	Count	11	12	4	1	28
		% within Baseline	57.9%	35.3%	22.2%	20.0%	36.8%
Total		Count	19	34	18	5	76
		% within Baseline	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.35: SDQ: Burden to Others Experienced at Baseline and Follow Up (Parents)

			Baseline				Total
			Not at all	Only a little	Quite a lot	A great deal	
Second Follow-up	Not at all	Count	7	9	4	6	26
		% within Baseline	35.0%	23.7%	9.1%	16.7%	18.8%
	Only a little	Count	10	13	17	9	49
		% within Baseline	50.0%	34.2%	38.6%	25.0%	35.5%
	Quite a lot	Count	2	14	18	12	46
		% within Baseline	10.0%	36.8%	40.9%	33.3%	33.3%
	A great deal	Count	1	2	5	9	17
		% within Baseline	5.0%	5.3%	11.4%	25.0%	12.3%
Total		Count	20	38	44	36	138
		% within Baseline	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.36: SDQ: Burden to Others Experienced at Baseline and Follow Up (Teacher)

			Baseline				Total
			Not at all	Only a little	Quite a lot	A great deal	
Second Follow-up	Not at all	Count	12	9	4	3	28
		% within Baseline	60.0%	20.5%	11.4%	8.1%	20.6%
	Only a little	Count	7	24	9	9	49
		% within Baseline	35.0%	54.5%	25.7%	24.3%	36.0%
	Quite a lot	Count	1	7	14	11	33
		% within Baseline	5.0%	15.9%	40.0%	29.7%	24.3%
	A great deal	Count		4	8	14	26
		% within Baseline		9.1%	22.9%	37.8%	19.1%
Total		Count	20	44	35	37	136
		% within Baseline	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.37: Rate of School Attendance at Baseline and Follow Up (%)

	N	Minimum	Maximum	Mean	Std. Deviation
School Attendance - Baseline	157	6.56	135.88	82.4818	17.5185
School Attendance - Second Follow-up	186	21.13	127.56	84.2497	15.5987
Valid N (listwise)	116				

Table A6.38: Children Contacted by School Attendance Officer at Baseline and Follow Up

			Baseline			Total
			Yes	No	Don't know	
Second Follow-up	Yes	Count	4	3	1	8
		% within Contacted by School Attendance Officer	30.8%	3.1%	2.9%	5.6%
	No	Count	4	63	19	86
		% within Contacted by School Attendance Officer	30.8%	65.6%	55.9%	60.1%
	Don't know	Count	5	30	14	49
		% within Contacted by School Attendance Officer	38.5%	31.3%	41.2%	34.3%
Total		Count	13	96	34	143
		% within Contacted by School Attendance Officer	100.0%	100.0%	100.0%	100.0%

Table A6.39: Lateness for School at Baseline and Follow Up

			Baseline					Total
			Always	Often	Sometimes	Rarely	Never	
Second Follow-up	Always	Count	5	5	5	3		18
		% within Lateness for school	31.3%	14.7%	11.4%	7.0%		9.5%
	Often	Count	3	8	11	11	3	36
		% within Lateness for school	18.8%	23.5%	25.0%	25.6%	5.8%	19.0%
	Sometimes	Count	4	8	13	4	9	38
		% within Lateness for school	25.0%	23.5%	29.5%	9.3%	17.3%	20.1%
	Rarely	Count	3	8	12	14	8	45
		% within Lateness for school	18.8%	23.5%	27.3%	32.6%	15.4%	23.8%
	Never	Count	1	5	3	11	32	52
		% within Lateness for school	6.3%	14.7%	6.8%	25.6%	61.5%	27.5%
Total		Count	16	34	44	43	52	189
		% within Lateness for school	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.40: Coming to School Hungry at Baseline and Follow Up

			Baseline					Total
			Always	Often	Sometimes	Rarely	Never	
Second Follow-up	Always	Count	1	1	1	1		4
		% within Comes to schoo hungry	25.0%	6.3%	5.6%	3.2%		2.4%
	Often	Count		4	1	3		8
		% within Comes to schoo hungry		25.0%	5.6%	9.7%		4.8%
	Sometimes	Count		4	7	7	5	23
		% within Comes to schoo hungry		25.0%	38.9%	22.6%	5.2%	13.9%
	Rarely	Count	2	4	5	6	10	27
		% within Comes to schoo hungry	50.0%	25.0%	27.8%	19.4%	10.3%	16.3%
	Never	Count	1	3	4	14	82	104
		% within Comes to schoo hungry	25.0%	18.8%	22.2%	45.2%	84.5%	62.7%
Total		Count	4	16	18	31	97	166
		% within Comes to schoo hungry	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.41: Coming to School Without Lunch at Baseline and Follow Up

			Baseline					Total
			Always	Often	Sometimes	Rarely	Never	
Second Follow-up	Always	Count	1	2	3	2	1	9
		% within Comes to schoo without lunch	25.0%	22.2%	13.0%	5.9%	.9%	5.1%
	Often	Count		1	2	2		5
		% within Comes to schoo without lunch		11.1%	8.7%	5.9%		2.8%
	Sometimes	Count	1	3	6	3	3	16
		% within Comes to schoo without lunch	25.0%	33.3%	26.1%	8.8%	2.8%	9.1%
	Rarely	Count	1	1	7	16	14	39
		% within Comes to schoo without lunch	25.0%	11.1%	30.4%	47.1%	13.2%	22.2%
	Never	Count	1	2	5	11	88	107
		% within Comes to schoo without lunch	25.0%	22.2%	21.7%	32.4%	83.0%	60.8%
Total		Count	4	9	23	34	106	176
		% within Comes to schoo without lunch	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table A6.42: Healthboard Assessment of Risk of Abuse at Baseline and Follow Up

			Baseline				Total
			High risk	Moderate risk	Low risk	No risk	
Second Follow-up	High risk	Count	6		1		7
		% of Total	2.6%		.4%		3.1%
	Moderate risk	Count	11	10	1	6	28
		% of Total	4.8%	4.4%	.4%	2.6%	12.3%
	Low risk	Count	10	28	29	12	79
		% of Total	4.4%	12.3%	12.8%	5.3%	34.8%
	No risk	Count	2	4	38	69	113
		% of Total	.9%	1.8%	16.7%	30.4%	49.8%
Total		Count	29	42	69	87	227
		% of Total	12.8%	18.5%	30.4%	38.3%	100.0%

Table A6.43: Healthboard Assessment of Going into Care at Baseline and Follow Up

			Baseline				Total
			High risk	Moderate risk	Low risk	No risk	
Second Follow-up	High risk	Count	5		1	1	7
		% of Total	2.2%		.4%	.4%	3.1%
	Moderate risk	Count	9	5	5	3	22
		% of Total	4.0%	2.2%	2.2%	1.3%	9.8%
	Low risk	Count	3	20	26	5	54
		% of Total	1.3%	8.9%	11.6%	2.2%	24.1%
	No risk	Count	6	9	33	93	141
		% of Total	2.7%	4.0%	14.7%	41.5%	62.9%
Total		Count	23	34	65	102	224
		% of Total	10.3%	15.2%	29.0%	45.5%	100.0%

Table A6.44: Children Cautioned by JLO at Baseline and Follow Up

			Baseline		Total
			Yes	No	
Second Follow-up	Yes	Count	5	8	13
		% of Total	2.0%	3.2%	5.2%
	No	Count	4	233	237
		% of Total	1.6%	93.2%	94.8%
Total		Count	9	241	250
		% of Total	3.6%	96.4%	100.0%

Table A6.45: Children Arrested at Baseline and Follow Up

			Baseline		Total
			Yes	No	
Second Follow-up	Yes	Count	1	3	4
		% of Total	.4%	1.2%	1.6%
	No	Count	1	245	246
		% of Total	.4%	98.0%	98.4%
Total		Count	2	248	250
		% of Total	.8%	99.2%	100.0%

A9:Background Characteristics of Parents

Table A9.1: Gender of Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	168	88.0	88.0	88.0
	Male	23	12.0	12.0	100.0
	Total	191	100.0	100.0	

Table A9.2: Number of Parents in Household

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	106	55.5	55.5	55.5
	2	85	44.5	44.5	100.0
	Total	191	100.0	100.0	

Table A9.3: Number of Problems Experienced as a Child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	83	43.5	43.5	43.5
	1	37	19.4	19.4	62.8
	2	18	9.4	9.4	72.3
	3	7	3.7	3.7	75.9
	4	4	2.1	2.1	78.0
	5	8	4.2	4.2	82.2
	6	14	7.3	7.3	89.5
	7	5	2.6	2.6	92.1
	8	6	3.1	3.1	95.3
	9	5	2.6	2.6	97.9
	10	3	1.6	1.6	99.5
	12	1	.5	.5	100.0
	Total	191	100.0	100.0	

Table A9.4: Type of Problems Experienced as a Child

	Number	%
Early School Leaver	83	43.5
Emotional abuse	53	27.7
Parent(s) with alcohol problem	42	22.0
Domestic violence	39	20.4
Physical abuse	38	19.9
Separation of parents	30	15.7
Neglect	29	15.2
Parent(s) suffering depression	25	13.1
Time in care	24	12.6
Sexual abuse	20	10.5
Parent(s) with drug problem	8	4.2
Other	7	3.7
One parent only	6	3.1

Table A9.5: Correlations Between Problems Experienced as a Child

	Physical abuse	Emotional abuse	Sexual abuse	Domestic violence	Time in care	Separation of parents	One parent only	Parent(s) with alcohol problem	Parent(s) with drug problem	Parent(s) suffering depression	Early School Leaver
Neglect											
Physical abuse	.56										
Emotional abuse	.59	.69									
Sexual abuse	.38	.30	.32								
Domestic violence	.51	.72	.64	.25							
Time in care	.41	.41	.37	.28	.32						
Separation of parents	.38	.40	.47	.28	.46	.49					
One parent only					.21	.20	.34				
Parent(s) with alcohol problem	.48	.62	.63		.78	.26	.47	.20			
Parent(s) with drug problem	.20	.29	.34		.28		.41		.39		
Parent(s) suffering depression	.31	.39	.45		.46	.23	.34		.51	.31	
Early School Leaver	.39	.44	.47	.22	.45	.24	.32		.43		.22

Table A9.6: Number of Parents Experiencing Problems

Problem Area	Not a problem	Not so serious	Fairly serious	Serious	Very serious
1 Difficulty managing children	37	48	52	26	17
2 Couple / marital problems	47	26	29	25	30
3 Violent relationship	92	14	14	11	10
4 Violent to children	117	19	6	2	3
5 Partner is violent to children	105	8	10	4	4
6 Alcohol problem	112	17	10	5	4
7 Partner with alcohol problem	69	5	16	11	16
8 Drug problem	128	4	5	4	4
9 Partner with drug problem	96	7	3	7	4
10 Child(ren) with drug problem	137	7	9	1	1
11 Physically ill	126	20	8	4	4
12 Partner physically ill	121	4	1	3	3
13 Psychiatric problem	99	21	20	5	1
14 Partner with psychiatric problem	81	10	10	5	4
15 Physical disability	145	5	1	3	4
16 Partner with physical disability	128	2	0	3	3
17 Child(ren) with physical disability	138	5	8	1	2
18 Debt problem	39	38	33	20	13
19 Living in overcrowded conditions	91	29	20	7	10
20 Living in bad housing	83	31	26	14	9
21 Other	23	3	5	5	10

Table A9.7: Proportion of Parents Experiencing Problems

Problem Area %	Not a problem %	Not so serious %	Fairly serious %	Serious %	Very serious
1 Difficulty managing children	20.4	26.5	28.7	14.4	9.4
2 Couple / marital problems	26.0	14.4	16.0	13.8	16.6
3 Violent relationship	50.8	7.7	7.7	6.1	5.5
4 Violent to children	64.6	10.5	3.3	1.1	1.7
5 Partner is violent to children	58.0	4.4	5.5	2.2	2.2
6 Alcohol problem	61.9	9.4	5.5	2.8	2.2
7 Partner with alcohol problem	38.1	2.8	8.8	6.1	8.8
8 Drug problem	70.7	2.2	2.8	2.2	2.2
9 Partner with drug problem	53.0	3.9	1.7	3.9	2.2
10 Child(ren) with drug problem	75.7	3.9	5.0	0.6	0.6
11 Physically ill	69.6	11.0	4.4	2.2	2.2
12 Partner physically ill	66.9	2.2	0.6	1.7	1.7
13 Psychiatric problem	54.7	11.6	11.0	2.8	0.6
14 Partner with psychiatric problem	44.8	5.5	5.5	2.8	2.2
15 Physical disability	80.1	2.8	0.6	1.7	2.2
16 Partner with physical disability	70.7	1.1	0.0	1.7	1.7
17 Child(ren) with physical disability	76.2	2.8	4.4	0.6	1.1
18 Debt problem	21.5	21.0	18.2	11.0	7.2
19 Living in overcrowded conditions	50.3	16.0	11.0	3.9	5.5
20 Living in bad housing	45.9	17.1	14.4	7.7	5.0
21 Other	12.7	1.7	2.8	2.8	5.5

Table A9.8: Number of Serious Problems Experienced by Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	34	17.8	17.8	17.8
	1	28	14.7	14.7	32.5
	2	27	14.1	14.1	46.6
	3	33	17.3	17.3	63.9
	4	18	9.4	9.4	73.3
	5	15	7.9	7.9	81.2
	6	16	8.4	8.4	89.5
	7	6	3.1	3.1	92.7
	8	4	2.1	2.1	94.8
	9	2	1.0	1.0	95.8
	10	2	1.0	1.0	96.9
	11	2	1.0	1.0	97.9
	12	3	1.6	1.6	99.5
	14	1	.5	.5	100.0
	Total	191	100.0	100.0	

Table A9.9: Co-operativeness of Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very co-operative	95	49.7	51.6	51.6
	co-operative	78	40.8	42.4	94.0
	unco-operative	10	5.2	5.4	99.5
	very unco-operative	1	.5	.5	100.0
	Total	184	96.3	100.0	
Missing	System	7	3.7		
Total		191	100.0		

A10: Interventions with Parents

Table A10.1: Number of Weeks Attended by Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than half a year	44	23.0	27.8	27.8
	between half and one year	48	25.1	30.4	58.2
	between one and one-and-a-half yea	38	19.9	24.1	82.3
	over one-and-a-half years	28	14.7	17.7	100.0
	Total	158	82.7	100.0	
Missing	System	33	17.3		
Total		191	100.0		

Table A10.2: Individual Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	78	40.8	41.7	41.7
	5 to 20 Hours	46	24.1	24.6	66.3
	21 to 40 Hours	24	12.6	12.8	79.1
	over 40 Hours	39	20.4	20.9	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

Table A10.3: Group Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	126	66.0	67.4	67.4
	5 to 20 Hours	35	18.3	18.7	86.1
	21 to 40 Hours	14	7.3	7.5	93.6
	over 40 Hours	12	6.3	6.4	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

Table A10.4: Family Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	100	52.4	53.5	53.5
	5 to 20 Hours	60	31.4	32.1	85.6
	21 to 40 Hours	11	5.8	5.9	91.4
	over 40 Hours	16	8.4	8.6	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

Table A10.5: Drop-in Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 5 Hours	111	58.1	59.4	59.4
	5 to 20 Hours	55	28.8	29.4	88.8
	21 to 40 Hours	8	4.2	4.3	93.0
	over 40 Hours	13	6.8	7.0	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

Table A10.6: Administration Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 20 Hours	128	67.0	68.4	68.4
	21 to 60 Hours	44	23.0	23.5	92.0
	61 to 100 Hours	9	4.7	4.8	96.8
	101 to 140 Hours	1	.5	.5	97.3
	over 140 Hours	5	2.6	2.7	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

Table A10.7: Total and Average Intervention Time with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	under 20 Hours	61	31.9	32.6	32.6
	21 to 60 Hours	48	25.1	25.7	58.3
	61 to 100 Hours	29	15.2	15.5	73.8
	101 to 140 Hours	17	8.9	9.1	82.9
	over 140 Hours	32	16.8	17.1	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

	N	Minimum	Maximum	Sum	Mean
Individual work with parents	187	0	199	4271	22.84
Group work with parents	187	0	237	2218	11.86
Family work with parents	187	0	531	2638	14.11
Drop-in work with parents	187	0	176	1840	9.84
Hours of admin for parents	187	0	295	4399	23.52
Total hours intervention with parents	187	0	580	15366	82.17
Valid N (listwise)	187				

Table A10.8: Examples of Individual Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Support	25	23.6	36.2	36.2
	Parenting issues and skills	10	9.4	14.5	50.7
	One to One	8	7.5	11.6	62.3
	House visits	7	6.6	10.1	72.5
	Counselling	7	6.6	10.1	82.6
	Assessment of needs	6	5.7	8.7	91.3
	Housing/hospitals	4	3.8	5.8	97.1
	FAS/SW benefits	1	.9	1.4	98.6
	Child behaviour	1	.9	1.4	100.0
	Total	69	65.1	100.0	
Missing	System	37	34.9		
Total		106	100.0		

Table A10.9: Examples of Group Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Outings/Programmes	21	19.8	61.8	61.8
	Involved in school/group	4	3.8	11.8	73.5
	Meeting goals	3	2.8	8.8	82.4
	Difficulties practical and otherwise	3	2.8	8.8	91.2
	Financial assistance	1	.9	2.9	94.1
	Monitoring progress	1	.9	2.9	97.1
	Interagency meetings	1	.9	2.9	100.0
	Total	34	32.1	100.0	
Missing	System	72	67.9		
Total		106	100.0		

Table A10.10: Examples of Family Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Family Meetings	16	15.1	25.0	25.0
	Outings/family support	13	12.3	20.3	45.3
	Addressing Family Issues	12	11.3	18.8	64.1
	Child behaviour	10	9.4	15.6	79.7
	Support and Encouragement	5	4.7	7.8	87.5
	Encouraging communication	3	2.8	4.7	92.2
	Playtime with child	2	1.9	3.1	95.3
	Avoiding contact	1	.9	1.6	96.9
	Liasing with other agencies	1	.9	1.6	98.4
	Child sessions	1	.9	1.6	100.0
	Total	64	60.4	100.0	
Missing	System	42	39.6		
Total		106	100.0		

Table A10.11: Examples of Drop-in Work with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Home visits/help with children	21	19.8	31.3	31.3
	Monitoring progress	14	13.2	20.9	52.2
	Crisis occurred	9	8.5	13.4	65.7
	Drops in to seek help & advise	8	7.5	11.9	77.6
	Daily drop-in	7	6.6	10.4	88.1
	Involvement in clubs	4	3.8	6.0	94.0
	Helping with doctors, courts etc.	2	1.9	3.0	97.0
	Linking with agencies	1	.9	1.5	98.5
	Day trips & family excursions	1	.9	1.5	100.0
	Total	67	63.2	100.0	
Missing	System	39	36.8		
Total		106	100.0		

Table A10.12: Other Agencies Involved with Parents

	N	Sum
School	187	114
Health Board Social Worker	187	98
Other	187	63
Hospital	187	54
Garda Siochana	187	50
Youth Services	187	49
Public Health Nurse	187	46
Child Psychiatric Services	187	35
Neighbours of Family	187	30
Neighbourhood Youth Project	187	28
Adult Psychiatric Services	187	27
Community Development Project	187	22
Health Board Family Support Worker	187	12
Health Board Community Childcare Worker	187	10
Community Mothers Programme	187	1
Valid N (listwise)	187	

Table A10.13: Number of Agencies Involved with Parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	25	13.1	13.4	13.4
	1	23	12.0	12.3	25.7
	2	28	14.7	15.0	40.6
	3	28	14.7	15.0	55.6
	4	24	12.6	12.8	68.4
	5	20	10.5	10.7	79.1
	6	12	6.3	6.4	85.6
	7	14	7.3	7.5	93.0
	8	8	4.2	4.3	97.3
	9	4	2.1	2.1	99.5
	10	1	.5	.5	100.0
	Total	187	97.9	100.0	
Missing	System	4	2.1		
Total		191	100.0		

Table A10.14: Was Involvement of Other Agencies Initiated by Springboard?

	N	Sum
School	187	65
Other	187	47
Youth Services	187	32
Health Board Social Worker	187	31
Neighbourhood Youth Project	187	22
Child Psychiatric Services	187	17
Garda Siochana	187	14
Community Development Project	187	13
Public Health Nurse	187	12
Hospital	187	9
Neighbours of Family	187	6
Adult Psychiatric Services	187	5
Health Board Community Childcare Worker	187	3
Health Board Family Support Worker	187	3
Community Mothers Programme	187	1
Valid N (listwise)	187	

A11: Changes Experienced by Parents

Table A11.1: GHQ Scores at Baseline and Second Follow Up

			Baseline			Total
			Below Threshold (0-2)	Above Threshold (3-7)	Well Above Threshold (8+)	
Second Follow-up	Below Threshold (0-2)	Count	58	37	25	120
		% of Total	30.4%	19.4%	13.1%	62.8%
	Above Threshold (3-7)	Count	7	15	27	49
		% of Total	3.7%	7.9%	14.1%	25.7%
	Well Above Threshold (8+	Count	2	9	11	22
		% of Total	1.0%	4.7%	5.8%	11.5%
Total		Count	67	61	63	191
		% of Total	35.1%	31.9%	33.0%	100.0%

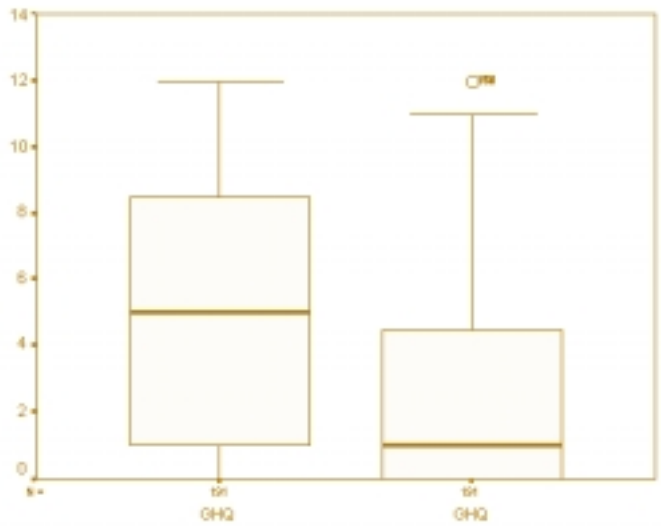


Table A11.2: Changes in PCRI Support Scores between Baseline and Follow Up

			Baseline			Total
			Weak	Modest	Strong	
Second Follow-up	Weak	Count	112	11	3	126
		% of Total	58.6%	5.8%	1.6%	66.0%
	Modest	Count	22	23	3	48
		% of Total	11.5%	12.0%	1.6%	25.1%
	Strong	Count	7	5	5	17
		% of Total	3.7%	2.6%	2.6%	8.9%
Total		Count	141	39	11	191
		% of Total	73.8%	20.4%	5.8%	100.0%

Table A11.3: Changes in PCRI Satisfaction Scores between Baseline and Follow Up

			Baseline			Total
			Weak	Modest	Strong	
Second Follow-up	Weak	Count	103	20	1	124
		% of Total	53.9%	10.5%	.5%	64.9%
	Modest	Count	16	24	3	43
		% of Total	8.4%	12.6%	1.6%	22.5%
	Strong	Count	3	11	10	24
		% of Total	1.6%	5.8%	5.2%	12.6%
Total		Count	122	55	14	191
		% of Total	63.9%	28.8%	7.3%	100.0%

Table A11.4: Changes in PCRI Involvement Scores between Baseline and Follow Up

			Baseline			Total
			Weak	Modest	Strong	
Second Follow-up	Weak	Count	36	15	6	57
		% of Total	18.8%	7.9%	3.1%	29.8%
	Modest	Count	33	32	11	76
		% of Total	17.3%	16.8%	5.8%	39.8%
	Strong	Count	4	28	26	58
		% of Total	2.1%	14.7%	13.6%	30.4%
Total		Count	73	75	43	191
		% of Total	38.2%	39.3%	22.5%	100.0%

Table A11.5: Changes in PCRI Communication Scores between Baseline and Follow Up

			Baseline			Total
			Weak	Modest	Strong	
Second Follow-up	Weak	Count	49	17	3	69
		% of Total	25.7%	8.9%	1.6%	36.1%
	Modest	Count	27	59	6	92
		% of Total	14.1%	30.9%	3.1%	48.2%
	Strong	Count	3	14	13	30
		% of Total	1.6%	7.3%	6.8%	15.7%
Total		Count	79	90	22	191
		% of Total	41.4%	47.1%	11.5%	100.0%

Table A11.6: Practical Help for Parents at Baseline and Second Follow Up

			Baseline			Total
			Weak Support	Medium Support	Strong Support	
Second Follow-up	Weak Support	Count	10	10	6	26
		% of Total	5.2%	5.2%	3.1%	13.6%
	Medium Support	Count	21	25	22	68
		% of Total	11.0%	13.1%	11.5%	35.6%
	Strong Support	Count	21	28	48	97
		% of Total	11.0%	14.7%	25.1%	50.8%
Total		Count	52	63	76	191
		% of Total	27.2%	33.0%	39.8%	100.0%

Table A11.7: Emotional Help for Parents at Baseline and Second Follow Up

			Baseline			Total
			Weak Support	Medium Support	Strong Support	
Second Follow-up	Weak Support	Count	20	11	4	35
		% of Total	10.5%	5.8%	2.1%	18.3%
	Medium Support	Count	34	18	11	63
		% of Total	17.8%	9.4%	5.8%	33.0%
	Strong Support	Count	18	25	50	93
		% of Total	9.4%	13.1%	26.2%	48.7%
Total		Count	72	54	65	191
		% of Total	37.7%	28.3%	34.0%	100.0%

Table A11.8: Information and Advice for Parents at Baseline and Second Follow Up

			Baseline			Total
			Weak Support	Medium Support	Strong Support	
Second Follow-up	Weak Support	Count	20	12	5	37
		% of Total	10.5%	6.3%	2.6%	19.4%
	Medium Support	Count	23	22	17	62
		% of Total	12.0%	11.5%	8.9%	32.5%
	Strong Support	Count	23	24	45	92
		% of Total	12.0%	12.6%	23.6%	48.2%
Total		Count	66	58	67	191
		% of Total	34.6%	30.4%	35.1%	100.0%

A14: Perceptions of Parents and Children

Table A14.1a Ages of Parents Attending Springboard

Age of Parents	Parents*	
	N	%
Less than 30years	11	18
30 to 35 years	18	28
36-39 years	15	23
Over 40 years	20	31
Total	64	100

Parents consist of mothers (56), fathers (7) and partner of father (1).

Table A14.1b Ages of Children Attending Springboard

Age of Children	Children*	
	N	%
Less than 9 years	15	25
9-12 years	29	47
13+ years	17	28
Total	61	100

*Children comprise 31 boys and 30 girls.

Table A14.2 Number of Children from Surveyed Parents Who Attend Springboard

Children of Surveyed ParentsWho Attend Springboard	Total	
	N	%
One	21	33
Two	17	27
Three or more	23	36
None	3	4
Total	64	100

Table A14.3 Length of Time Attending Springboard

Time Attending	Parents		Children		Total	
Springboard (In Months)	N	%	N	%	N	%
Less than 9 months	14	22	25	41	39	31
9-12 months	17	26	18	30	35	28
More than 12 months	33	52	18	29	51	41
Total	64	100	61	100	125	100

Table A14.4 Statements About the Quality of Services in Springboard

How frequently are the following statements true?	Perceptions based on % of answers to this question by:*					
	Parents (1)		Children (2)		Total (3)	
	Always	Often	Always	Often	Always	Often
I was made to feel welcome by the project	100	0	96	2	98	1
I was listened to by the project	97	1	86	14	92	7
I was understood by the project	86	11	76	21	82	15
I enjoy coming to the project	81	13	92	3	86	8
The project gave me help just when I needed it	81	10	77	14	80	11
The project gave me very good advice	77	8	80	13	78	10
The project is always there to support you	89	8	72	24	84	13

*Only responses which were "always" or "often" since the vast majority of responses were in this category.
(1) The number of responses by parents to this question ranged from 62 to 64.
(2) The number of responses by children to this question ranged from 25 to 60.
(3) The number of responses by everyone to this question ranged from 88 to 124.

Table A14.5a Statements About the Personal and Family Impact of Springboard

How frequently are the following statements true?	Perceptions based on % of answers to this question by:*					
	Parents (1)		Children (2)		Total (3)	
	Always	Often	Always	Often	Always	Often
The project has been a big help to me	91	3	86	11	89	7
The project has been a big help to my family	84	8	84	11	84	9

*Only responses which were "always" or "often" since the vast majority of responses were in this category.
The number of responses by parents to this question ranged from 62 to 63.
The number of responses by children to this question was 44.
The number of responses by everyone to this question ranged from 106 to 107.

Table A14.5b Change of Life Since Coming to Springboard

Has life changed for you since coming to Springboard?	Perceptions based on % of answers to this question by:*								
	Parents (1)			Children (2)			Total (3)		
	Much Better	Better	Same	Much Better	Better	Same	Much Better	Better	Same
Life changed?	47	42	11	36	52	10	42	47	11

*Only responses which were "always" or "often" since the vast majority of responses were in this category.
(1) The number of responses by parents to this question was 62
(2) The number of responses by children to this question was 58.
(3) The number of responses by everyone to this question was 120.

Table A14.6 Statements About the Quality of Staff in Springboard

How frequently are the following statements true?	Perceptions based on % of answers to this question by:*					
	Parents (1)		Children (2)		Total (3)	
	Always	Often	Always	Often	Always	Often
Staff in the project genuinely care about you	92	5	82	18	89	9
Staff in the project know how to respect people	95	5	86	14	92	8
Staff in the project are fair	88	8	84	16	86	11
Staff in the project are very good at what they do	95	5	90	7	94	5

*Only responses which were "always" or "often" since the vast majority of responses were in this category.
(1) The number of responses by parents to this question ranged from 63 to 64.
(2) The number of responses by children to this question ranged from 28 to 31.
(3) The number of responses by everyone to this question ranged from 92 to 98.

Table A14.7 Statements About the Local Profile of Springboard

How frequently are the following statements true?	Perceptions based on % of answers to this question by:*					
	Parents (1)		Children (2)		Total (3)	
	Always	Often	Always	Often	Always	Often
The project is respected in the area	60	25	25	70	50	36
The project has given a boost to the area	77	22	47	53	70	29
The project is needed in the area	95	3	80	16	91	7

*Only responses which were "always" or "often" since the vast majority of responses were in this category.
(1) The number of responses by parents to this question ranged from 52 to 63.
(2) The number of responses by children to this question ranged from 19 to 25.
(3) The number of responses by everyone to this question ranged from 72 to 88.

Table A14.8 Comparison of Springboard to Other Services

How does Springboard compare to other services such as:	Perceptions of Parents*					
	Much Better %	Better %	Same %	Worse %	Total %	Total N
Social Worker (Health Board)	65	28	7	0	100	54
Public Health Nurse	33	27	40	0	100	45
Community Welfare Officer	55	20	24	1	100	51
Primary Schools	32	29	39	0	100	59
Secondary Schools	31	39	28	2	100	39
Garda Síochána	40	25	35	0	100	40
Probation and Welfare Service	27	20	53	0	100	15
Local Authority	56	24	20	0	100	46
Dept of Social Welfare	45	18	37	0	100	40
FÁS	26	18	56	0	100	27
MABS	33	4	63	0	100	24
Society of VdP	18	15	68	0	100	40

Table A14.9a Activities Participated in at Springboard

What activities did you do at Springboard?	Perceptions based on % of answers to this question by:*					
	Parents (1)		Children (2)		Total (3)	
	N	%	N	%	N	%
A. Individual work	46	72	32	53	78	63
B. Group work	24	38	49	80	73	58
C. Family work	41	64	27	48	68	55
D. Drop-in	34	53	20	33	54	43

A. Individual work typically involves one-to-one sessions with the parent or child for the purpose of assessing needs and meeting therapeutic goals.
B. Group work refers to sessions with groups and typically involves sharing experiences or activities such as sports, recreation, arts and crafts, courses, etc. for the purpose of meeting therapeutic goals.
C. Family work usually involves sessions with two or more members of the family for the purpose of assessing needs and meeting therapeutic goals.
D. Drop-in is where the parent or child visits the centre and engages in unstructured activities such as meeting others, participating in recreation activities, and generally having fun.
(1) The number of responses by parents to this question was 64.
(2) The number of responses by children to this question ranged from 59 to 61.
(3) The number of responses by everyone to this question ranged from 123 to 125.

Table A14.9b Helpfulness of Activities at Springboard

What activities did you find most helpful?	Perceptions based on % of answers to this question by:*		
	Parents (1) Most Helpful	Children (2) Most Helpful	Total (3) Most Helpful
Individual work	36	15	26
Group work	14	64	39
Family work	36	19	27
Drop-in	15	2	8
Total	100	100	100

(1) The number of responses by parents to this question was 59.
(2) The number of responses by children to this question was 58
(3) The number of responses by everyone to this question was 117.

A15: Perceptions of Professionals

Table A15.1 Quality of Springboard's Work with Client Groups

How well has the project worked with the following client groups?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good
Families in general	60	40	60	39	60	40	56	41	59	39
Mothers	68	28	60	40	47	47	57	38	58	38
Pre-teenage children	63	32	63	35	40	50	50	44	56	40
Pre-school children	41	43	51	34	57	43	52	41	50	39
Teenagers	27	49	39	44	44	44	30	49	36	45
Fathers	13	31	22	44	10	50	22	33	18	38

*Only responses which were 'very good' or 'good' since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question varied from 28 to 40.
(2) The number of responses by health board staff to this question varied from 29 to 46.
(3) The number of responses by schools to this question varied from 5 to 20.
(4) The number of responses by others to this question varied from 29 to 57.
(5) The number of responses by all respondents to this question varied from 77 to 155.

Table A15.2 Quality of Springboard's Work with Organisations & Agencies

How well has the project worked with the following organisations and agencies?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good
Primary schools	59	31	50	44	65	26	50	43	55	39
Health Board	62	24	67	26	33	57	47	44	57	34
Voluntary organisations	62	26	67	22	40	50	51	40	57	31
Local Authority	35	49	35	53	20	60	36	56	36	52
Youth projects	49	31	57	34	46	54	38	44	45	39
Community projects	30	52	53	47	44	44	32	39	40	43
Local residents groups	21	61	36	57	14	71	21	44	28	53
Garda Síochána	24	38	46	37	86	14	24	50	32	48
Dept. Social Welfare	24	31	38	46	17	67	31	44	33	45
FÁS	36	26	45	38	40	40	23	37	35	36
Probation and Welfare	36	25	29	55	17	68	38	31	30	46
Secondary schools	26	34	31	39	50	17	19	51	30	43

*Only responses which were 'very good' or 'good' since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question varied from 28 to 40.
(2) The number of responses by health board staff to this question varied from 29 to 46.
(3) The number of responses by schools to this question varied from 5 to 20.
(4) The number of responses by others to this question varied from 29 to 57.
(5) The number of responses by all respondents to this question varied from 77 to 155.

Table A15.3 Staff Competencies

How well equipped is Springboard project to deal with vulnerable families in term of staff competencies?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good
Approach of staff team	59	39	74	26	72	28	61	36	68	31
Skills of staff team	54	46	65	35	67	28	62	37	64	35
Project administration	59	37	61	32	53	47	57	37	59	34
Size of staff team	12	37	13	38	41	29	27	39	21	39

*Only responses which were "very good" or "good" since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question varied from 38 to 42.
(2) The number of responses by health board staff to this question varied from 54 to 46.
(3) The number of responses by schools to this question varied from 17 to 19.
(4) The number of responses by others to this question varied from 60 to 64.
(5) The number of responses by all respondents to this question varied from 149 to 159.

Table A15.4 Support to Springboard Staff

Has Springboard project been adequately supported?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Always	Often	Always	Often	Always	Often	Always	Often	Always	Often
Staff supported	33	54	28	51	27	18	33	40	32	43

* Only responses which were "always" or "often" since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question varied from 37 to 39.
(2) The number of responses by health board staff to this question varied from 46 to 47.
(3) The number of responses by schools to this question varied from 10 to 11.
(4) The number of responses by others to this question varied from 45 to 49.
(5) The number of responses by all respondents to this question varied from 122 to 123.

Table A15.5 Physical Facilities

How well equipped is Springboard project to deal with vulnerable families in term of physical facilities?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good
Location of premises	57	36	57	27	63	26	52	34	59	28
Facilities & equipment	36	36	33	26	32	26	30	44	35	34
Layout of premises	18	28	20	20	26	11	18	35	20	26
Size of premises	10	20	15	19	26	11	14	20	15	19

* Only responses which were "very good" or "good" since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question varied from 38 to 42.
(2) The number of responses by health board staff to this question varied from 54 to 46.
(3) The number of responses by schools to this question varied from 17 to 19.
(4) The number of responses by others to this question varied from 60 to 57.
(5) The number of responses by all respondents to this question varied from 149 to 159.

Table A15.6 Support to Springboard Projects

Has Springboard project been adequately supported?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Always	Often	Always	Often	Always	Often	Always	Often	Always	Often
Project supported	24	51	24	44	30	30	37	43	30	44

* Only responses which were "always" or "often" since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question varied from 37 to 39.
(2) The number of responses by health board staff to this question varied from 46 to 47.
(3) The number of responses by schools to this question varied from 10 to 11.
(4) The number of responses by others to this question varied from 45 to 49.
(5) The number of responses by all respondents to this question varied from 122 to 123.

Table A15.7 Relationship Between Springboard and Health Board

How would you describe the relationship between Springboard project and the Health Board?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good	Very Good	Good
Relationship is	42	42	61	32	57	43	35	57	47	46

* Only responses which were "very good" or "good" since the vast majority of responses were in this category.
(1) The number of responses by project staff to this question was 38.
(2) The number of responses by health board staff to this question was 46.
(3) The number of responses by schools to this question was 20.
(4) The number of responses by others to this question was 46.
(5) The number of responses by all respondents to this question was 127.

Table A15.8 Living up to Expectations

Has Springboard Lived Up to Your Expectations?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Up to expectations?	92	8	92	8	77	23	86	14	87	13

(1) The number of responses by project staff to this question was 37.
(2) The number of responses by health board staff to this question was 46.
(3) The number of responses by schools to this question was 22.
(4) The number of responses by others to this question was 56.
(5) The number of responses by all respondents to this question was 148.

Table A15.9 Value for Money

Is Springboard Value for Money?	Perceptions Based on % of Answers to this Question														
	Project Staff (1)			Health Board (2)			Schools (3)			Other (4)			Total (5)		
	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK
Value for Money?	90	0	10	84	0	16	63	0	38	75	3	22	78	1	21

(1) The number of responses by project staff to this question was 40.
(2) The number of responses by health board staff to this question was 46.
(3) The number of responses by schools to this question was 24.
(4) The number of responses by others to this question was 57.
(5) The number of responses by all respondents to this question was 161.

Table A15.10 Future Funding of Springboard

Should Springboard continue to be funded?	Perceptions Based on % of Answers to this Question														
	Project Staff (1)			Health Board (2)			Schools (3)			Other (4)			Total (5)		
	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK
Continue to fund?	93	0	7	97	0	3	96	0	4	94	0	6	95	0	5

(1) The number of responses by project staff to this question was 42
(2) The number of responses by health board staff to this question was 46
(3) The number of responses by schools to this question was 25
(4) The number of responses by others to this question was 66
(5) The number of responses by all respondents to this question was 168

Table A15.11 Suggestions for Making Springboard More Effective

Any suggestions for Springboard?	Perceptions Based on % of Answers to this Question*									
	Project Staff (1)		Health Board (2)		Schools (3)		Other (4)		Total (5)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Any suggestions	87	13	80	20	90	10	90	10	87	13

(1) The number of responses by project staff to this question was 37
(2) The number of responses by health board staff to this question was 50
(3) The number of responses by schools to this question was 19.
(4) The number of responses by others to this question was 60.
(5) The number of responses by all respondents to this question was 145.