Meitheal and Child and Family Support Networks

Interim Report on the Meitheal Process and Outcomes Study

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The Development and Mainstreaming Programme for Prevention Partnership and Family Support

The research and evaluation team at the UNESCO Child and Family Research Centre, NUI Galway provides research, evaluation and technical support to Tusla's Development and Mainstreaming Programme for Prevention, Partnership and Family Support (PPFS). This is a new programme of action being undertaken by Tusla, the Child and Family Agency as part of its National Service Delivery Framework. The programme seeks to transform child and family services in Ireland by embedding prevention and early intervention into the culture and operations of Tusla. The UNESCO Child and Family Research Centre's work focuses on research and evaluation on the implementation and the outcomes of Tusla's Development and Mainstreaming Programme and is underpinned by the overarching research question:

> ... whether the organisational culture and practice at Tusla and its services are integrated, preventative, evidence informed and inclusive of children and parents and if so, is this contributing to improved outcomes for children and their families.

The research and evaluation study is underpinned by the Work Package approach. This has been adopted to deliver a comprehensive suite of research and evaluation activities involving sub-studies of the main areas within Tusla's Development and Mainstreaming Programme. The work packages are: Meitheal and Child and Family Support Networks, Children's Participation, Parenting Support and Parental Participation, Public Awareness and Commissioning.

This publication is part of the Meitheal and Child and Family Support Networks Package.

About the UNESCO Child and Family Research Centre

The UNESCO Child and Family Research Centre (UCFRC) is part of the Institute for Lifecourse and Society at the National University of Ireland. Founded in 2007, through support from The Atlantic Philanthropies and the Health Services Executive, with a base in the School of Political Science and Sociology, the mission of the Centre is to help create the conditions for excellent policies, services and practices that improve the lives of children, youth and families through research, education and service development. The UCFRC has an extensive network of relationships and research collaborations internationally and is widely recognised for its core expertise in the areas of Family Support and Youth Development.

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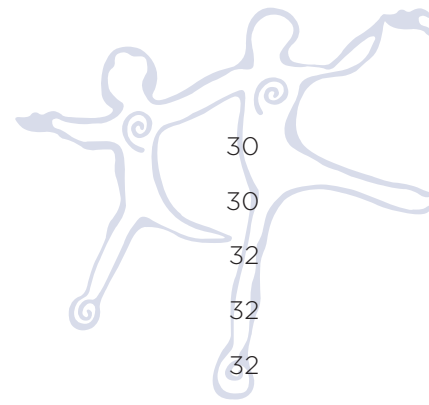Tel: +353 91 495398
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Glossary of Terms

CFSN (Child and Family Support Network)

These are multi-agency networks (ideally one per 30,000–50,000 inhabitants) developed within each Tusla administrative area as part of Tusla's Prevention, Partnership and Family Support strategy. These partnership-based networks are open to any services that have an input into families' lives, including Tusla staff as well as statutory organisations and community and voluntary agencies.

ISA (Integrated Service Area)

Tusla is regionally divided up into 17 administrative areas, each with its own management structure and Child Protection and Welfare department(s).

Lead Practitioner

This is a key person in a Meitheal process. Typically they are expected to have a previous relationship with the family who are participating in a Meitheal, and they are responsible for initiating a Meitheal with a family, which includes completing the required documentation. Lead Practitioners can work for Tusla, the community and voluntary sector or other statutory services. They are expected to take a lead role in organising Meitheal Review Meetings and liaising with the family and other participants in a Meitheal process.

Meitheal

For the purposes of this research, Meitheal is defined as such when the preparation stage has been completed, consent has been obtained from a family, and a decision has been made to proceed to the discussion stage. This primarily relates to interventions that require a multi-agency response, but in certain circumstances can also include a single-agency response.

Meitheal Review Meetings

When a multi-agency Meitheal process is organised, regular meetings should take place with all the participants in the Meitheal. Their main purpose is to review progress to date and develop action plans for helping a child, young person or family to reach their desired outcomes. They cannot be held without the presence of at least one parent.

Tusla, the Child and Family Agency

Tusla is the Irish statutory agency with responsibility for safeguarding children and young people's welfare and supporting families.

PPFS (Prevention, Partnership and Family Support)

This programme was developed with the intention of placing greater emphasis on early intervention and Family Support principles in the work Tusla carries out with children, young people and their families. Central to this programme are five distinct but complementary and interwoven work packages: parental support, public awareness (i.e., increasing awareness of where to access help among the general public), participation (i.e., enhancing child and youth participation at all levels of their engagement with Tusla), commissioning, which focuses on the funding of services, and the development of the Meitheal and CFSN model.

Acknowledgements

Executive Summary

Overview

This research study is being conducted as part of the UNESCO Child and Family Research Centre's evaluation of the Development and Mainstreaming Programme for Prevention, Partnership and Family Support (PPFS) that Tusla, the Child and Family Agency, which is responsible for safeguarding children and young people's welfare and supporting families, is currently implementing. The purpose of the PPFS Programme is to integrate early intervention and prevention practices and principles into the work that Tusla and partners in the statutory and community and voluntary sector carry out with children, young people and their families. The PPFS Programme has five core domains; parenting support and participation; children's participation; commissioning of services; public awareness and the implementation of Meitheal and the Child and Family Support Networks (CFSNS). Meitheal is an early intervention model, which is used to support children, young people and their families with unmet needs who do not meet the threshold for a child protection response. The Meitheal is coordinated by a Lead Practitioner who supports the family throughout the process[1]. The Meitheal model is underpinned by the Child and Family Support Networks (CFSNs), which are multi-agency area-based networks designed to support the implementation of Meitheal and the development of a partnership approach to working with children, young people and their families at a local level[2].

Aim of the Report

The aim of this report is to provide an overview of the interim findings of the Meitheal and CFSNs Process and Outcomes Study, for which data collection is ongoing. This is a longitudinal study with three waves of data collection that focus on gathering data at a pre-, post- and follow-up stage. This report focuses specifically on data gathered on the implementation and impact of Meitheal from January to June 2017. These are preliminary findings reflecting the views of parents, children, young people and Lead Practitioners on the experience and effect of participating in Meitheal. A final study will be published reporting longitudinally on the impact of Meitheal on families' outcomes and well-being as well as their experience of the process in 2018. Note that the number of fathers who are included in these findings is quite low, it is expected that this number will increase in the final study.

Methodology

A mixed methods approach drawing on both qualitative and quantitative techniques was used in this study. The qualitative findings included in this report are based on interviews conducted with 41 participants representing 18 families (10 children and young people, 19 parents and 12 Lead Practitioners). The quantitative data collected through a number of standardised tools represents 106 participants from 35 families (40 children and young people, 41 parents and 25 Lead Practitioners) and young people from a total of 35 families. In order to provide context for the study's findings and to understand the impact of Meitheal on the Irish system of help-provision to families a secondary data analysis was carried out on Tusla's Performance Reports from 2014-2017.

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[1] An extensive overview of the model including its underpinning principles, initiation pathways and mode of working are included in section 3.1 of the report.
[2] Further details about the CFSNs are provided in section 3.1 of the report.
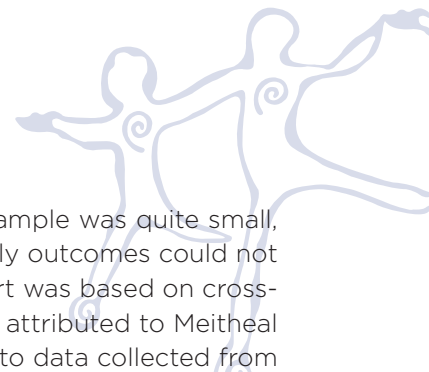
Limitations

There are some methodological limitations that impacted on the findings. The sample was quite small, which meant that some analyses could not be carried out and predictors of family outcomes could not be explored in relation to child self-reports of well-being. In addition, as the report was based on cross-sectional data it was not possible to assess whether changes over time could be attributed to Meitheal compared to other variables. The analysis was also limited by not having access to data collected from the Strengths and Needs Forms[3] and incomplete records in the national Meitheal database. The CFSNs are not reported on in this study due to data not being available and the focus of the research study at this time. Some of the families who are included in the quantitative sample are not represented in the qualitative data so this limited potential comparisons between the two sets of data. Lastly, changes over time in the style and content of Tusla's Performance Activity Reports meant that the secondary data analysis that was carried out was restricted in the level of detail that could be provided.

Findings

Experience of Meitheal

Overall the qualitative findings highlighted that participants were positive about their experience of Meitheal to date. This included both the process of taking part as well as improvements in the families' well-being and outcomes that had already begun to occur in some cases. In general parents reported that they were engaged with the Meitheal process and felt empowered and listened to. Children and young people reported that they felt listened to and supported, with some noting improvements in their lives as a result of taking part in Meitheal. Lead Practitioners were generally satisfied with Meitheal and felt that it was an effective method of supporting families.

The Relationship Between the Lead Practitioner and the Families

A key finding is that within the Meitheal process the relationship between the Lead Practitioner and the families is of crucial importance. The Lead Practitioner acts as a source of ongoing support in the families' engagement with services, provides practical assistance within their own remit and is viewed as trustworthy and empathetic. A number of other strengths associated with Meitheal are also outlined. These include its multi-agency approach, less duplication of services provided to families, improvements in communication between practitioners and between practitioners and parents and the development of more tailored plans to support families in reaching their outcomes.

Impact of Meitheal on the System of Help Provision in the Irish Context

Although it is too early to determine the impact of Meitheal on the system of help provision in the Irish context its introduction has heightened the visibility of the work that Tusla carries out with families who do not meet the threshold for an intervention by Child Protection and Welfare services. Additionally, it provides greater scope for the effective operation of a continuum of support for children, young people and their families with unmet needs. Overall the analysis of Tusla activity demonstrates that Meitheal is operating at an appropriate level, which suggests that suitable screening processes are in place and the correct response has been selected. Secondary analysis of Tusla performance data carried out for this report reveals that the agency's work in early intervention and prevention and with families with lower levels of need is more visible then was previously the case.

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[3] This form is completed with the family at the start of the Meitheal process and records parents/guardians and children's views on, for example, their strengths and needs.

Participation in Meitheal

Both the parent and Lead Practitioner cohorts reported overall satisfaction with the nature of parents' participation in the Meitheal process. However, while there was evidence of best practice in how children and young people participate in Meitheal, issues remain with how this is interpreted at an individual level. This is further complicated by the fact that not all Lead Practitioners had, as of yet, developed strong relationships with the children and young people for whom the Meitheal was initiated and that other practitioners who were taking part in the Meitheal did not always understand the nature of their involvement and presence at the Meitheal Review Meetings.

Implementation Challenges

Some challenges emerged in the findings in relation to Meitheal's implementation. These include the need to increase awareness around the existence of this model among the service community and the wider general public. Furthermore, the potential for Meitheal to support families continues to be hindered by a lack of resources and inconsistent engagement by relevant bodies. In addition, the qualitative data shows that children, young people and parents do not always fully understand what Meitheal is or their role in the process.

Importance of a Holistic Approach to Working with Families

The report highlights the importance of utilising a holistic approach to working with children, young people and their families to improve their outcomes. Although the sample size was small, maternal well-being emerged as the most significant predictor of family outcomes, which shows the need to broaden the focus beyond the child or young person for whom the Meitheal was initiated. The qualitative and quantitative findings in this report, which demonstrate that there are discrepancies between parental reports of their children's strengths and needs and the children and young people's, further highlight the need to develop a holistic understanding of a family's issues.

Impact of Meitheal on Outcomes

While the majority of respondents (75%) reported scores of over 50% on the Outcomes Star[4] some had scores lower than 50. This suggests that these families might need additional support beyond Meitheal's capacities. In terms of parental well-being, approximately 40% of mothers scored above the threshold for possible difficulties in this area on the General Health Questionnaire[5]. There were discrepancies between maternal reports and child and youth self-reports of well-being with the latter reporting slightly lower levels. At this early stage of the Meitheal processes model fidelity appeared to be quite low, this is in part due to the fact that the final phases of the model have not been completed as of yet but this will be more accurately reported on in the final report. Some potential patterns emerged in the findings regarding potential relationships between greater model fidelity and higher levels of well-being among children and young people as well as differences in model fidelity according to the Meitheal's initiation pathway. These trends will be further investigated when the data collection is fully completed. Overall maternal well-being was identified as the most significant predictor of family outcomes but this could be subject to change as the sample size increases. Children and young people's age and gender did not have a significant bearing on outcomes, well-being or model fidelity. However, there were significant differences in family outcomes depending on the region[6] they came from as children and young people from the West had significantly lower levels of family outcomes than elsewhere.

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[4] This is a tool that is used to measure outcomes. Three different versions were used in this study-one for parents/guardians, one for children and one for young people. For further details on this please see Section 2.5.2 of the report.
[5] This is a screening tool used to assess current state of well-being. For further information please see Section 2.5.2 of the report.
[6] Tusla is organised into four regions: the West, the South, Dublin Mid-Leinster and Dublin North East.
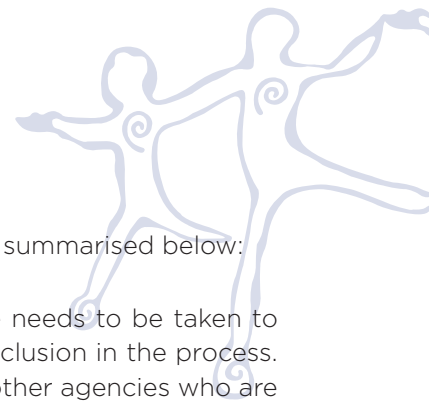
Recommendations

The report concludes with a number of recommendations for practice, which are summarised below:

- Where a Lead Practitioner is only known to one member of a family care needs to be taken to ensure that other individuals receive adequate support to facilitate their inclusion in the process. Measures could include co-working arrangements with practitioners from other agencies who are known to these individuals.

- Increasing engagement among essential services and agencies is of crucial importance to the success of the overall Meitheal model and individual processes.

- Meitheal processes need to be monitored for how families are supported to participate to the fullest possible extent.

- Attention should be paid to what needs are identified for inclusion in action plans so that children and young people are not placed under undue pressure or unfairly blamed for their family's issues.

- Consideration should be given to introducing a mentoring process to support Lead Practitioners in carrying out their work within Meitheal. This is particularly important where they are new to the role.

- It is recommended that a public awareness and communications strategy be developed by Tusla to raise awareness about Meitheal among practitioners and the wider population.

- Careful attention should be paid to ensuring that all relevant data is uploaded to the Meitheal database in local areas so that it is available for analysis at a national level. This could be facilitated by the introduction of appropriate supports such as the inclusion of a Meitheal and CFSN module in the National Child Care Information System.

- The importance of using defined, measurable outcomes to underpin the work that Tusla and its partner agencies carries out with children, young people and their families should be embedded into practice.

- A consistent and systematic approach to recording and reporting Tusla performance data should be developed with, for example, similar vocabulary used throughout the system. This could help to ensure that data is made more accessible and possible trends could be more easily tracked over time.

Conclusion

The capacity of the research team to report on the impact of Meitheal on families' outcomes and their experience of participating in the process was somewhat limited by the small sample size, the low number of fathers and the early point in the individual Meitheals that the data was collected at. The final report, which will be published on this study will help to remedy these issues as the sample will be larger, more fathers will be included and the findings will include analysis drawing on later stages of Meitheals. Nevertheless, this report does demonstrate that for families and Lead Practitioners who participate in the Meitheal process the experience is largely positive with potential scope to resolve issues and improve outcomes.

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Chapter One: Introduction

1.1 Introduction

The aim of this report is to provide an interim overview of the data collected to date with children and young people, parents/guardians[7] and Lead Practitioners (January to May 31st 2017) for the Meitheal and Child and Family Support Networks Process and Outcomes study. This interim report focuses on Meitheal and does not include findings on the Child and Family Support Network (CFSN) dimension of the model, as data has not been collected on this subject yet. The objective of the interim study is to evaluate the impact of the Meitheal model on outcomes for families in Ireland, the process of implementation and its impact on the system of help provision. This report includes qualitative data on the experience of participating in Meitheal, its perceived impact, its strengths and the challenges that have been encountered to date. The quantitative data is focused on understanding the profile of participants early on in the Meitheal process to determine their levels of needs and outcomes in order to be able to track changes in outcomes over time. A secondary data analysis was also carried out to understand the impact of Meitheal in the overall support system.

This chapter firstly outlines the aims and objectives of the interim report. It then provides an overview of the Programme for Prevention, Partnership and Family Support and the Meitheal and CFSN model. Lastly, it describes the overall research aims and objectives of the Meitheal and CFSN work package.

1.1.1 Aims and Objectives

The aims of this interim report are to:

(a) Evaluate the preliminary impact of the Meitheal model on outcomes for children, young people and families in Ireland;

(b) Assess the process of implementing the Meitheal Model so far;

(c) Consider the impact of Meitheal thus far on the system of help-seeking/help provision.

The overall study objectives are to:

1. Provide a detailed understanding of the preliminary provision of Family Support through Meitheal nationwide, including the perspectives of children, young people, families and practitioners;

2. Ascertain and describe the impact of Meitheal in the context of the Irish child welfare system so far;

3. Determine the relationship between the process (implementation and fidelity) and the outcomes of Meitheal at this stage.

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[7] Where the terms parents term is used in this Report it includes both parents and guardians.
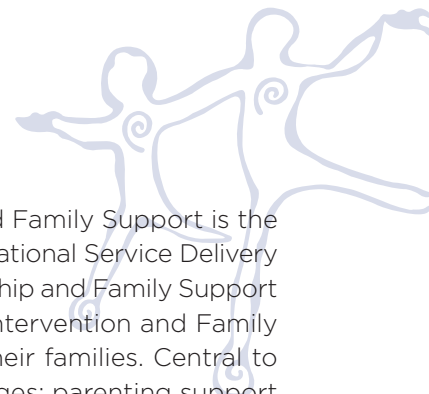
1.2 The Prevention, Partnership and Family Support Programme

The Development and Mainstreaming Programme for Prevention, Partnership and Family Support is the title given to a new programme of action being undertaken by Tusla as part of its National Service Delivery Model. Tusla's Development and Mainstreaming Programme for Prevention, Partnership and Family Support (PPFS) was developed with the intention of placing greater emphasis on early intervention and Family Support principles in the work it carries out with children, young people[8] and their families. Central to this programme are five distinct but complementary and interwoven work packages: parenting support and parental participation, public awareness (i.e., increasing awareness of where to access help among the general public), children's participation (i.e., enhancing child and youth participation at all levels of their engagement with Tusla), commissioning, which focuses on the funding of services, and the development of the Meitheal model and the CFSNs. The latter is a distinct stream but it also acts as a fulcrum for much of the development of the other aspects of the programme. Implementation of this programme was supported by the creation of the post of PPFS manager in each Integrated Service Area (ISA), whose role includes overseeing the introduction and management of Meitheal and the CFSNs and developing a smoother continuum of support for families, from low-level universal supports through to more acute interventions.

The PPFS programme, which is funded by the Atlantic Philanthropies, Ireland, is driven by a series of medium-term and long-term outcomes, as follows:

Medium-term Outcomes (2015–2017)

1. Tusla's prevention and early intervention system is operating effectively, delivering a high-quality, standardised and consistent service to children and families in each of the 17 management areas.

2. Tusla's service commissioning is increasingly rigorous and evidence-informed and privileges prevention and early intervention.

3. A strategic approach to parenting is increasingly delivering cost-effective better practice and better outcomes for parents and children, thus reducing inequalities.

4. Children and families are increasingly aware of available supports and are less likely to fall through gaps, as all relevant services are working together in Tusla's prevention and early intervention system.

5. The participation of children and parents is embedded in Tusla's culture and operations.

Long-term Outcomes (2018 and beyond)

1. Intensive implementation support has delivered transformative change in Tusla policies and practice in Family Support, child welfare and protection, leading to enhanced child and family well-being, less abuse and neglect and a changed profile of children in care.

2. Improved outcomes for children and parents and value for money in service provision, achieved through shifting Tusla's Family Support budget in favour of evidence-informed prevention and early intervention services.

3. Tusla is recognised as a best-practice model nationally and internationally in delivering on the public sector reform objective of the cost-effective achievement of better outcomes for children and families, based on a core commitment to prevention and early intervention.

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[8] 'Children and young people' refers to all individuals who are under the age of 18.

These outcomes will be achieved through an integrated programme of work, spanning the application of a new model of early intervention and support, through to the embedding of evidence-based commissioning in Tusla. It will involve significant workforce development activities covering the implementation of new early-intervention structure and processes, evidence-based commissioning, children's participation and parenting. It will facilitate enhanced cross-sectoral and inter-agency cooperation and collaboration, ensuring services are integrated and coordinated. This will be allied to a public awareness programme geared towards increasing understanding and encouraging service take-up by parents.

1.3 The Meitheal and Child and Family Support Networks Model

As previously outlined, the development of the Meitheal and CFSN model is one of the five work packages in the PPFS programme. This section briefly explains these terms and outlines some of their key components.

Tusla defines Meitheal as 'a national practice model to ensure that the needs and strengths of children and their families are effectively identified, understood and responded to in a timely way so that children and families get the help and support needed to improve children's outcomes and to realise their rights' (Gillen et al., 2013: 1). For the purposes of this research, Meitheal is constituted as such when the preparation stage has been completed, consent has been obtained from a family, and a decision has been made that the discussion stage will be proceeded to. This primarily relates to interventions that require a multi-agency response, but in certain circumstances can also include a single-agency response.

The Meitheal model is a process-based system, which is not linked to a particular physical infrastructure or network but rather revolves around the development of an approach that can be applied by disparate organisations in the community and voluntary sector, by Tusla and other statutory services. This is grounded in a set of principles and structures that help to ensure that the type of support a family can expect to receive is similar across the country irrespective of the ISA they live in (Tusla, 2015a). There are a number of principles that Meitheal operates under as set out by Tusla:

- **Parents are made aware at the outset that child protection concerns in relation to their child or children will be referred to Tusla Child Protection and Welfare Services in line with 'Children First: National Guidance' (2011).**

- **Meitheal is a voluntary process. All aspects are led by the parent/guardian and child/young person, from the decision to enter the process, to the nature of information to be shared, the outcomes desired, the support delivered, the agencies to be involved and the end point of the process.**

- **A Meitheal Review Meeting cannot take place without the involvement of at least one parent.**

- **The Meitheal model looks at the whole child in a holistic manner, in the context of their family and environment. It takes into account strengths and resilience, as well as challenges and needs.**

- **The Meitheal process privileges the voices of the parent/guardian and child, recognising them as experts in their own situations and assisting them to identify their own needs and ways of meeting them.**

- **The Meitheal model is aligned with the wider Tusla National Service Delivery Framework.**

- **The Meitheal model should be focused on outcomes and implemented through a Lead Practitioner (Tusla, 2015a: 15–16).**
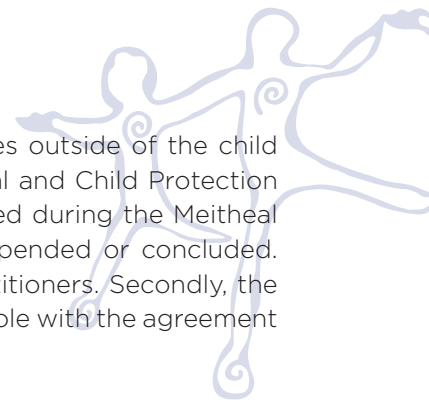
This is complemented by two core features. Firstly, the Meitheal model operates outside of the child protection system in that, for instance, families cannot be involved with Meitheal and Child Protection and Welfare (CPW) at the same time. Should child protection concerns be raised during the Meitheal process, a referral will be made to CPW, and the Meitheal process will be suspended or concluded. However, support can continue to be provided by individual agencies and practitioners. Secondly, the Lead Practitioner should have a prior relationship with the family and take on the role with the agreement of the family.

There are three initiation pathways into Meitheal. The first is the direct or self-initiated Meitheal, where a request is made by a practitioner or by a family themselves. The second avenue is where a case is diverted by the CPW Intake Team into Meitheal. In this situation, social workers must be satisfied that there are no child protection concerns but that there are unmet needs, which can potentially be addressed through this process. The final method is the step-down pathway, which again is initiated by the CPW department. This occurs when child protection concerns have been dealt with by CPW but where social workers feel that further support would be beneficial as the family transition out of the system or where there are still some unmet welfare needs.

In order to support Tusla's aim of developing an 'integrated service delivery' framework (Gillen et al., 2013: 14) for working with families, CFSNs are being established. In each ISA a number of these multi-agency networks (ideally one per 30,000–50,000 inhabitants) are to be developed with either virtual or physical hubs such as Family Resource Centres at their core. These partnership-based networks are open to any service that has an input into families' lives, including Tusla staff as well as other statutory organisations and community and voluntary agencies. The model's goals are to work with families to ensure that there is 'No Wrong Door'[9] and that services are available to support them as locally as possible. Members' roles include supporting the implementation of Meitheal by agreeing to act as Lead Practitioners or participating in a process in other ways, and working in a collaborative way with other agencies in their network (Gillen et al., 2013).

1.4 Aim and Research Questions

This interim report fits within the overall evaluation of the Meitheal and CFSN model but only focuses on the implementation of Meitheal, with data collection to take place on the CFSN dimension in the coming months. The overarching research aim of the Meitheal and CFSN model work package is to establish whether Child and Family Support Networks are established across all 17 management areas with meaningful engagement from a wide spectrum of practitioners and delivering timely, integrated support to children, young people and families with additional needs.

This aim can be broken down into a series of main research questions:

- To what extent are networks established across all 17 areas?

- What is the profile of practitioners engaged in these networks?

- To what extent are these practitioners meaningfully engaged in the networks?

- To what extent are these practitioners delivering timely, integrated support to children, young people and families with additional needs?

Following from these main questions are a series of more detailed questions focusing on the establishment of structures, processes and roles; the value of training and support; and the experience of key interfaces

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[9] This is based on the idea that service providers are able to direct families to the appropriate agency even if they or the sector they operate in do not offer that service themselves ('No Wrong Door', 2014).

between Meitheal and the CFSNs and other key structures and processes. Particular attention is paid to the key interface between Meitheal and Tusla CPW and between Tusla PPFS staff and the main stakeholders required to deliver Meitheal. Each of these occurs at the case level, and between PPFS and Child and Young People's Services Committees (CYPSC) at the steering committee level.

This report is focused on the preliminary findings of the impact of the Meitheal on outcomes and the overall system of help provision. The report introduces an in-depth qualitative understanding of the perceptions and experiences of families and practitioners in Meitheal, followed by a quantitative description of the level of outcomes early on in the Meitheal process. Thirdly, a description of the help-provision system is provided between 2014 and early 2017 looking at the time period when Meitheal was introduced. These findings are discussed and limitations and recommendations outlined.

1.5 Structure of the Report

The structure of the report to follow is:

- Chapter 2: Methodology

- Chapter 3: Findings related to the qualitative research

- Chapter 4: The impact of Meitheal on child and family outcomes

- Chapter 5: Meitheal and the help-seeking and help-provision context

- Chapter 6: Discussion, conclusions and recommendations for practice.

2

Chapter Two: Methodology

2.1 Introduction

This chapter outlines the methodological approach that underpins this study. It details the mixed method approach that was developed to explore the process of participating in Meitheal from the perspective of parents, children and young people, and Lead Practitioners to evaluate its impact on outcomes for children, young people and families. Lastly, it describes the recruitment process, the data collection phase and the ethical considerations that were taken into account in this study.

2.2 Research Design

The Meitheal Process and Outcomes Study has an exploratory, longitudinal, mixed methods design which consists of qualitative and quantitative methodologies. This combination can provide answers to complex research questions (Muncey, 2009; Johnson & Onwuegbuzie, 2004). Within the study the quantitative and qualitative phases of data collection take place simultaneously. It also has a convergent parallel design (Creswell & Plano Clark, 2011), which involves concurrent timing to implement the qualitative and quantitative phases of the study, prioritising both methods equally. The mixing phase occurs during the overall interpretation of results, where findings complement each other (Muncey, 2009).

The study is longitudinal. Van Belle et al. (2004: 1) defined longitudinal designs as a type of research 'where participant outcomes and possibly treatments or exposures are collected at multiple follow-up times'. This kind of design is suitable for outcomes evaluations, as it can measure changes in outcomes and is also suitable for observing individual patterns of change (Van Belle et al., 2004). Longitudinal (Xue et al., 2015; Long et al., 2012; Waxman et al., 2009) and mixed methods designs (McDonell et al., 2015; Waxman et al., 2009; Brady et al., 2008) are among the most common designs used in outcomes evaluations of family interventions at a national and international level.

The research team were supported throughout the development and implementation of this study by a steering group, which was attended by members of the UCFRC research team and Tusla staff, including the Regional Implementation Managers and representatives from Tusla's information office and Tusla Workforce Learning and Development. They provided advice and feedback, for example, on the design of the study and participant recruitment. Meetings were held every two months.

2.3 Sample Size

The Meitheal outcomes evaluation is a longitudinal nationwide evaluation that requires a large sample to be able to be representative and provide in-depth information that presents a description of Meitheal nationwide. Previous studies of this kind have included samples of between 601 families (Pancer et al., 2013) and 6, 693 children (Brannstrom et al., 2013). Sample sizes in the Irish context have included up to 1,200 participants (McKeown, 2004).

The Meitheal outcomes evaluation has a representative sample recruited nationwide from all Tusla regions: Dublin Mid-Leinster (DML), Dublin North-East (DNE), the South, and the West. This interim report is a snapshot of families that have engaged in the research to date; however, the sample is small and cannot be considered to be representative nationwide. In this study the sample size for the qualitative component will be determined by data saturation (no new information or themes emerge from the data), at which point data collection will cease.

The sample size in this report differs between the quantitative and qualitative sections. The qualitative findings are based on data collected with 41 participants representing 18 families; 10 children and young people, 19 parents/ guardians and 12 Lead Practitioners. The quantitative data included consists of 40 children and young people from 35 families, their parent(s)/ guardians (N=41) and Lead Practitioners (N=25).

2.4 Recruitment Strategy

The study was implemented in each Tusla ISA when agreement was secured with the relevant PPFS manager. The time at which the study was introduced to an area depended on, for example, how advanced the implementation of Meitheal was, and whether resources such as CFSN Coordinators were in place who could provide support. The next phase in the recruitment strategy in each ISA focused on creating awareness among relevant individuals involved in implementing the Meitheal model: PPFS managers, CFSN Coordinators and Lead Practitioners (including Tusla employees and individuals from other statutory agencies and the community and voluntary sector). A number of briefing sessions were held with PPFS managers to increase awareness of the study and regional PPFS meetings were attended by members of the research team as well. To support recruitment for the study, UCFRC researchers delivered a number of training sessions in 15 of the 17 ISAs between September 2016 and April 2017. A breakdown of training sessions by Tusla region and number of participants is outlined in Table 1. An outline of the number of briefing sessions and PPFS meetings attended by Tusla region is included in Table 2.

In these two-hour workshops, participants were briefed about the aims of the study and the research design, particularly the data collection process, and were trained in how to complete the quantitative scales. Subsequently, Lead Practitioners were requested to ask all families who were referred to Meitheal if they wished to participate in the study.

Tusla Region	Number of Training Sessions	Number of Participants
DML	5	73
DNE	7	82
South	6	115
West	8	118
Total	26	385

Table 1: Service Providers Trained by Region and Number of Participants

Tusla Region	Briefing Sessions	Number of Participants	PPFS Regional Meetings	Number of Participants
DML	0	0	1	6
DNE	0	0	1	9
South	3	30	1	5
West	1	5	1	8
Total	4	35	4	28

Table 2: Briefing Sessions Provided and PPFS Regional Meetings Attended by the Research Team

2.5 Data Collection

2.5.1 The Data Collection Process

In order to protect the confidentiality of families who participate in Meitheal, it was decided that either the Lead Practitioner or the CFSN coordinator would introduce the study to the family and seek their consent. The Lead Practitioners/CFSN Coordinators verbally introduced the study to the family and provided them with Participant Information Sheets. Where Lead Practitioners were willing to collect the quantitative data (and subject to the agreement of the family), they did so and received permission from parents for UCFRC researchers to contact them to organise the qualitative interviews. In these cases the Lead Practitioners were asked on completion of the relevant tools to return them to the UCFRC research team, who were responsible for inputting the data. The interviews were then carried out at times and in locations selected by the families. In other cases, where both the qualitative and quantitative data was collected by UCFRC researchers, the Lead Practitioner sought and received permission from the family for the research team to make contact with them to organise this. A member of the research team then met with the family to complete the quantitative tools and carry out the interview. Where children were of an appropriate age to participate in the research process, they were asked to take part by completing the quantitative tools and the interview. In some cases children and young people chose to complete the quantitative tools but not the interview. In others, parents participated in the data collection but their children opted not to. In addition, Lead Practitioners were contacted by the research team to take part in the research by completing the Fidelity Checklist which is included in appendix 1, and an interview (usually by phone). Interviews ranged from 10 to 45 minutes. Data will be collected from these participants either once or twice more, depending on when they first took part in the study.

As a token of appreciation, parents who took part in the research were given a €30 One4all voucher, while children and young people were given a small gift. This will be repeated each time they take part in the data collection.

2.5.2 Quantitative Scales

Participants (children, young people, parents and families) will complete these scales face to face three times: pre-test, post-test and at six months follow-up, to determine if changes in outcomes are sustainable over time. This interim report is based on the preliminary data at the pre-test. Data collected from these scales was entered into SPSS Version 20. Data was prepared and screened for normality and reliability. Bivariate analyses were carried out on the data set (independent sample t-test, analysis of variance ANOVA, Pearson correlation coefficient). Predictors of child, parent and family outcomes were analysed using hierarchical regressions. Quantitative scales and questionnaires can be found in Appendix 1. The scales for children and young people are the Strengths and Difficulties Questionnaire (SDQ) and the My Star and Youth Star. Parents and guardians completed the General Health Questionnaire (GHQ) and the Family Star Plus. Practitioners completed the Meitheal Fidelity Checklist.

General Health Questionnaire

The General Health Questionnaire (GHQ) is one of the most common, reliable and effective measures used to assess mental well-being. The GHQ is a screening tool that can be used to detect people that are likely to or already suffer from psychiatric disorders and common mental health problems (Jackson, 2007). Due to its ease of completion, the 12-item version of the GHQ was selected for this study. The scoring method selected was binary and the cut-off score selected was 3/4 (Goldberg and Williams, 2006).

The Outcomes Stars

The Family Star Plus outcomes tool, which is completed with parents is focused on 10 specific areas that can be matched onto the five National Outcomes[10]. It was designed to meet the needs of organisations working in the UK as part of the Troubled Families Initiative, but it has also been used as part of the outcomes evaluation of the Children & Young People's Strategic Partnership in Northern Ireland. The areas covered by the Family Star plus are: physical health, well-being, meeting emotional needs, keeping children safe, social networks, education and learning, boundaries and behaviour, family routine, home and money, and progress domains. Each of these domains is evaluated with a 10-point scale to specify any difficulties that parents may be experiencing in this area and where they consider themselves to be in terms of addressing these issues. The five stages are: (1) Stuck, (2) Accepting help, (3) Trying, (4) Finding what works and (5) Effective Parenting. Although specific figures are not provided, the Outcomes Star Briefing (2014) has suggested that it performs well as a reliable outcome measure, demonstrating good internal consistency, low item redundancy and good responsiveness. The Outcomes Star also has a child-friendly version called 'My Star' and a version for young people called 'Youth Star'. All child and youth participants in the study completed an outcomes tool suitable for their age.

Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a behavioural screening questionnaire that asks questions about 25 different attributes of child behaviour, both positive and negative. The scale is divided into five subscales with five items each, corresponding to conduct problems, hyperactivity, emotional symptoms, peer problems and pro-social behaviour. All, excluding the last one, are added together to provide a total problem scale. This questionnaire has been previously used in outcomes evaluations (Long et al., 2012), and was also recommended as a compatible tool with the Outcomes Stars. It is available in different versions for different ages, starting with three years of age, and it has also been translated into other languages. Depending on the age, children and young people can complete the scale themselves; otherwise a parent or carer needs to provide the information for young people below 11 years. Goodman (2001) demonstrated that the questionnaire had a satisfactory level of reliability based on internal consistency (Cronbach's alpha 0.73), inter-informant reliability (mean 0.34) and retest stability between four and six months (mean 0.62).

2.5.3 Qualitative Data Collection

Qualitative data was collected for this study from children and young people, parents and Lead Practitioners. Data was analysed using thematic analysis (Braun and Clarke, 2006), which is a method to identify, analyse and report patterns (themes) in data and reveal core consistencies and meanings in a text (Buetow, 2010). This allowed the data that was collected to date (until 31 May 2017) to be organised and analysed. The qualitative findings included in this interim report represent the views of children and young people, parents and Lead Practitioners. Semi-structured interviews were carried out with children and young people and their parents focused on their perception of Meitheal, the impact that Meitheal had on their lives and whether or not they received the help they required. Edelbrock and Bohnert (2000) considered face-to-face interviews to be a natural and indispensable method of gaining information about emotional and behavioural functioning, as well as physical health and social relationships in both the past and present. This method of data collection has been very widely used in outcome evaluation research (Xue et al., 2015; Li et al., 2014; Hurley et al., 2012; Brandon, 2011; Canavan & O'Brien, 2005; Fernandez, 2004; Beck, et al. 1998). Interviews were also carried out with individuals who were Lead Practitioners for participating families. These interviews focused on their general experience

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[10] These outcomes are outlined in the Better Outcomes Better Future: The National Policy Framework for Children and Young People 2014-2020 document, which outlines the Irish government's current policy for children and young people between the ages of 0-24. These outcomes are: for children and young people to be active and healthy; achieving full potential in learning and development; safe and protected from harm; economically secure with opportunities and connected, respected and able to make a contribution (Department of Children and Youth Affairs, 2014).

of participating in Meitheal, potential barriers and strengths, and the infrastructure in place to support them. They were also asked questions about the experience of supporting the participating families. All sessions were audiotaped for transcription. Interview scripts and participatory research prompts for children and young people are included in Appendix 2.

2.5.4 Secondary Data Analysis

Researchers also had access to Meitheal databases to obtain socio-demographic data (family name, age, gender, address, nationality, relationship to the child, siblings) and participants' family history in their involvement in child and family services provided by Tusla or partner agencies and services. These databases are exclusively for Meitheal and only contain information included in the Meitheal forms. This information is provided by parents, children and young people in conjunction with their Lead Practitioner. The unique Meitheal identity number that is assigned to each case by Tusla staff was provided to the research team in the UNESCO Child and Family Research Centre. This list was then given to Tusla's Information Officer, who extracted the relevant information from the database and returned it to the research team.

A descriptive secondary data analysis was also carried out to explore and evaluate the impact of Meitheal and CFSNs on the system of help-seeking and help provision by analysing Tusla's Integrated Performance and Activity data between 2014 and 2017, when data was available. This analysis helped identify how the help system has been changed over time and whether any changes have occurred since the introduction of the Meitheal and CFSN model.

2.6 Research Ethics

This study was submitted to NUI Galway's Research Ethics Committee and to Tusla's Research Ethics Committee, and full ethical approval was received from both. Extensive measures were taken to ensure that participants were fully informed about what taking part in the study entailed and their right to decline and withdraw if they so wished. The Lead Practitioner or CFSN coordinator explained the study and gave families the opportunity to ask questions if they wished. Four separate Participant Information Sheets and Informed Consent Forms were designed: for children and young people in age-appropriate formats, and for parents and Lead Practitioners. These can be found in Appendix 3.

In order to protect participants' anonymity, a code was assigned to each case. Along with a number, each type of participant was given a letter. So, for example, Lead Practitioners were coded A, mothers B, fathers C, and children and young people D upwards. These codes were used throughout the data management and analysis, so interview transcripts were immediately anonymised by changing individuals' names to the codes they were assigned. For the purposes of this study, parents are identified in quotations as P, children and young people as YP and Lead Practitioners as LP, in addition to the number assigned to the family. Information from Meitheal databases was exchanged by using participant Meitheal IDs and encrypted data files. Passwords were only released between quantitative database managers in Tusla and the UCFRC.

2.7 Methodological Limitations

The analysis carried out was restricted by the sample size, which was small. Some analyses, particularly non-parametric statistics, could not be carried out because there were not enough people in the groups. A larger sample would allow for the use of parametric statistics throughout and the use of more complex analyses, such as moderation and mediation.

Predictors of family outcomes need to be evaluated in more detail. Due to sample size restrictions, only some variables were included in the model, so it is not fully clear at this stage what role child self-reports of well-being (measured with the Strengths and Difficulties Questionnaire) may have on family outcomes. The sample was too small to be included in the model. Child and youth outcomes need to be evaluated to determine if the predictors of family outcomes are the same as for child and young people's outcomes. Sample size restrictions did not allow such analyses to be carried out.

This report is based on cross-sectional data only; therefore it is not possible to suggest that change over time has happened due to Meitheal. Current associations identified in the data need to be evaluated over time to determine if these are sustained and therefore possibly associated with the model and not resulting from by any other variable.

Data available in the Meitheal databases is incomplete for some of the children and young people; therefore the population profile lacks detail. The researchers had no access to the Meitheal Strengths and Needs forms, as these are not uploaded to the Meitheal database. There were also limitations due to the nature and purpose of the Meitheal database. Currently, this does not act as a case management system meaning that there may still be duplication of data input into the overall Tusla databases, which is not ideal in terms of time and resource usage.

Data available in the Meitheal databases was also incomplete regarding the composition of the CFSNs; therefore it was not possible to provide an accurate description of these networks at a national level. Additionally, interviews with members of CFSNs and coordinators will be carried out in the future and will be reported on in the final report.

The style and content of Tusla Performance Activity Reports have been modified over time; therefore the information and the way it is presented differs over time and not all the data could be followed with the same level of detail. For example, in 2014 child abuse referrals were divided according to the type of abuse, but this information was no longer available from 2015. Some of the data available was also incomplete, so it had to be excluded from the analysis as changes over time could not be reported accurately.

2.8 Conclusion

This chapter outlined the methodology that underpinned this study. It described the aims and objectives and provided an overview of the research design, including the data collection methods, the data analysis and ethical issues. Finally, the methodological challenges and limitations were described.

3

Chapter Three: Qualitative Findings

3.1 Introduction

This chapter explores the qualitative data that has been collected to date in the study. It provides a profile of the participants who are included in these findings, then it discusses participants' views on the overall experience of participating in Meitheal and outlines the perceived impact on families and the system of help provision. It then focuses on the strengths and challenges of the Meitheal model and the topic of participation, including its positive impact and some issues that have arisen with regard to this concept. Finally, it outlines some of the key aspects of the process that are perceived to have helped in the implementation of Meitheal.

3.2 Participant Profile

Participant Type	Male	Female	Total
Children and Young People	8	2	10
Parents/Guardians	1	18	19
Lead Practitioners	0	12	12
Total	9	32	41

Table 3: Profile of Participants in the Qualitative Research Phase

A total of 41 participants were included in this study, with 18 families represented. The discrepancy between the number of families included in the qualitative and quantitative parts of this report is due to a combination of factors. In a number of cases (n = 9), the parent took part but their child(ren) did not. The children and young people ranged in age from 8 to 17, with six aged 8–12 and four aged 13–17. This was because they were either too young, they did not wish to take any part in the study, or they completed the quantitative tools but chose not to be interviewed. In some other instances the qualitative data was not available for analysis prior to the completion of this report. Note that there was a very small number of fathers included in this data analysis. It is expected that these numbers will increase for the final report on this study.

3.3 Overall Experience

Almost all of the participants in this research expressed very positive views about their experience of Meitheal to date. One indicator of parents' satisfaction with Meitheal was that nearly all of this cohort stated that they would be happy to recommend the process to other families. Several commented that they had already suggested the possibility of self-referring into Meitheal to family members and friends. Parents were happy with Meitheal due to the practical supports and services they were provided with, their increased access to support structures that could help resolve their child's issues, and the identification and addressing of individual family members' needs. The benefits of involvement in Meitheal also arose from the experience of participating in it, particularly because of its style of implementation, which was

viewed as empowering and non-judgemental. This also led to a sense of trust in the process and its potential impact.

One important feature of parents' experiences of Meitheal was that it had given them hope that their situations could be improved. In some instances parents' hopes centred on the changes that they desired for their child (such as improved behaviour, reductions in self-harming, better attendance at school) and through this the positive affect it could have on their family:

Well, what I'd hope to see my family in a year's time is working together in a hell of a lot more harmony than they'd be doing now. Just where they can kind of communicate without shouting and roaring, and my child can be basically, how would you say, all round just a calmer person and less angry and less emotional. And I think with him being in that mind space I think it would definitely change the dynamics of the house altogether, you know. So that's the way I see us in twelve months' time. Calmer. (P8)

In other cases parents were optimistic that positive changes would occur in themselves, for example, through the development of stronger support networks and improvements in their parenting skills. A number of parents were hopeful that the Meitheal process could support the entire family by, for instance, helping them to access more secure housing.

Overall it was more difficult to gauge children and young people's satisfaction levels with Meitheal, as some were more focused on the day-to-day experience of, for example, meeting with the Lead Practitioner rather than reflecting on the wider process, while for others their age potentially limited their willingness or capacity to engage on this subject. However, several young people appeared to have found the overall experience of participating in Meitheal to be very helpful. For one young person the team approach that underpins Meitheal seemed to be very important, as it had led to better communication and a more coordinated approach:

Everything works out better than going in separate directions, and that makes a difference. I didn't feel threatened or nothing. I went with, like what are you going to lose? Nothing. You're going to gain something from it, take it, go for it. (YP17)

While children and young people were less vocal about the possible impact of Meitheal, some did express hope that Meitheal would lead to positive changes in their family's lives. These centred on improving their own behaviour, school attendance and performance, as well as making their family happier and changing the atmosphere in the household.

The vast majority of Lead Practitioners who were interviewed for this study had positive attitudes towards the Meitheal process and its potential impact, including those who had been involved in a number of Meitheals and those who were leading their first case. As one Lead Practitioner noted:

You have to do it to see the benefits. You have to see the process, and it does work, like. Even just taking that step and putting the family towards Meitheal, it does work, like. Once you get that first Meitheal over you and you see that process, it's amazing, like. (LP5)
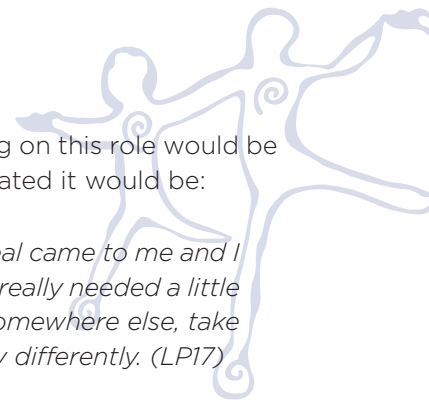
Other Lead Practitioners noted that although they had been unsure of what taking on this role would be like beforehand, they found that it was easier to implement than they had anticipated it would be:

I don't see any drawbacks at the moment, I really don't, because as I said, Meitheal came to me and I was very apprehensive about it, but it came to me at a time with the family that I really needed a little bit; I needed something else to work with them [the family] and to take them somewhere else, take them into the meeting and meet all these other people and to engage the family differently. (LP17)

For another participant, Meitheal was strongly aligned to their model of practice as well as their academic learning:

It sort of feels that it draws in from all of them, the whole strengths-based thing, the strengths-based model, all of that; the environment and supports that are around them. Yeah, it matches very well with my own professional learning, if you know what I mean. So I love working with it, I really do. (LP2)

3.4 Impact of Meitheal

Although the Meitheal processes were at an early stage, many participants already felt that they had begun to have an effect. For some parents Meitheal had an impact on the family beyond the child or children for whom it had been initiated. In one case where Meitheal's holistic approach to meeting a family's needs was emphasised, both the child and the parent had begun to attend counselling. As a result, not only had the child's behaviour started to change, but the parent had begun to use the tools they were given in counselling to react differently to situations:

Myself and my child are attending counselling at the minute, but myself, I'm bringing the tools in that they give me in the counselling, bringing the tools and their ideas and using them in certain situations at home. So that's helping. My child is using his own little skills. So it's definitely changing the dynamics in the house so it's a little bit calmer, quieter. (P8)

Participants believed that Meitheal had an impact on the whole family due to changes that could be brought about, such as access to more secure housing and changes in children's behaviour. Some parents had already noticed improvements in themselves as a result of taking part in the process. These included increased capacity and confidence in parenting skills, greater self-assurance in their communication and interactions with practitioners and other professionals, accessing services to address their own needs, and improved parent–child interactions. For other parents there had been benefits for their children, including, for instance, improved school attendance, better behaviour and greater adherence to boundaries they were set.

Among the child and youth participants, several mentioned that Meitheal had already begun to make a difference. In some cases they directly attributed this to the intervention of the Lead Practitioner, but in general Meitheal was regarded as having helped them to manage their behaviour better, to be more cooperative with their parents, to improve their school attendance and performance, and to regulate their emotions more effectively. As one young person stated:

I was struggling at school and I'm getting better at school. I'm a bit more focused now in school as well. At home; I'm after getting a lot of help at home. I'm after getting; I don't know whether it's counselling or what, but it's something. […] I feel much more; like I don't feel like I'm going to blow a gasket and mill it now, like; if someone annoys me, I'm not going to blow. I'll try to walk away, and sometimes I'll stay there but I feel much better and more relaxed, like. (YP8)

Some also noted that their family life had improved as there was a better atmosphere in the household, with less tension and conflict present.

Lead Practitioners also felt that even at this early stage of the Meitheal processes there had been positive changes for families. In one case the parents and the Lead Practitioner had developed strategies to try to address the young person's lack of attendance at school, which the practitioner felt had already begun to make a difference. By taking a joint approach that involved the parents, the Lead Practitioner believed that the young person was challenged in an effective, supportive manner, resulting in positive changes to their educational performance and the family dynamic. Other participants highlighted reductions in parental stress levels, improved service user–provider interactions, and some progress towards resolving children and young people's unmet needs.

3.5 Impact on the System

Overall, Lead Practitioners suggested that it was too soon to identify changes to the system of help provision resulting from the introduction of Meitheal, but a small number of potential consequences were discussed. In two interviews, Lead Practitioners noted that whereas prior to engaging with Meitheal a parent might have a negative perception of Tusla, a positive experience in this process could change this. In addition, a Lead Practitioner believed that having access to a structure such as Meitheal could reduce the number of families referred into Child Protection and Welfare services, as support could be provided at an earlier stage. Meitheal was also identified as a means of introducing a stronger culture of inter-agency work into the help provision system, which brings with it benefits as outlined below:

I do think that there is something very powerful about bringing those agencies together and those groups of people together, each having their own strand and bringing that together. That's how change can happen. So I would see that as maybe the big thing that Meitheal can bring about. (17LP)

3.6 The Strengths of the Meitheal Process

3.6.1 Relationship Between Families and the Lead Practitioner

One of the most crucial dimensions of the Meitheal process is the relationship between Lead Practitioners and families. Their positive connection usually appeared to be present whether or not they had a known relationship prior to the Meitheal being initiated. This was extensively discussed by parents, who repeatedly noted the importance of the relationship they had with the Lead Practitioner as well as the practical support they provided:

It's just given me more tips and to know that there's somebody there that you can go to and be able to talk to rather than getting a practitioner that you can't relate to. Like we can relate to the Lead Practitioner and she relates to us and explains everything as we're going along. (P3)

One of the key features of this relationship was how empathetic the Lead Practitioners were towards the families, with most parents reporting that they felt supported and understood by them. In addition, the vast majority of parents found the Lead Practitioner to be very accessible and responsive, with several mentioning how easy it was to contact them and how immediate the support they provided was:

They give an awful lot of time, both of them. They always return our calls; if we've anything bothering us they give us the time; we can come over and have meetings with them. They put us in if they can; they help us in the right direction. (P12)
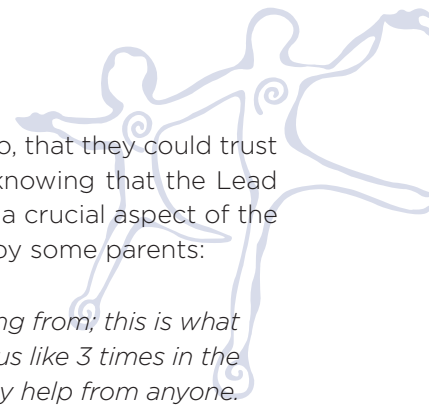
Other key characteristics of the relationship were that most parents felt listened to, that they could trust the Lead Practitioner, and that they could confide in them. For many parents, knowing that the Lead Practitioner was available to talk to and the space they provided for this became a crucial aspect of the whole process. In addition, the Lead Practitioners' reliability was commented on by some parents:

I told [the Lead Practitioner] my situation of this family, this is where we're coming from; this is what happened to us and she's been in contact almost 3 times in the month and visit us like 3 times in the month in this house. [...] And is always telling us give a chat [call] if you need any help from anyone. [P11]

This seemed to have strongly influenced the trust that had built up between the parents and the Lead Practitioners. For example, one parent noted that with other services she had felt unsure that scheduled appointments would actually take place, but she had confidence in the Lead Practitioner because 'she delivers exactly what she says she'll do' (P13). In a number of cases having the kind of relationship with the Lead Practitioner that was outlined here was of great significance, irrespective of what action plan was developed or what service providers engaged with the family. For these parents this relationship was a positive intervention in their lives in itself and had already helped to alleviate their stress.

In general the children and young people who participated in this study were happy with the relationship they had with their Lead Practitioner. Most felt listened to and agreed that they could trust the Lead Practitioner and were comfortable talking to them. One child, for example, stated that they got on very well with their Lead Practitioner because they 'always talk and have fun' (YP13). Children and young people appeared to be particularly comfortable with a Lead Practitioner where they had a prior relationship with them. However, it should be noted that in some cases the children and young people did not as yet seem to have a strong relationship with the Lead Practitioner. This was particularly the case where the Lead Practitioner had had a prior relationship with the parent rather than with them. In these situations, while a strong rapport might exist between the Lead Practitioner and the parents, the same could not always be said of the child or young person. This had potentially negative consequences, as it meant that in some instances the Lead Practitioner and child or young person only met for the first time when the latter's views were being sought for the Strengths and Needs form.

While most children and young people appeared satisfied with their Lead Practitioner, some did not seem to fully trust them. For instance, one younger participant had not discussed their issues in school with their Lead Practitioner, and another did not feel that they had been helped very much. In addition, this young person felt very unsure about what would happen in the Meitheal despite having discussed it with their Lead Practitioner.

Almost all of the Lead Practitioners described the relationship between them and the families as being positive and engaged. Some viewed this as of critical importance, as it ensured that when issues arose the family would engage with them and look for their support. In one case a Lead Practitioner stated that in the initial stages a parent was wary of them because of ongoing negative experiences with other services. However, through the development of this positive relationship, the Lead Practitioner believed that the parent felt supported and that their issues were being taken seriously. In one situation where the Lead Practitioner was known to the family before the Meitheal, the relationship was described as being very strong with a high degree of trust:

From the word go it was very much about working together, and then there was coming to a point that no matter what we were doing, it wasn't going anywhere. Then Meitheal came and I suppose it was a real case that both parents saw that a real need was there for other things to be, to come into play. (LP17)

The positive connection with parents in particular did not always appear to depend on whether the Lead Practitioner was known to the family prior to commencement of Meitheal. In one case a Lead Practitioner described the strong relationship that had developed between them and the family they supported and that they had 'click[ed] straightaway'. One notable feature of the Meitheal process was how parents were actively engaging with and responsive to the Lead Practitioners and the wider Meitheal process, as demonstrated in the following quotation:

She's [the parent] quite friendly, and because she's friendly and she's proactive and she wants to know everything, what her children are doing, what they're up to, who they talk to, who they see. (LP13)

3.6.2 Role of the Lead Practitioner

It was clear from the findings that the Lead Practitioner could fulfil different roles in Meitheal processes. One of these is that the Lead Practitioner can act as a conduit for families to access services they were previously unaware of, with several parents mentioning the benefits arising from this already. This point was confirmed by Lead Practitioners too, as noted by one who stated that she had 'utilised what I've known myself in the locality' to support a young person (LP17). In addition, a number of parents were relieved that they were no longer forced to 'chase' appointments with service providers, as Lead Practitioners were either willing to make contact with agencies or would secure their attendance at Meitheal Review Meetings where arrangements could be made:

For me it's sort of less work and less stress trying to get everyone together, trying to get the services connect together so that they're all working to the same goal rather than me always trying to chase up different appointments and trying to tell them well someone else is going to be doing this; so getting everyone to work together so that it benefits my son more then. (P9)

It should be noted that Lead Practitioners also carried out work themselves that families perceived to be very valuable. In some cases they acted as advocates for the family in their interactions with, for example, housing services; in other cases they were valuable sources of advice that could help the family to manage on a day-to-day basis, or they provided direct support which was specifically tailored to meet the needs of the child or young person, their parents or the family as a whole.

3.7 Challenges to the Implementation of Meitheal

3.7.1 Understanding of Meitheal

A clear challenge that emerged was around families' understanding of the concept of Meitheal. While some parents appeared to be quite clear about the purpose of Meitheal and their role within it, others were not. In some situations this can be partially attributed to the early stage of the process, but it also points to a lack of clarity in how the Meitheal 'message' is conveyed. In a small number of instances it appeared that although parents had agreed to participate in Meitheal, they did not fully understand what they had signed up for, with one parent showing little real understanding of what Meitheal would involve. In fact, this individual seemed to have agreed to participate because of the positive prior relationship they had with their Lead Practitioner rather than because they understood the process or recognised it as a means of helping their family. Another parent also seemed to be quite unsure of what Meitheal was:

Well, from what I've seen, I don't know, I feel like it's some kind of investigation and then balancing things up and then doing a report and then everybody getting together. That's my opinion. (P5)
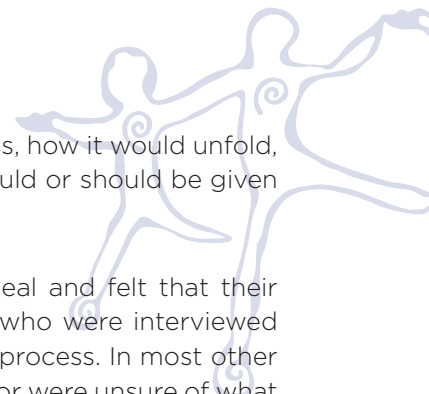
Other parents also appeared to be confused as to their role in the Meitheal process, how it would unfold, the extent to which they were to participate, and the kind of information they could or should be given by professionals who were supporting their child.

While in general children and young people appeared to be happy with Meitheal and felt that their questions about it were answered, only two of the children and young people who were interviewed were confident in their understanding of what Meitheal was and their role in the process. In most other interviews children or young people either appeared to not know what it involved or were unsure of what would happen. In some cases it became clear that Meitheal had not been fully discussed with the child or young person; one young person, who had a prior relationship with their Lead Practitioner, said it had not been explained to them and they did not understand it. They also did not know where to access information on the process and noted that they were further confused because they had recently signed up to start a new course, so it was difficult to distinguish one from the other. This participant had signed several forms relating to both of these, but, in their words: 'I didn't know what it was like, I just did it'. In this instance the young person had agreed to participate in Meitheal as:

> [I am] just doing everything that's been thrown at me like at the moment. (YP7)

Furthermore, the purpose and format of the Meitheal Review Meeting did not always seem to be explained to children and young people. One person stated that they expected it to be like a school meeting where they would be 'roared at', while another expressed consternation at the appearance of some members of their family at it.

Some Lead Practitioners also felt that families struggled to understand the Meitheal process, particularly in the early stage prior to the first Meitheal Review Meeting, as demonstrated in the following quotation:

> I think every family kind of struggles initially until they really see it in action. I think they all struggle to really comprehend it. They tell me they get it but I think when they see after the first meeting, they kind of go, Ah, OK, I get it now. There's a bit of confusion I think with a lot of people; they think it's a service or they think I'm there to fix things. So until they realise at the meeting that no, I'm just there to bring these other people together and we're all there to thrash out some ideas. (LP8)

3.7.2 The Challenge of Meeting Needs

One issue that emerged was tension between the presenting needs identified by parents and their children. In some situations the needs identified by parents appeared to lead to unfair emphasis being placed on children and young people as the source of the family's issues. In one case a parent identified their child as being the cause of the family's difficulties, but the young person noted that they had issues with their parents' behaviour, which had contributed to the challenges they faced. Despite this, at the Meitheal Review Meeting it was the young person who had been given a list of actions to take, with the Lead Practitioner also commenting that the other participants had 'loaded' blame onto them. In another situation a young person appeared to have been given responsibility for resolving their own needs, with no actions directed at their parent despite their own underlying issues. A further challenge to meeting this young person's needs was that their parent expressed concern over their own capacity to even support agreed actions:

> I feel like a bad parent because I'm not able to [say no]. You know, he can throw tantrums; I mean he's not exactly a wee boy, do you know what I mean? I mean I won't say he'd lash out at me, but he'd hurt himself. He'd end up punching doors and punching walls and slamming doors. (P5)

The Lead Practitioner also noted that it would be very difficult for the parent to put the required boundaries in place due to their own issues. Another Lead Practitioner described a Meitheal process where the young person felt that it was the parent who was at the root of their family's issues, which had exacerbated their own difficulties. However, the parent refused to engage in the process any further, because for them it was 'the child's issue', so, as a result, the family withdrew from the Meitheal (LP15).

Some families might also not have the capacity or necessary insight to identify their unmet needs, and could require significant support to reach a point where they would be able to engage in this way. In one case a parent expressed confidence that Meitheal could help their child, as it would enable them to articulate their own needs and to help them participate in developing an action plan. However, their child stated that they did not fully understand the process and in the interview they were unable to say what they wanted to see happen in Meitheal over the coming period.

3.7.3 Availability of Appropriate Services

Despite participants' satisfaction with Meitheal, in some instances it was not certain that a family's unmet needs could be addressed within the processes, particularly where appropriate services were not available to participate. It is clear from the data that Meitheal's effectiveness often depends on the type of needs identified, with, for example, fewer challenges where support was required around parenting, school attendance and improving children and young people's behaviour. However, where there were more complex needs relating to, for instance, disability, housing or mental health, there were fewer resources available to families. In these situations families continued to face lengthy waiting lists for services:

We received a letter from the agency that [the parent] was referred to, and it said we are currently doing the intake for January 2011 and your son is on the waiting list. This was in October of 2016. That is scandalous. (LP10)

Although the parent was appreciative of the support that she was receiving, especially from the Lead Practitioner, she shared similar views:

Like, my son needs a service and he's still not getting it, apart from the help from a child and family project; he's on a waiting list. [...] He's on a two-and-a-half-year waiting list, but it could be longer. (P10)

Another need that was particularly challenging to deal with was housing. Although in some situations appropriate services were participating in the Meitheal and were actively providing support, this was not always the case. Several families were experiencing ongoing difficulties in this area, which was exacerbated by the lack of engagement on the part of relevant agencies.

3.7.4 Engagement by Services with Meitheal

Although both parents and Lead Practitioners agreed that there was noticeably positive engagement by many professionals within individual Meitheal processes, engagement continues to be uneven across the system of help provision and geographically. For example, in some areas representatives from local authorities were participating in Meitheal processes, but in others they did not appear to fully value the process, as they failed to attend meetings that they had agreed to participate in. Part of the challenge around engagement was identified as lack of awareness of Meitheal's existence, while the unwillingness of some services to work together was also highlighted. Difficulties in securing support from all relevant professionals for a Meitheal was identified by Lead Practitioners as one of the most significant challenges in the process. Concerns were raised that families would eventually lose interest and that a Meitheal's efficacy would be limited, as action plans could not be developed to address all unmet needs that were identified.
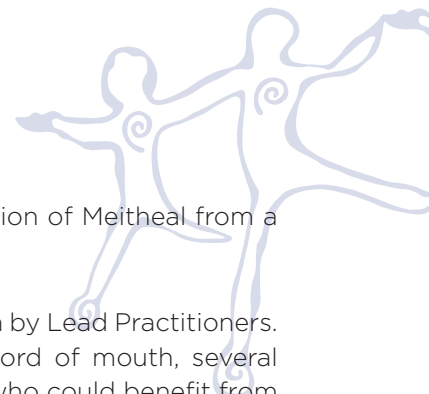
3.8 Barriers to Implementation

Lead Practitioners identified a number of barriers to the successful implementation of Meitheal from a service provider point of view:

- Awareness of Meitheal among the general public was identified as a concern by Lead Practitioners. While they believed awareness was gradually beginning to spread by word of mouth, several Lead Practitioners pointed out that this was not enough to reach families who could benefit from participating in Meitheal but who were unaware of its existence.

- The workload associated with Meitheal, particularly in relation to the completion of paperwork and the coordination of meetings, was viewed as a challenge by some Lead Practitioners.

- There is a lack of practitioners willing to take on the Lead Practitioner role.

3.9 Participation

Parental participation emerged as a significant feature in the implementation of Meitheal, with strong evidence of its integration into individual processes and across the system. A number of parents who had previously been involved with services argued that taking part in Meitheal was a very different experience because of the extent to which they and their children could participate in the process, how their views were listened to and the control they could exert over how their family's issues were to be resolved. Similar views were expressed by Lead Practitioners:

I think families love that part; it's all about them and the child and hearing their voice, whereas I think in a lot of other services professionals can kind of take the lead too much. It's more about what they think the family need. (LP8)

Parents' participation included identifying their family's needs, completing the Strengths and Needs form, discussing who should be asked to participate in the process, giving active input into the Meitheal Review Meetings, and having clearly identified tasks in the action plan. For some parents their control was demonstrated by how their family's needs shaped the Meitheal process rather than being driven, for example, by what the Lead Practitioner believed should be prioritised. This control appeared to increase the quality of their experience of the help provision process. Other parents were happy that through the Meitheal mechanism they could control the pace of service delivery to their family:

With Meitheal you can't, Rome wasn't built in a day; you have to do it in like a stepping process, and that's what we're getting and that's what I like about it – that it's not, there's not too much of an overload, too much to take in at once. You can speed it up if you want, you can slow it down if you want; you're in control. (P2)

Lead Practitioners appeared to play a crucial role in enabling parents to participate in the Meitheal process. Their role included supporting and encouraging parents' participation through, for example, explaining in detail what would happen in the process and facilitating their involvement in the Meitheal Review Meetings. As part of this they strongly advocated for parental participation in the process and understood its importance:

So once she knows she has some element of control and then she knows she can stop that at any time if she wants to. She can say, No, I don't want to any longer take part. But I think that's a great, that's a bonus for her. (LP12)

For several Lead Practitioners, the control that parents could exert made a significant difference to the nature of their engagement:

They [parents] really embrace it when they're given that space to take charge or voice what their own needs are from their own perspective. (LP2)

While most parents seemed to be actively and authoritatively participating in Meitheal, this was not universal, as a small number did not appear to be centrally involved in the process. In these instances it appeared that either parents had received insufficient information about how the Meitheal would be implemented, or the agenda for the Meitheal Review Meetings was not discussed with them prior to their taking place. In other situations, parents did not seem to have played proactive roles in the creation of action plans, or professionals and practitioners did not actively engage with them subsequently:

I don't know if it's a thing that Meitheal is helping with him, because we haven't heard from the school. [...] Is there stuff I'm supposed to continue at home? [...] I don't know then am I supposed to be practising those [techniques] with him as well. (P14)

Overall, while there seemed to be reasonably good levels of participation among the children and young people who took part in this study, they appeared to be less centrally involved than their parents. Child and youth participation manifested itself in various ways, including feeling listened to, input into what services were invited to participate in the process and having the opportunity to attend Meitheal Review Meetings where they had the chance to express their views. Efforts were made by many Lead Practitioners to include children and young people in the process, for example, by sharing information with them and updating them on what was taking place. Parents were supportive and appreciative of these efforts:

But it was offered that we could meet somewhere else if he was more comfortable but he was happy enough for me to come along [to the Meitheal Review Meeting]. But I thought it was lovely that he had the option; he knew he had the option (P18).

A number of Lead Practitioners stated that supporting children and young people's participation was very important to them. Their attitudes towards this appeared to be empathetic and cognisant of both capacity and willingness to engage:

I would always present to a family in terms of them being the experts of what they need in their family or what they feel the young person needs. I also talk to the young person in the same way. (LP2)

This was motivated in part by the belief that through, for example, completing the Strengths and Needs form with them, they could gain greater awareness of children and young people's views on their own and their family's needs. In addition, Lead Practitioners argued that the process of participating could begin to help children and young people:

The value of working with networks is the child gets to hopefully [in] a non-threatening way to see how other people perceive them, what their strengths are, what their difficulties are, what they can work on, what the Meitheal shows where improvements can be made and how it can be attained. (LP14)

The extent to which Lead Practitioners included children and young people in the Meitheal process in part seemed to depend on how much involvement they wanted themselves. In some instances children and young people chose not to actively engage but were kept informed about the process, while in

others they helped to complete the Strengths and Needs form but chose not to attend the Meitheal Review Meetings. Yet more children and young people had been supported to take a full and active part in these meetings and in discussions about the family action plan.

While it was clear from all the interviews that efforts were made to ensure that children and young people participated in Meitheal to some degree, in several cases the kind of relationship between them and the Lead Practitioner that could facilitate meaningful engagement had not yet developed. In some situations Lead Practitioners had had minimal contact with children or young people, either because they did not know the family prior to Meitheal or because their main focus had been on working with the parents. In these cases, while relationships with parents were described as positive, contact with children and young people was sometimes limited to completing the relevant parts of the Strengths and Needs form. In addition, how much information was shared with the child or young person and, crucially, when it was shared, varied from family to family. Some children and young people, even where they were of an appropriate age, had not been included in the discussion about whether to participate or not or were asked their opinion after their parents had agreed to the Meitheal's initiation. In other instances, young people did not seem to have been included in the decision on who should be invited to the Meitheal Review Meetings, as in their interviews they mentioned the attendance of individuals who they had difficult relationships with.

While some children and young people appeared to have positively participated in the Meitheal Review Meetings, there is cause for concern, as a child-centred approach was not always taken at them. Several young participants stated that while they felt listened to, they were also uncomfortable at the meetings largely because of the attitude of some practitioners and professionals who were stern and wanted to reproach them rather than engage in meaningful dialogue. In one interview a young person described feeling frustrated, angry and under pressure during the meeting. This view was supported by their parent, who stated that the atmosphere was 'harsh' towards their child and that '[my child] was sliding down the chair as people was talking' (P5). These issues appear to be linked to how other individuals involved in the process understand and interpret children and young people's attendance at the meeting. In some cases interviewees noted that certain participants attended meetings with the intent to express their anger about a child or young person's behaviour, or to show that they were in control.

3.10 What Helped in the Meitheal Process

There were a number of factors which contributed to the positive perceptions of being involved in the Meitheal process. These factors relate to both external structures and systems, the process associated with the model and the supports provided to Lead Practitioners.

3.10.1 External Structures

The multi-agency approach embedded in Meitheal was regarded as a very useful aspect of the process, for the following reasons:

- In some cases families began to access services that would not have been available to them otherwise. This enabled them to begin to address a broader spectrum of needs across the family in a holistic manner.

- It allowed Lead Practitioners to focus on supporting families within their own area of expertise and facilitated easier communication with other service providers.

- It prevented duplication of work, highlighted gaps in the services being provided to a family, allowed more tailored supports to be put in place, and increased awareness among practitioners of the work others were doing.

- Multiple perspectives could be gathered about a child, young person or family from a range of contexts, including environments where they might be more positively or negatively engaged than others. This allowed a broader overview to be developed of a family's needs and, just as importantly, strengths.

- For parents the multi-agency approach helped to reduce their sense of isolation and stress, particularly where their family's issues were complex and multifaceted.

- This approach was perceived to differ from prior experiences of services, where parents were often required to act as the information conduit between agencies who were working with their family.

Overall, parents viewed the relationship with other service providers who were involved in their Meitheal to be very helpful. A number of parents commented on the understanding and supportive attitude that participants displayed towards them, particularly at the Meitheal Review Meetings. One parent felt that she could completely trust the practitioners who were involved with Meitheal:

Because I knew what they want is what I want and the best for my child, you know what I mean? So if they didn't care, they wouldn't have came, you know what I mean? And as I said, I just trust them, I do, 100 per cent, like. (P6)

3.10.2 The Meitheal Process

There were a number of specific aspects in the Meitheal process, which participants found very helpful. These included the Meitheal Review Meetings, the timeliness of the response, the voluntary nature of their participation and the fact that family members did not have to repeatedly recount their circumstances.

Despite the issues, which emerged in the data around children and young people's participation the Meitheal Review Meetings were viewed by a number of participants to be one of the most positive aspects of the model in how support could be provided to families:

- **They acted as the mechanism within which the multi-agency approach could be put into effect with optimal efficiency.**

- **They provided a forum for all relevant individuals – whether from within the family or from the service provision community – to hear each other's views and, consequently, to collaborate in developing an action plan to help resolve unmet needs.**

- **They improved the coordination of services and the speed at which supports could be put in place for families.**

- **The meetings appeared to help improve the flow of information, particularly from service providers to parents, as the latter had the opportunity to directly ask questions and be part of the conversation around their child to a greater extent.**

- **The Meitheal Review Meetings were believed by some participants to have increased practitioners' accountability towards families and other service providers because the nature of their contact had changed.**
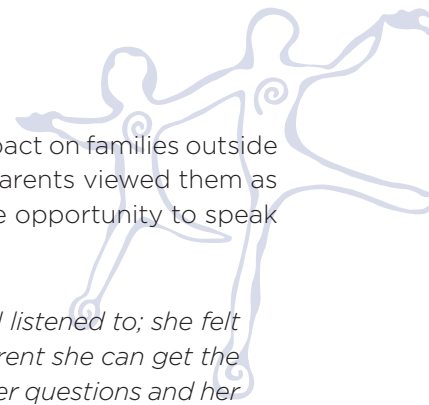
Several participants noted that attending these meetings could have a positive impact on families outside of any supports that were arranged through them. Both Lead Practitioners and parents viewed them as very empowering experiences in that families, particularly parents, were given the opportunity to speak up and be listened to:

She felt really patronised [in a previous interaction with services]; she didn't feel listened to; she felt that they looked down on her. She didn't feel she had a voice [...]. So, like the parent she can get the professionals sitting around a table and that they will have to listen and answer her questions and her queries in a respectful manner. And I think that for my parents is huge. (LP10)

Some Lead Practitioners argued that families could become more open to engaging with service providers as a result of seeing what supports were actually in place and how many practitioners and professionals were keen to help them. Indeed, after attending one meeting, a young person had already reached this conclusion:

I said, ah if all these people around me are trying to help me, I should actually do my part of it, because they're all concentrating on me. It would be a waste of time for them for me doing nothing of what they're trying to achieve with me. (YP17)

One notable aspect of the Meitheal processes that were included in this study was the promptness of the initial contact by either the Lead Practitioner or the CFSN coordinator, and how quickly the Meitheal was then initiated. Most parents mentioned that the Lead Practitioner had been in contact very quickly to start the process:

They brought her on to a meeting say of a Wednesday and she [the Lead Practitioner] was with me then the following week. No, they just asked me one week and I said yeah, and then they brought her to me then the following week. So I wasn't long waiting for her. (P19)

In some cases parents and young people were very surprised at the speed at which the Meitheal had begun, as this was not reflective of their previous engagement with service providers. This appeared to have increased confidence in the process, as it was perceived to be a good indication of how Meitheal would be implemented.

The voluntary nature of Meitheal was viewed as a beneficial aspect of the process by some parents. The fact that they could withdraw from it whenever they wished was perceived to have increased their sense of control:

You could do it [Meitheal], participate or not participate, and it didn't affect you in any way [...]. Yeah I like that it's voluntary, that you can stop it even if you're half way through a process, you can stop it. (P2)

This is a point with which some Lead Practitioners agreed:

I suppose it's good in the sense that it's voluntary and the family; the first thing you say is it's voluntary, you don't have to do this. (LP8)

Voluntary participation in Meitheal was also believed to reduce anxieties, especially about attending the Meitheal Review Meetings, because they could be stopped at any point if they became too overwhelming or if family members became upset.

A feature of Meitheal that parents found helpful was that they only had to tell their story once to the Lead Practitioner, rather than having to repeat it many times. This reduced their stress levels, as retelling their story was often distressing and uncomfortable where very intimate personal details had to be repeatedly shared (for example, in non-clinical settings with no purpose other than to secure an appointment). These were one parent's views on the subject:

> *You don't have to meet everybody individually; the fact that we went and, you know, pouring out your heart for an hour and a half and you're going around doing it the whole time. So you can go to one person […], explain everything that's been going on with everybody in the house. (P16)*

### 3.10.3 Supports Available to Lead Practitioners

One finding that emerged in the Lead Practitioners' interviews was that they felt quite supported in their participation in Meitheal. A number of participants stated that their managers or supervisors were very supportive and could be relied on as sources of advice and to help with case management where required. Others noted that their local CFSN Coordinator was very important in this regard, as in some situations they shared in Meitheal coordination duties and in others acted as mentors. These were one participant's views on the subject:

> *The CFSN Coordinator is, for me right from the moment I met her at the training and right through, I just know that if I have an issue or a problem I can pick up the phone. I have spoken to her about one or two things and it's been clear from her. I find her very, very good. (LP17)*

While Meitheal chairpersons were not extensively discussed, they were perceived to play an important role in managing Meitheal Review Meetings, as they could give direction to them, facilitate appropriate engagement with families and enable the Lead Practitioner to concentrate on supporting the family.

In general the Meitheal standardised training that Lead Practitioners attended was viewed positively, as it was regarded as providing useful skills and knowledge on implementing the model. However, there were some issues identified in relation to this. Firstly, the length of time between the training taking place and the first Meitheal could mean that key implementation points would be overlooked. Secondly, the need for ongoing support after training was noted, as this could help to reduce isolation and improve confidence levels among Lead Practitioners in their capacity to take on this role. Thirdly, a small number of participants noted that further training on supporting families to complete the Strengths and Needs form would be beneficial.
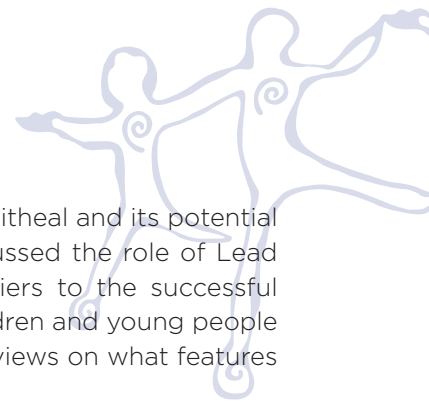
3.11 Conclusion

This chapter focused on participants' perceptions of the overall experience of Meitheal and its potential impact on outcomes for families and the system of help-provision. It also discussed the role of Lead Practitioners, including their relationship with the family. Challenges and barriers to the successful implementation of Meitheal were then outlined. Participation by parents and children and young people was also explored, and the chapter concluded with a discussion of participants' views on what features of Meitheal were helpful from the perspective of families and Lead Practitioners.

Overall, most participants were satisfied with their experience of Meitheal. Many participants felt that unmet needs had already begun to be addressed, including the needs of specific individuals and the overall family. The process of participating in Meitheal was also viewed positively, as it was perceived as, for example, having empowered parents to work with practitioners and professionals to resolve their family's issues.

The relationship between the family and the Lead Practitioner is a crucial feature of the Meitheal process. The Lead Practitioner's empathetic and facilitative approach can increase levels of trust and contribute to greater engagement on the part of families. Lead Practitioners appear to have flexible roles that encompass advocacy, direct work with families and coordination of service provision frameworks, depending on what is required in each case.

However, challenges to the implementation of Meitheal remain, including parents' and particularly children and young people's understanding of the process and tensions over the identification of needs. In some Meitheals there continue to be issues with engagement by service providers and professionals and delays to the provision of support because of resources being unavailable. There are barriers to implementation such as lack of public awareness, Lead Practitioner workload, and the reliance on a small number of individuals willing to take on the role.

Parental participation in Meitheal is well facilitated, and there was evidence that children and young people had some opportunity to take part in the process. Nevertheless, challenges remain around children and young people's engagement with the process and how they are perceived and responded to by other participants, especially at Meitheal Review Meetings. This chapter highlighted the importance of avoiding the burden and blame on families and young people about the difficulties they face as this may have a negative impact on the relationships between families and practitioners which can have detrimental effects on the provision of help.

Helpful features of the Meitheal process include its facilitation of a multi-agency response, the Meitheal Review Meetings, the speed of service delivery and its voluntary nature. Lead Practitioners appear to have access to support from their managers and CFSN Coordinators, which increases their confidence levels and the effectiveness of their work. It is very relevant that this study found a lack of services particularly those more specialised services needed to target children with additional needs. The impact of Meitheal is currently challenged by this and the help provided that families require will be limited by the lack of services available, rather than lack of efficiency or the implementation of the model.

4

Chapter Four: The Impact of Meitheal on Child and Family Outcomes

4.1 Introduction

This chapter provides a socio-demographic profile of the children, young people, parents and guardians included in this interim report. The aim of this chapter is to report on the impact of Meitheal on outcomes for children, young people and families. This analysis is only a description of the profile of children and families at the time of engagement into Meitheal; The data is cross-sectional.

The chapter includes an overview of the level of outcomes, parental well-being, child well-being and model fidelity at Meitheal intake to gain a more in-depth understating of the characteristics of the sample.

Additional analyses were carried out to understand the differences in outcomes per age, gender, region, model fidelity and reason for Meitheal initiation. This analysis contributes to determining if these were significantly different in the Meitheal sample with the objective of gaining a more in depth understanding of participants' profiles according to their socio-demographic characteristics and geographical locations. The purpose of this was to identify possible patterns in outcomes at the onset of Meitheal and determine differences at a national level.

One of the main objectives of this research is to determine the impact of Meitheal on outcomes for children, young people, parents and guardians. To gain a better understanding of outcomes an explorative analysis was carried out to identify the main determinants of variance in family outcomes. This analysis provides a deeper understanding of how different family members' well-being impacts on the overall outcomes of the whole family and how the well-being of one member influences others and their own reported outcomes.

4.2 Description of the Sample

In total the 106 participants are represented in this sample. The data included in this quantitative analysis is based on 40 children and young people between 0 and 17 years of age; the mean age is 10 years nationwide. These children and young people correspond to 35 participating families; five of the families have two children in separate Meitheal processes. A total of 72.5% (n = 29) of children and young people in the sample are male. Data from 41 parents and 25 Lead Practitioners is also included. It is worth noting that only the first 18 families were included in the qualitative study; the quantitative sample includes an additional 17 families.

Regarding Tusla ISAs involved in the study, Dublin North City (22.5%) has the largest number of participants, followed by Dublin South-East Wicklow (20%) and Mayo (17.5%). The region with the highest number of participants in the study is the West (32.5%).

The most common initiation pathway was direct access (57.5%) followed by social work diversions at 20%. Regarding the main reason for initiation, emotional (22.5%) and behavioural issues (20%) were in the majority.
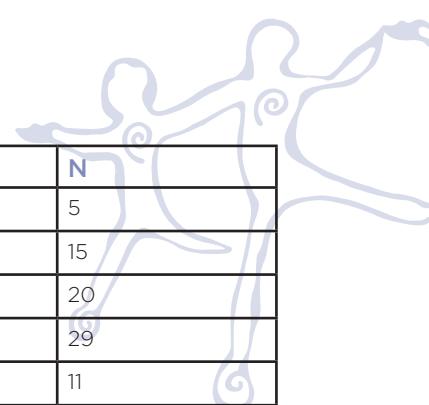
		N
Age	0–5	5
	6–10	15
	11–18	20
Gender	Male	29
	Female	11
Tusla ISA	Dublin South East/ Wicklow	8
	Dublin North City	9
	Louth/Meath	2
	Carlow/ Kilkenny/ South Tipperary	5
	Waterford/Wexford	3
	Galway/ Roscommon	4
	Mayo	7
	Donegal	2
Tusla Region	DML	8
	DNE	11
	South	8
	West	13

Table 4: Socio-Demographic Characteristics of the Sample

Request Source[11]	Tusla social work	8
	Adolescent/youth	2
	Community-based Family Support	8
	School	1
	Other	4
	No information provided	9
	Tusla Family Support	6
	Tusla other	2
Initiation Pathway	Social work diversion	8
	Direct access	23
	Social work step-down	2
	No information provided	7
Reason for Meitheal (Primary)	Emotional issues	9
	Behavioural issues	8
	Educational issues	4
	Financial/housing difficulties	4
	Social isolation	2
	Relationship issues	1
	Parenting support	2
	Family issue	1
	Physical illness/disability	1
	Learning disability	1

[11] Request source refers to the person/ organisation that completed and submitted the Meitheal Request Form.

Reason for Meitheal (Secondary)	Emotional issues	5
	Behavioural issues	8
	Educational issues	4
	Financial/housing difficulties	2
	Social isolation	2
	Parenting support	3
	Mental health issue	3
	History of domestic violence	2
	Other	1
	No secondary reason	3
	No information available	7

Table 5: Meitheal Request Sources, initiation Pathway, and Reasons for Meitheal

Meitheal request sources varied, with Tusla social work and Community based Family Support the most common, although information was not always available. The majority of Meitheals were initiated through Direct access and the most common reasons for initiation were emotional and behavioural issues.

		N	Mean	SD
My Star		10	32.1	3.7
Youth Star		11	20.3	6.0
Family Star		40	69.4	14.1
GHQ Mother		37	4.3	3.2
GHQ Father/other		4	4.8	4.3
SDQ Mother		33	18.5	6.6
SDQ Father/other		4	15.8	16.9
SDQ Self-Report		12	16.9	5.1
Fidelity	Low (1–8)	0	16.7	4.1
	Medium (9–17)	14		
	High (18–26)	13		

Table 6: Summary of Quantitative Scales

4.3 Descriptive Analyses of Quantitative Measures

4.3.1 Outcomes

Family outcomes were measured with the Family Star Plus. The maximum score that can be obtained in this scale is 100[12]. The mean score for families taking part in the study was 69.4. A total of 15% of the families obtained a score below 50.

Outcomes for young people were measured with the Youth Star. The maximum score for this scale is 30. Eleven young people completed the Youth Star; of these, 18.2% (n = 2) reported scores below 15. The average score was 20.3.

Children reported their outcomes using the My Star. The maximum score a child can obtain in this scale is 40. All children had scores above 20, and their average score was 32.1.

4.3.2 Parental Well-Being

Parental well-being was measured using the General Health Questionnaire (GHQ). This is a diagnostic scale and the cut-off score is four, suggesting that people with a score above this may be experiencing additional needs or issues. The majority of mothers in the sample (59.5%) obtained a score of 4 or below, which means 40.5% are at a risk of having additional needs or difficulties. Most carers and fathers (75%) reported scores of 4 or below, and only one scored more than 4.

4.3.3 Child and Young Person Well-Being

Child and young person well-being were measured using the Strengths and Difficulties Questionnaire (SDQ). For the purposes of this study, the total difficulties score was calculated. In the parental/other completed version of the SDQ, a score of 0–13 is close to average, 14–16 is slightly raised, 17–19 is high and 20–40 is very high. In children and young people's self-reports, 0–14 is close to average, 15–17 is slightly raised, 18–19 is high and 20–40 is very high.

Overall, maternal scores on the SDQ were the highest, with an average of 18.5. Children and young people self-reports showed an average of 16.9, which is slightly raised. Father/other reports were the lowest, with an average score of 15.8, which is slightly raised and corresponds with the category of children and young people's self-reports.

4.3.4 Model Fidelity

Model fidelity was measured using the Fidelity Checklist. This determines how closely the model principles and stages were followed during the Meitheal process. The maximum score that can be obtained is 26. The average score obtained by participants was 16.7, but this is due to the data collection taking place early on in the Meitheal process; a low score is therefore inevitable, since certain stages have not been completed[13].

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[12] The Family Star Plus does not have standardised cut off scores. For the purposes of this analysis the median was used as cut-off score to divide families into higher scores and lower scores. Higher scores represent better outcomes

[13] The Meitheal Fidelity Checklist consists of three sections: planning, discussion and delivery. The third section is non-applicable at the very early stages of the process as delivery is ongoing or has just commenced.

4.3.5 Age and Gender Differences

Differences in outcomes and well-being were subject to statistical analyses to determine if there were significant differences according to the age and gender of children. For the purposes of the analyses, only GHQ and SDQ maternal scores were used, because the number of other respondents was very small. To carry out a one-way analysis of variance[14] (one way between groups ANOVA), age was converted into a variable with three groups (0–5, 6–10, 10–18) to facilitate the analysis. Gender was evaluated using an independent sample t-test. Non-parametric[15] equivalents of these tests were used for My Star, Youth Star and SDQ self-reports, as the number of respondents was small. No significant differences were identified.

	Age	Gender
My Star	0.57	-0.92
Youth Star	Analysis not possible	0.00
Family Star	0.02	0.52
GHQ Mother	0.87	0.52
SDQ Mother	0.47	0.21
SDQ Self-Report	0.29	Analysis not possible
Fidelity	3.2	0.40

*Significant at ≤ 0.05

Table 7: Differences in Scores by Age and Gender

4.3.6 Differences Per and Primary Reason to Initiate Meitheal

Further analyses were carried out to determine if there were statistically significant differences per region in the profile of participants involved in the Meitheal process.

|	Region[16]	Primary reason**	Initiation pathway
My Star	0.99	0.04	1.44
Youth Star	4.95	0.36	N/A
Family Star	5.67*	1.6	2.29
GHQ Mother	1.04	1.1	0.16
SDQ Mother	1.79	1.4	0.34
SDQ Self-Report	0.73	0.11	1.58
Fidelity	0.66	0.12	4.4*

*Significant at ≤ 0.05

**The primary reasons for the initiation of Meitheals was recoded into three groups to facilitate the analysis: Emotional, Behavioural and Other.

Table 8: Differences in Scores by Region, Reason for Initiation and Initiation Pathway

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[14] Analysis of variance compares the variability of scores between and within different groups to determine if the means are significantly different.
[15] Non-parametric statistics are not based on probability distribution, therefore they do not assume that the population fits any parameter of distribution and are therefore more suitable for smaller samples.
[16] Regions refer to Tusla regions: DML, DNE, South and West.
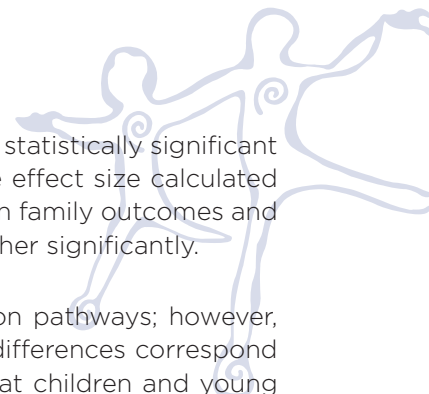
Significant differences were identified in family outcomes per region. There was a statistically significant difference in mean scores between the West and DML, DNE and the South. The effect size calculated was 0.3, which is a large effect, which means there is a strong association between family outcomes and the region where participants come from, with both variables influencing each other significantly.

Significant differences were identified in fidelity levels, according to the initiation pathways; however, post-hoc analysis could not be carried out and therefore it is not clear if these differences correspond to the data or limitations in the sample size. Graphical representations show that children and young people who entered Meitheal through direct access have a higher mean of model fidelity. This needs to be evaluated with a larger sample size over time, to determine if the significance of difference in fidelity according to initiation pathways remains and can be confirmed. Significant differences were not identified according to the primary reason to initiate Meitheal.

4.3.7 Differences Per Model Fidelity

For the purposes of this analysis, fidelity was divided into two variables, 1–13 and 14–26. As no Meitheal processes with low levels of fidelity were identified, this category was excluded and independent sample t-tests[17] were carried out; corresponding non-parametric measures were applied for My Star, Youth Star and SDQ self-reports.

	Model Fidelity
My Star	-1.358
Youth Star	-1.537
Family Star	3.52
GHQ Mother	0.42
SDQ Mother	0.03
SDQ Self-Report	-2.095

*Significant at ≤ 0.05

Table 9: Differences in Scores by Level of Fidelity

Statistically significant differences were identified in child and youth SDQ self-reports. The median score for the 1–13 group was 23.50 and the median for the 14–26 group was 17. The self-reported scores on the SDQ are statistically significantly higher for the 1–13 group, which suggests that this population report significantly lower levels of well-being than the 14-26 group, as measured by the SDQ.

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[17] T-Tests are carried out to identify statistically significant differences in the values of a continuous variable for two groups.

4.4 Exploring Predictors of Family Outcomes

Hierarchical multiple regressions were used to explore the variables that may be having an impact on predicting family outcomes[18]. In this model, model fidelity was introduced as a first step, as theory suggests that higher model fidelity can lead to higher outcomes for families that are involved in programmes (Gould et al., 2015 Berkel et al., 2011; Forgatch et al., 2005). Maternal GHQ was entered as a second step to evaluate the impact of maternal well-being, as parental outcomes have an impact on child outcomes (Miller et al., n.d.). Maternal SDQ was entered at the third level, as this is a maternal report of their children and in the descriptive analysis it varied from children and young people's self-reports. This means that the accuracy of these reports needs to be carefully considered.

Predictors	Family Outcomes					
	R^2	Adj R^2	R^2 change	Sig F Change	ß	Sig.
Model Fidelity	0.001	-0.052	0.001	0.902	0.070	0.751
Maternal GHQ	0.243	0.159	0.242	0.027*	-0.513	0.030
Maternal SDQ	0.248	0.115	0.005	0.738	0.074	0.738

*Significant at ≤ 0.05

Table 10: Predictors of Family Outcomes

After maternal GHQ is entered, the overall model explains 15.9% of the variance in family outcomes. After maternal SDQ is entered, the model explains 11.5% of the variance, which explains 4.4% less. Beta values show that maternal GHQ is the only variable that makes a significant contribution to variance in family outcomes; maternal SDQ and model fidelity do not make a unique contribution and are therefore not related to family outcomes. This means that the only variable, which significantly predicts or explains family outcomes is maternal well-being.

4.5 Findings

The majority of respondents (75%) that completed the Family Outcomes Star reported scores above 50; however, 15% reported scores below 50, suggesting that these parents/guardians had a perception that they may have additional needs or difficulties. The majority of young people reported outcome scores above 50% of the possible maximum score they could obtain; two of them reported lower scores. Overall, parents/guardians, children and young people report outcomes above 50% of the total scores they could obtain, but a few seem to be in more vulnerable situations and may require additional supports. It may be particularly important to follow these vulnerable families over time to determine if Meitheal can successfully provide for their needs.

Regarding parental well-being, as measured by the GHQ, the majority scored at the threshold or below. However, a large number of mothers (40.5%) may be experiencing additional issues. This is important to consider, as not only do children and young people in a Meitheal have needs but also their mothers may need to be supported for a Meitheal process to be successful.

Discrepancies were identified between maternal reports and child/youth self-reports of well-being. Maternal average scores are high, while self-reports were only in the slightly raised category. Average scores of child/youth well-being show that children and young people in a Meitheal have needs and issues that they require support for, their well-being is not optimal, and their needs are above average compared to the norm.

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[18] Regressions are used to explore the relationship between one continuous dependant variable and a number of independent variables or predictors. In hierarchical regressions variables are entered in steps or blocks in a predetermined order, which has the effect of statistically controlling for these variables, to determine if the new block of independent variables are still able to explain some of the variance (change) in the dependent variable.
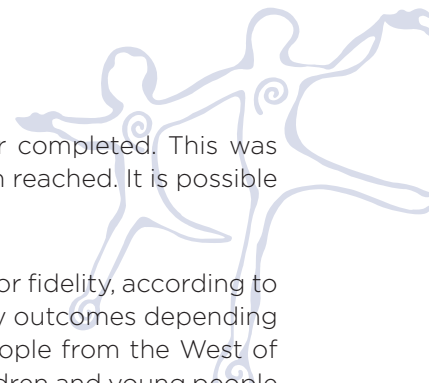
Model fidelity was between medium and high, but it was never fully applied or completed. This was expected, as early on in a Meitheal process some of the stages may not have been reached. It is possible to suggest that fidelity will increase over time as the processes develop.

No differences at entry to Meitheal were identified between outcomes, well-being or fidelity, according to children/young people's age and gender. Differences were only identified in family outcomes depending on the region of origin. This effect was particularly high. Children and young people from the West of Ireland have significantly lower levels of family outcomes (mean = 58.08) than children and young people in the other three regions. In DML this was 75.38, in DNE 74.91 and in the South 74.25. It is important to note, however, that the West is the region which has provided the largest number of families for the study, which may have an impact on the findings.

Regarding Meitheal model fidelity, higher fidelity showed that children and young people self-reported lower scores on the Strengths and Difficulties Questionnaire, which may suggest that higher model fidelity has a positive impact on children and young people's well-being. Additionally, differences were identified between model fidelity and initiation pathways; however, these will have to be confirmed over time.

Maternal well-being (GHQ) was identified as the most significant predictor of family outcomes. Model fidelity and maternal reports of child well-being do not make a significant contribution to family outcomes; however, this model needs further exploration with a larger sample size as regression analyses are sensitive to sample size, small samples may not generalise with other samples.

4.6 Conclusion

This chapter provided an overview of the level of outcomes that children, young people and families have at the early stages of a Meitheal process. Overall, it can be suggested that the levels of need are appropriate for the Meitheal model, as the majority of families seem to report outcomes between medium and higher levels at the beginning of the Meitheal process. There are however a small number of families that reported between medium and low levels of outcomes at the start of Meitheal, this suggests that they may require further attention and more detailed evaluation of their needs to make sure Meitheal is the suitable pathway to provide for their needs.

This chapter emphasises the importance of a holistic approach to needs evaluation and also in the development of action plans and subsequent provision of support, as it is clear that the needs of one family member can have an impact on the well-being of other family members. Of particular importance is maternal well-being, as this study identified that mothers report lower levels of well-being and that this is a significant predictor of family outcomes.

Significant patterns are emerging in the data regarding model fidelity; however, this needs to be evaluated over time to determine whether the impact of fidelity is sustained over time. Model fidelity is lower in the early stages of the Meitheal process; these differences may or may not be sustained at higher model fidelity.

Overall, findings were limited by a small sample size, and therefore a combination of parametric and non-parametric statistics had to be used. More complex analyses were not possible; therefore, it is crucial to increase and improve recruitment to be able to understand in more depth the impact of Meitheal on family outcomes. The findings suggest that the scales and questionnaires used in this study as outcomes measures are suitable to screen the well-being and also the needs of Irish children, young people and families accessing Tusla services.

5

Chapter Five: Meitheal and the
Help-Seeking and Help-Provision Context

5.1 Introduction

The aim of this chapter is to provide a contextual overview of the help-seeking and help-provision system in Ireland and to determine if and how the introduction of the Meitheal and CFSN model has changed the provision of help over time. The research aim underpinning this analysis is: 'Evaluate the impact of Meitheal and CFSNs on the system of help-seeking / help provision'.

The sources of data in this chapter are the Tusla Performance Activity Reports between 2014 and the end of 2016. A secondary, longitudinal data analysis was carried out on the data to determine possible changes over time in the said time period. Data specifically selected for this analysis included the number of children in care, number of foster carers, number of social work[19] referrals (child welfare concerns and child abuse), time waiting for allocation of referrals (high, medium and low priority), referrals to family support services, and Meitheal and CFSN statistics from 2015 to 2017. All of this data is presented at a national and a regional level.

5.2 Descriptive Longitudinal Analysis of the Help Provision System

5.2.1 Children in Care (National)

The number of children in care decreased from Q1 2014 to Q4 2015. Although there was an increase of 17 cases in Q1 2016, the number of children in care continued to decrease over time. The number of children in care between Q1 2014 and Q4 2016 decreased by 246 children. The number of children in care increased in Q1 2017 by 50 children.
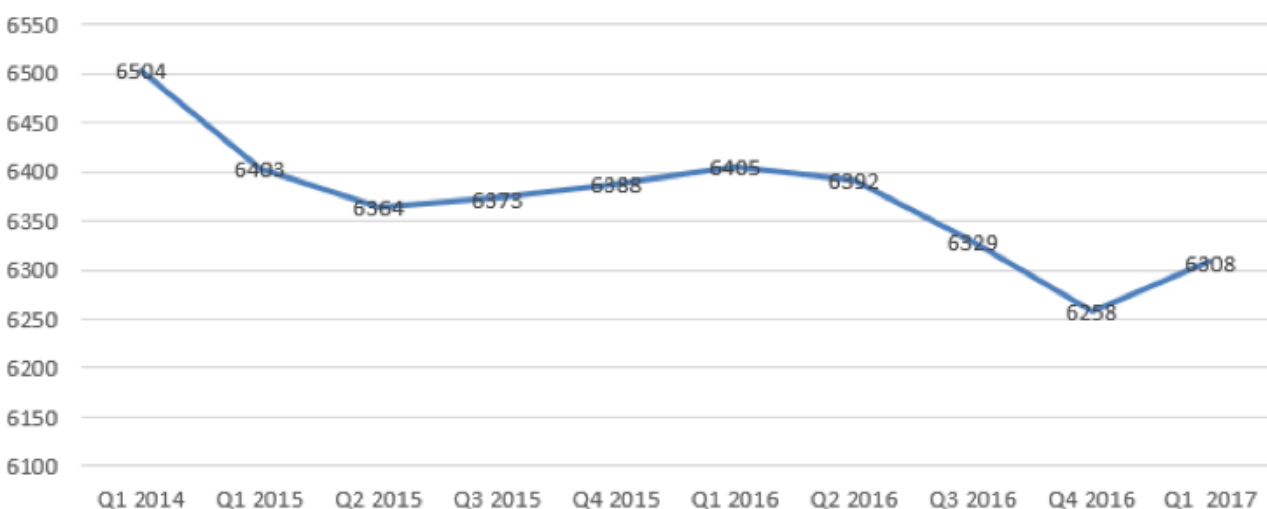

Figure 1: Children in Care (National)

5.2.2 Children in Care per Region

The general tendency per region is a decrease in the number of children in care over time. All regions show a decrease in the number of children between Q1 2014 and Q4 2016. DML reported 56 fewer, DNE 23 fewer, the South 137 fewer and the West 30 fewer. The South had the highest number of children in care but also the largest decrease over time.

	Q1 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017
DML	1563	1532	1526	1508	1531	1537	1540	1521	1507	1515
DNE	1508	1516	1517	1510	1516	1521	1514	1495	1485	1500
South	1940	1852	1837	1856	1873	1873	1857	1832	1803	1783
West	1493	1503	1484	1499	1468	1474	1481	1481	1463	1452

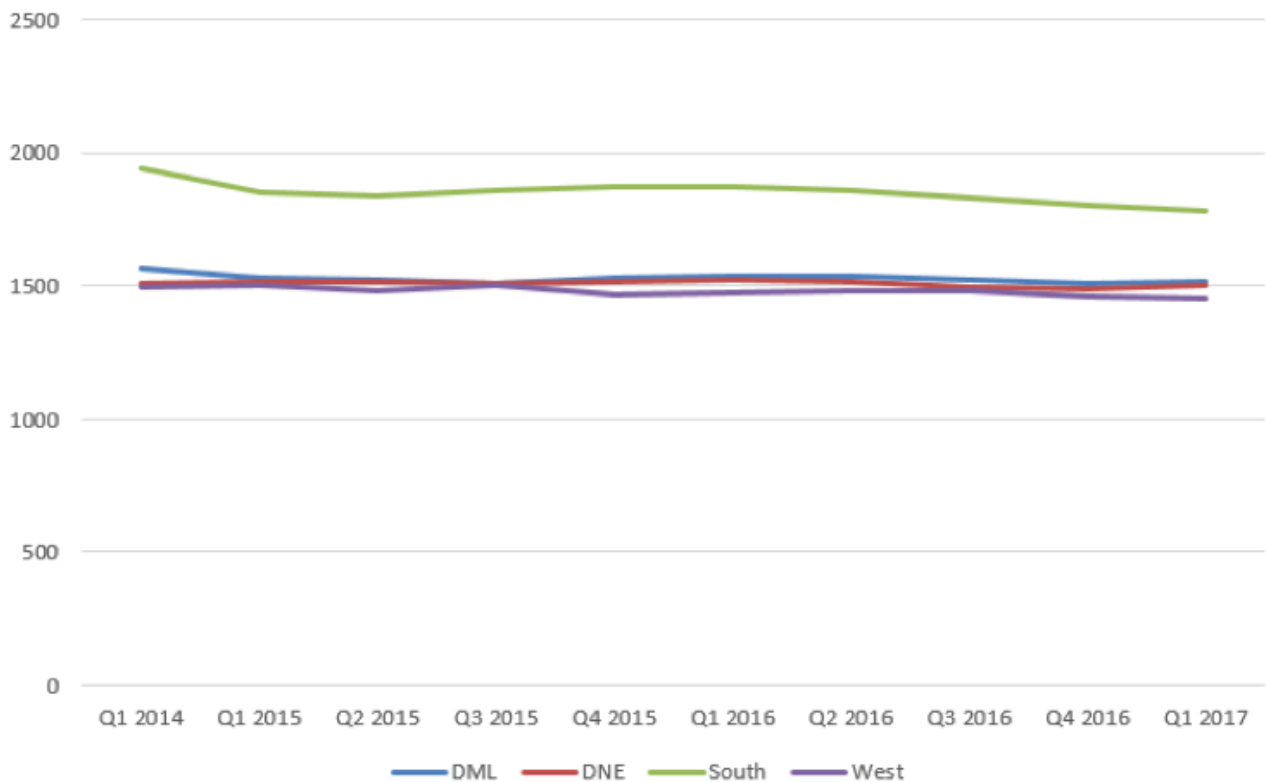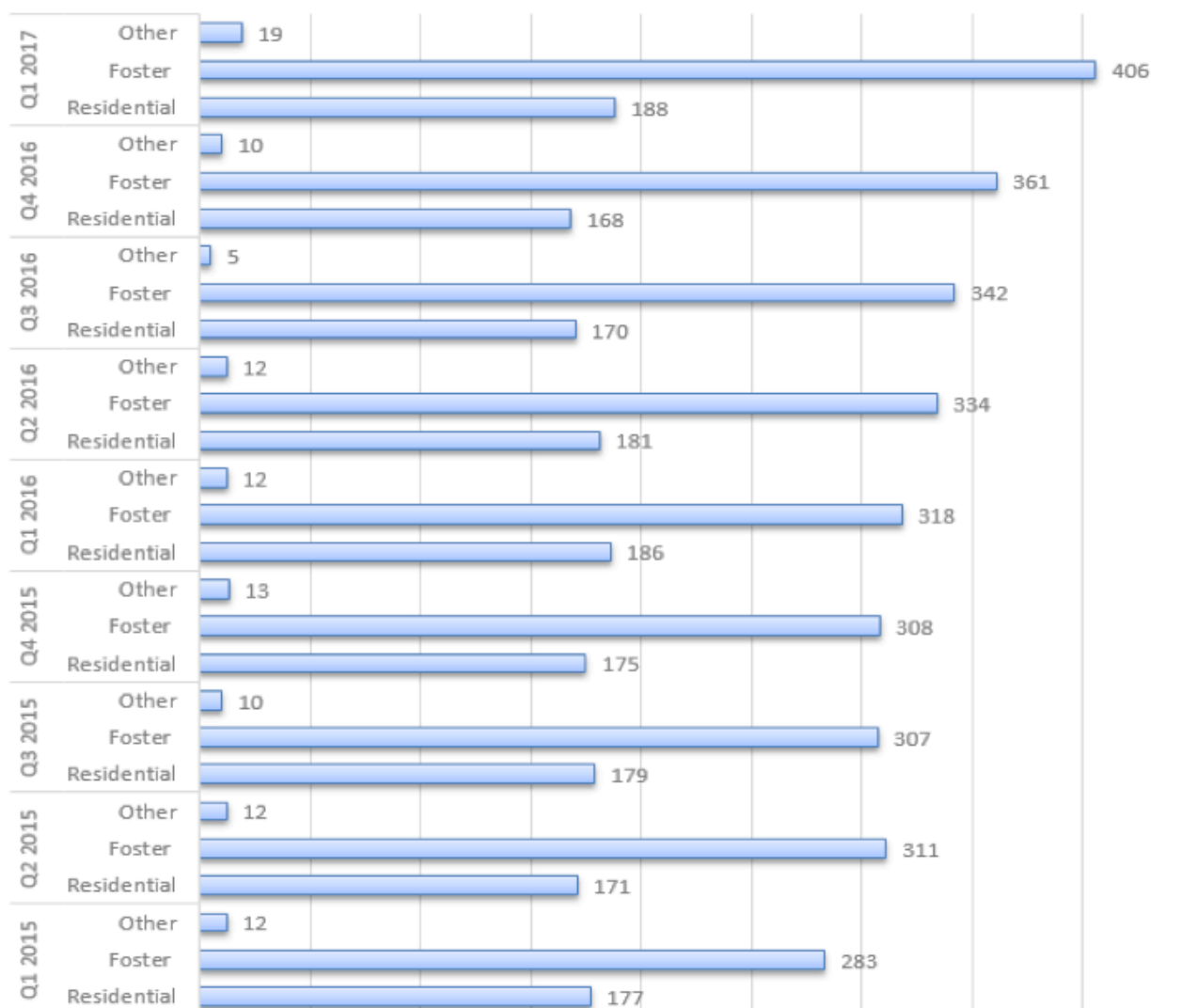**Table 11: Children in Care per Region 2014–2017**

Figure 2: Children in Care per Region

The number of children in care in all regions was lower in Q1 2017 than it was in Q1 2014. The area with the largest decrease was the South, with 157 fewer children in care.

5.2.3 Types of Care[20] (National)

Figure 3: Types of Care (National)

The number of children in foster care increased over time between 2015 and 2017, from 283 in Q1 2015 to 406 in Q1 of 2017. The number of children in residential care remained between 168 and 188 in the period 2015-2017. The number of children in other types of care ranged between 10 and 19, except in Q3 2016 where it dropped to 5. Overall, it can be suggested that the number of children in foster care has increased over time. Trends in foster and other care do not follow a specific pattern, as the number increased and decreased from one quarter to the next; however, the number of children in residential and other care was still lower than in foster care.

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[20] Other includes supported lodgings; at home under a care order; detention centre/prison; youth homeless facility; other residential centre (therapeutic; disability; residential assessment and mother & baby home)
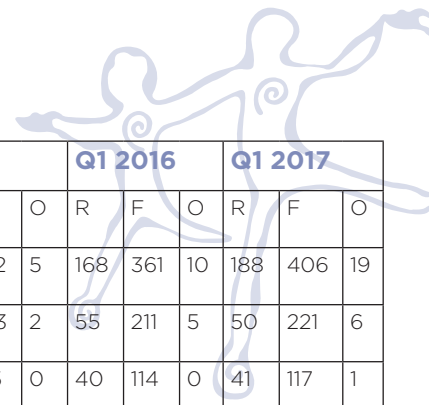
	Q1 2015			Q2 2015						Q3 2015						Q4 2015						Q1 2016			Q1 2017		
	R	F	O	R	F	O	R	F	O	R	F	O	R	F	O	R	F	O	R	F	O	R	F	O	R	F	O
National	177	283	12	171	311	12	179	307	10	175	308	13	186	318	12	181	334	12	170	342	5	168	361	10	188	406	19
DML	61	152	3	65	174	3	68	165	3	66	170	3	67	177	3	59	148	2	60	203	2	55	211	5	50	221	6
DNE	41	91	2	41	93	2	41	98	1	39	99	2	44	99	0	41	103	0	42	105	0	40	114	0	41	117	1
South	49	27	3	53	31	0	54	32	0	59	27	0	59	30	0	58	27	0	51	28	0	50	30	1	57	31	0
West	26	13	4	12	13	7	16	12	6	11	12	8	16	12	9	11	13	10	17	6	3	23	6	4	40	37	12

R = residential, F = foster, O = other

Table 12: Number of Children In Care by Type (Residential, Foster, Other)

5.2.4 Foster Carers (National)
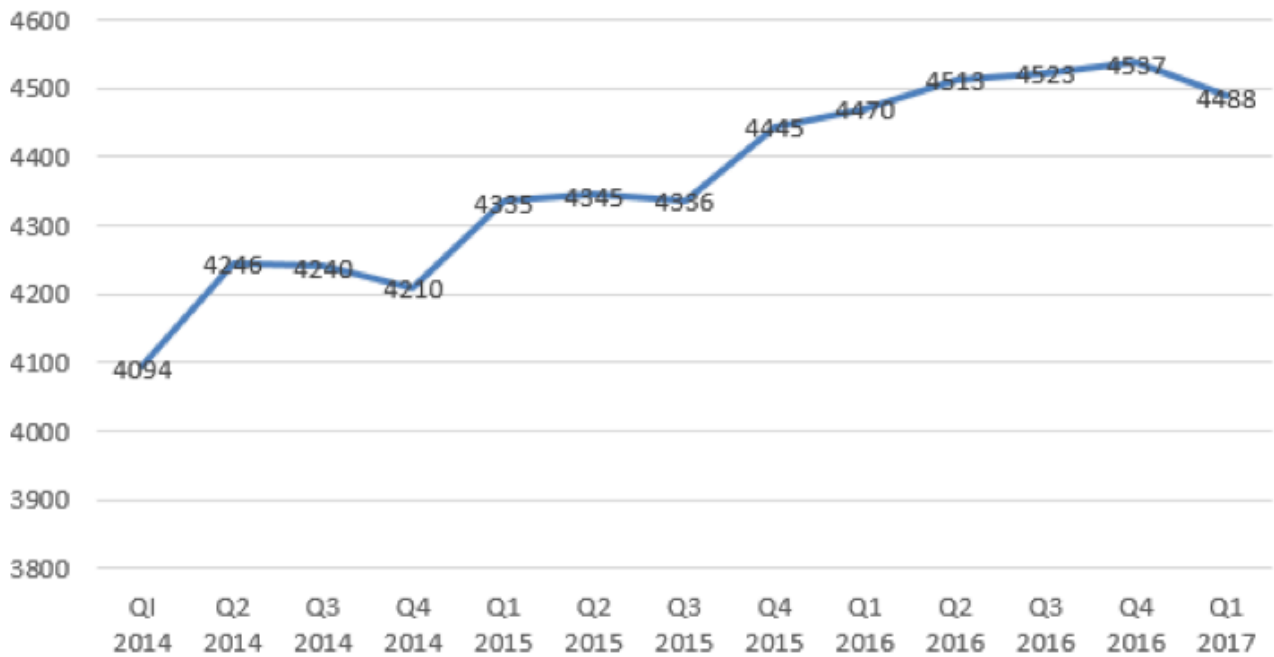
Figure 4: Foster Carers (National)

The number of foster carers nationally, including general, relative and private, increased over time, from 4094 in Q1 2014 to 4537 in Q4 2016: an increase of 443 foster carers. However, the number of foster carers decreased in Q1 2017 by 49.

5.2.5 Social Work Referrals (National)[21]

The total number of referrals to social work includes child welfare concerns and child abuse concerns
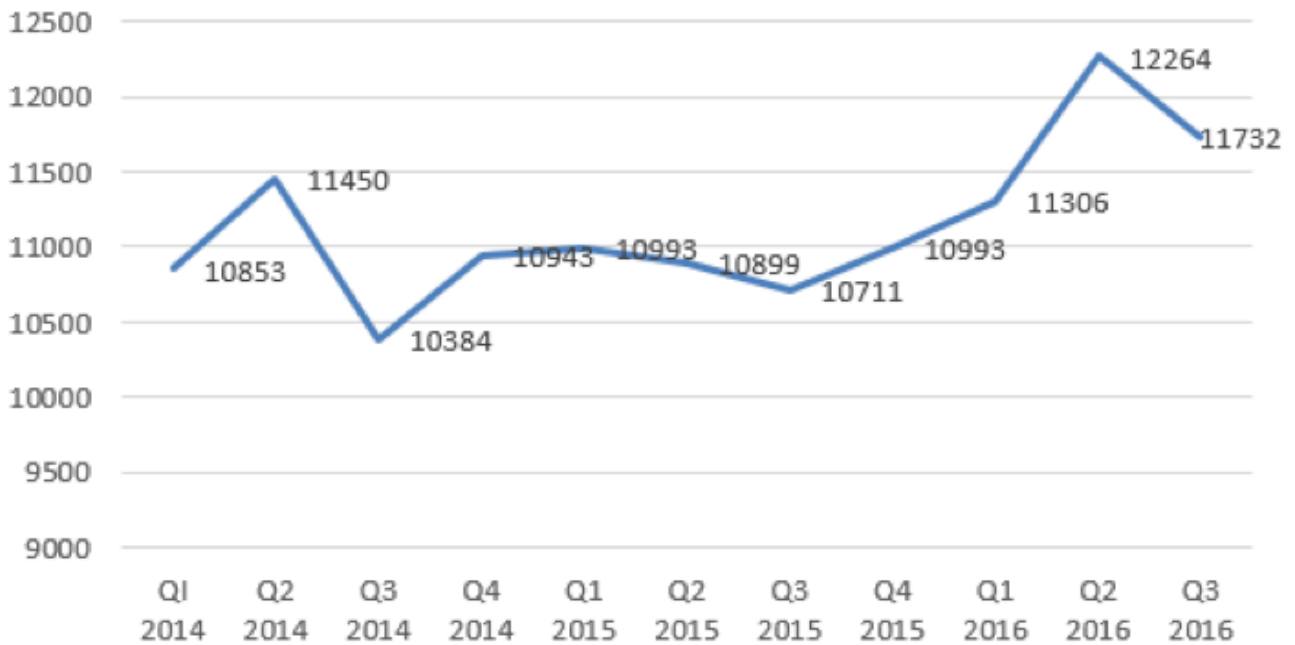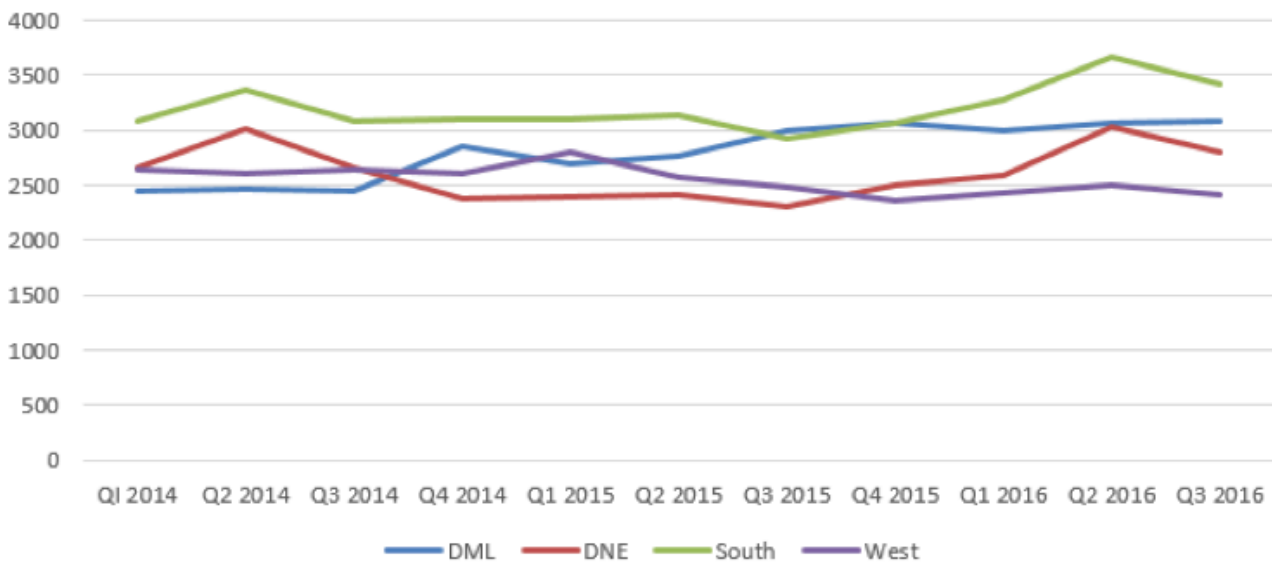

Figure 5: Social Work Referrals (National)

Social work referrals do not follow a definite trending pattern over time, as there was a combination of sharp increases, deep decreases from one quarter to the next, relative stability and a steady increase again in 2016. A sharp increase of 596 referrals happened in Q2 2014, but the figure decreased by 1066 in Q3 2014. Referrals continued to decrease until Q1 2016, when referrals began to increase again; a sharp increase of 958 referrals was registered in Q2 2016, but a decrease was identified again in Q3 2016[22]. Although there were fluctuations, overall this shows a tendency for national referrals to increase over time since 2014.

[21] Data reported every six months.
[22] The decrease in Q3 2016 could be explained by the appointment of a Project Team to examine the increase in the number of referrals and the number of unallocated cases in all ISAs.

5.2.6 Social Work Referrals per Region

Figure 6: Social Work Referrals per Region

This figure suggests a more stable pattern than the graph of social work referrals nationally (Figure 5). There is a similar peak in Q2, 2016 but only in two regions; DNE and the South.

|	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016
DML	2456	2463	2456	2861	2688	2771	3002	3061	3003	3063	3083
DNE	2668	3006	2668	2369	2393	2417	2303	2506	2584	3029	2809
South	3081	3365	3081	3097	3110	3144	2930	3073	3285	3674	3422
West	2648	2616	2648	2616	2802	2567	2476	2353	2434	2498	2418

Table 13: Referrals Per Region 2014–2016

Overall, there was a tendency for referrals to increase between Q1 2014 and Q3 2016. DML had an increase of 627 referrals, DNE reported an additional 141, and the South showed an increase of 341. The only region where referrals decreased was the West, by 230. The South had the largest number of referrals.

5.3 Social Work Referrals as Percentages of the Population of Children and Young People.

This section provides a description of data for 2014 until 2016 for the total number of referrals (child protection and welfare concerns) as per 1,000 of the under 18 population based on data from the 2011 Population Census.

**5.3.1 Total Number of Referrals per 1,000 of the Under 18 Population**
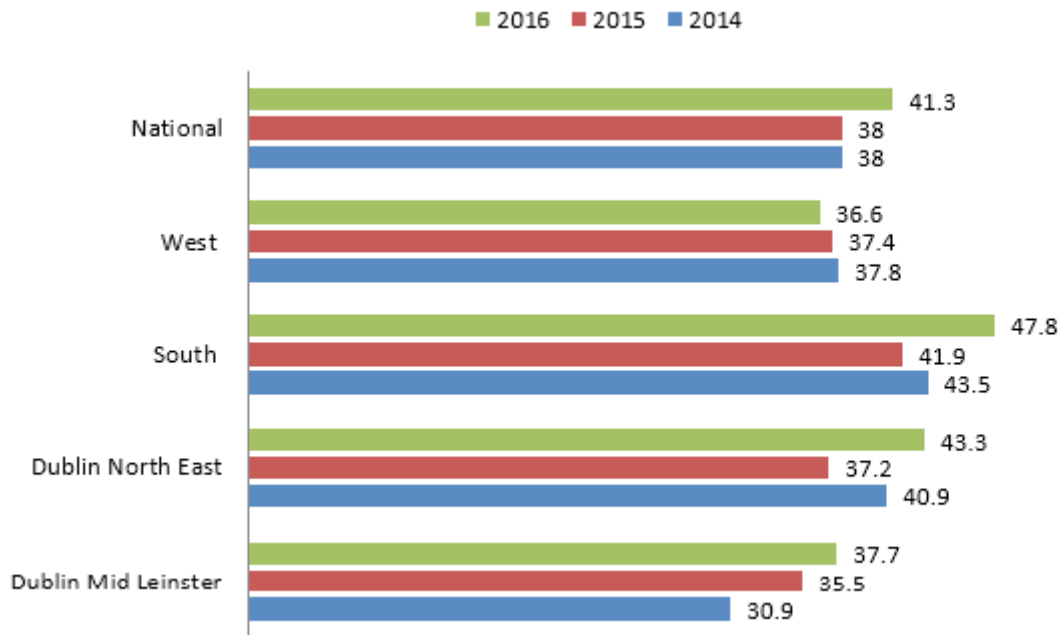
Figure 7: Total Number of Referrals Per 1,000 of the Under 18 Population

This figure shows that nationally there was an increase in the total number of referrals in the under 18 population between 2014 and 2016. In the West there was a slight increase in 2015 but in 2016 there was a marginal decrease. In DNE and the South the numbers decreased in 2015 but increased in 2016. In DML, it increased in both 2015 and 2016.
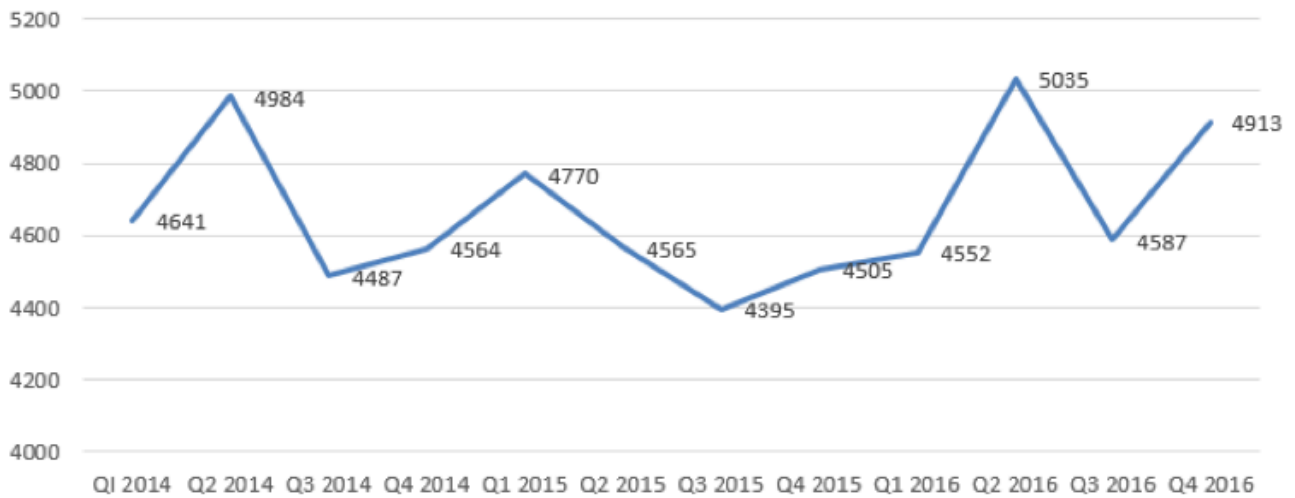
5.3.2 Child Welfare Concerns (National)
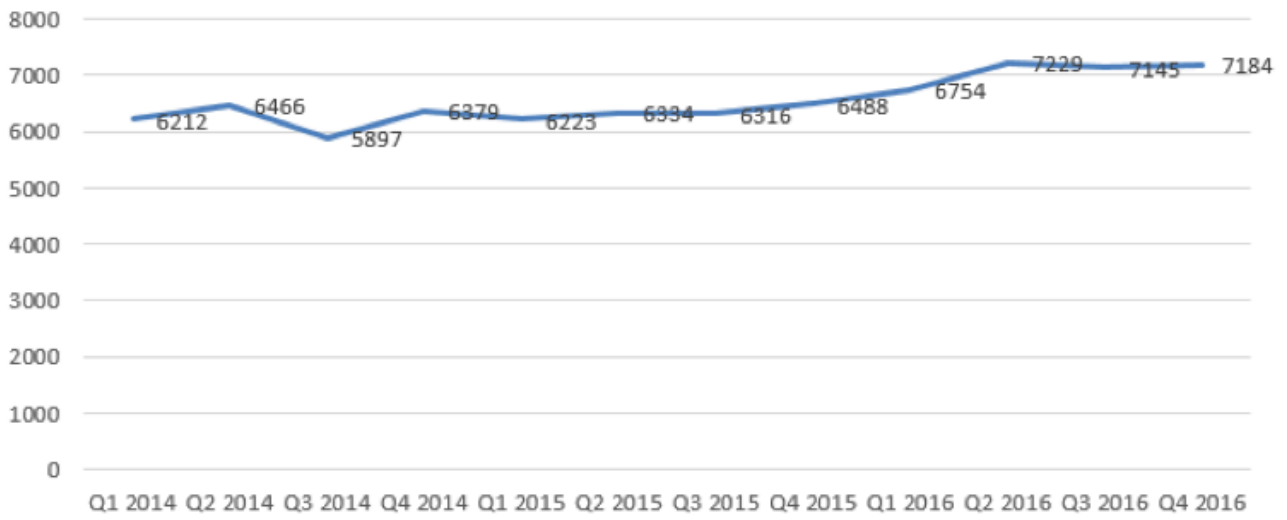
Figure 8: Child Welfare Concern Referrals (National)

Child welfare concern referrals increased over time between Q1 2014 and Q4 2016, by 972. A decrease only happened in Q3 2014.

5.3.3 Child Abuse Referrals (National)

Figure 9: Child Abuse Referrals (National)

The number of child abuse referrals increased between Q1 and Q2 2014 but then decreased in Q3. Referrals decreased again between Q2 and Q3 2015 but then increased for the following two quarters. The highest number of referrals happened in Q2 2016, when there was an increase of 483. In Q3 2016 the number of referrals decreased, but increased again by 326 in Q4 2016.

5.3.4 Open Cases (National)
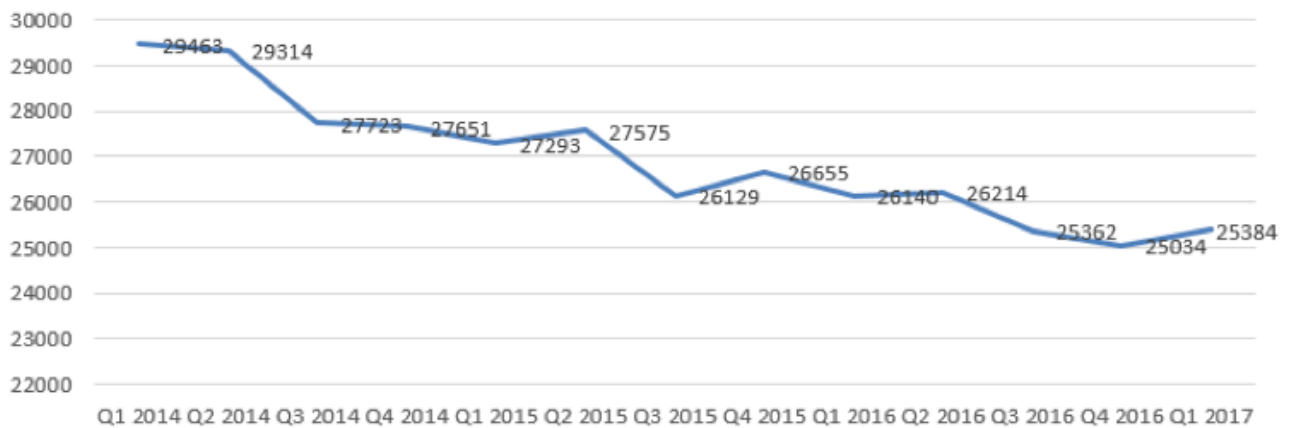
Figure 10: Open Cases (National)

The number of open cases nationwide generally decreased over time, by 4429 between Q1 2014 and Q4 2016. An increase of 350 open cases was reported for Q1 2017.

	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016
DML	42.90%	39.50%	31%	36.80%	36.50%	32%	26.20%	25.70%	28.60%
DNE	35.60%	29.90%	29.80%	31.70%	25.40%	17.80%	24.70%	17.60%	24.30%
South	23.70%	19.40%	22.40%	24.60%	19%	17%	17.40%	14.20%	16.30%
West	17.60%	20.50%	20.90%	19.30%	21.90%	20.40%	18.20%	12.10%	17.20%

Table 14: Open Cases per Region

The percentage of open cases awaiting allocation per region generally decreased from Q4 2014 to Q4 2016. The biggest decrease was in DML at 14.3%.

5.3.5 Time on Waiting List

This figure represents 'time waiting', which refers to the number of high priority cases[23] awaiting allocation to a social worker[24].
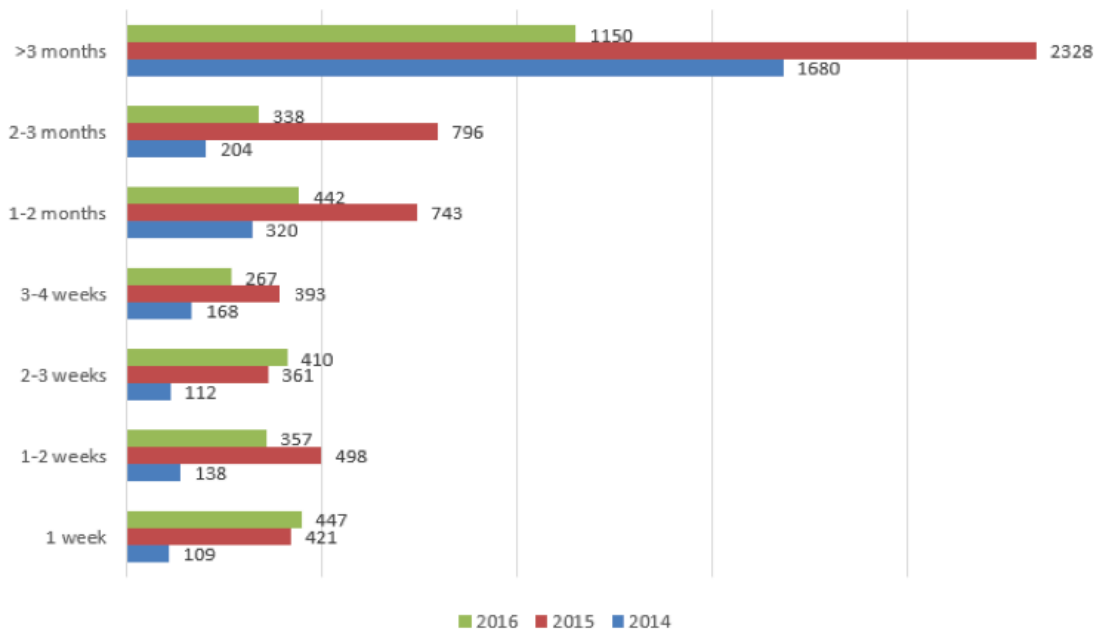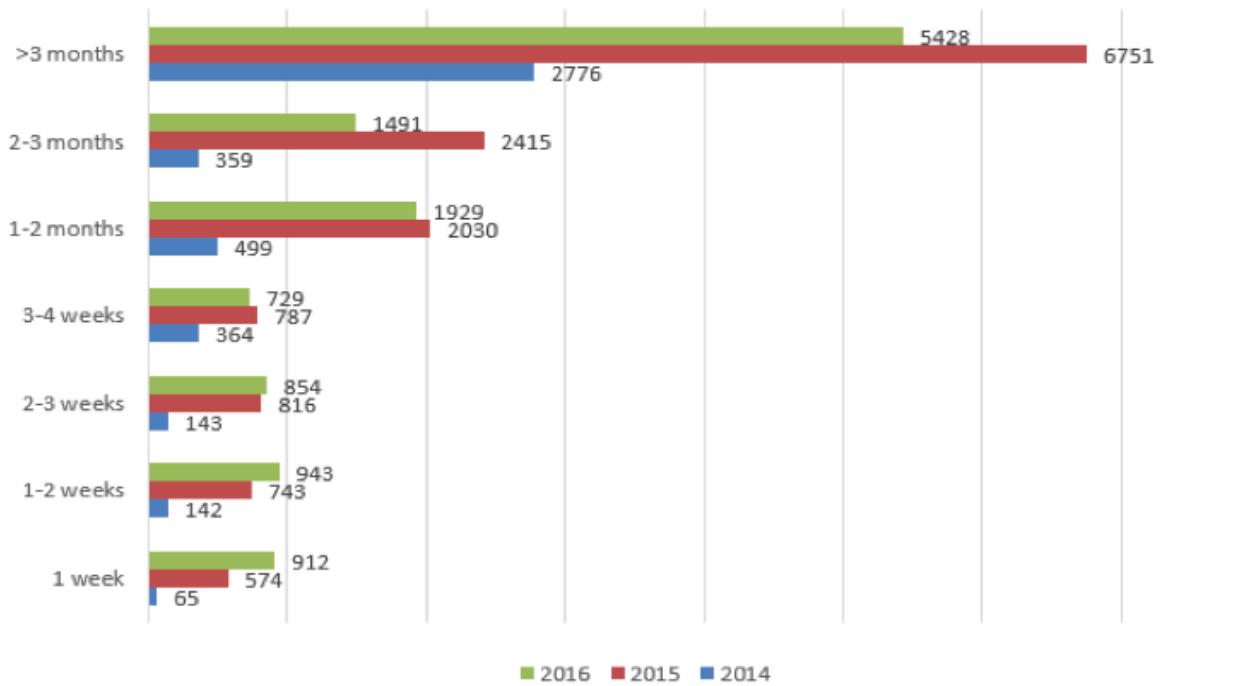

Figure 11: Waiting Times: High Priority

The number of cases awaiting allocation at a high level for more than three months was noticeably reduced in 2016, compared to 2014 and 2015. The number of cases that waited one week increased from 2014 to 2016.

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[23] A case represents one child. A child can have more than one referral simultaneously.
[24] High priority cases are defined by the 'Measuring the Pressure report', which evaluates if the child was subject to an initial assessment with a child protection concern, further assessment required, child awaiting a Child Protection Conference, child subject to a Child Protection Plan, child subject to Court Proceedings, child in care with non-approved carers, child in care less than six months and child in unstable placement.

Figure 12: Waiting Times: Medium Priority

The number of open cases of medium-priority allocation for two or more months increased noticeably from 2014 to 2015, but it was reduced in 2016.
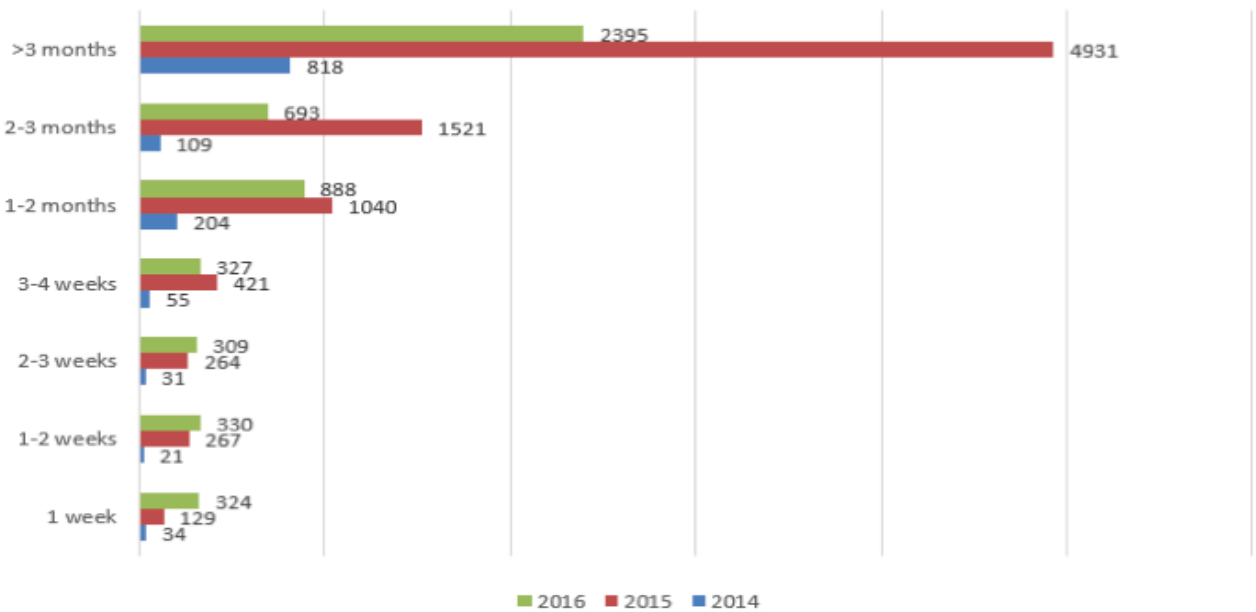

Figure 13: Waiting Times: Low Priority

The number of low priority cases awaiting allocation increased between 2014 and 2016 by 290. The number of cases allocated between 1–2 weeks also increased. The number of cases waiting to be allocated for more than three months increased between 2014 and 2015 and decreased between 2015 and 2016, but it still had 1577 cases more than in 2014.

5.3.6 Referrals to Family Support Services (National)

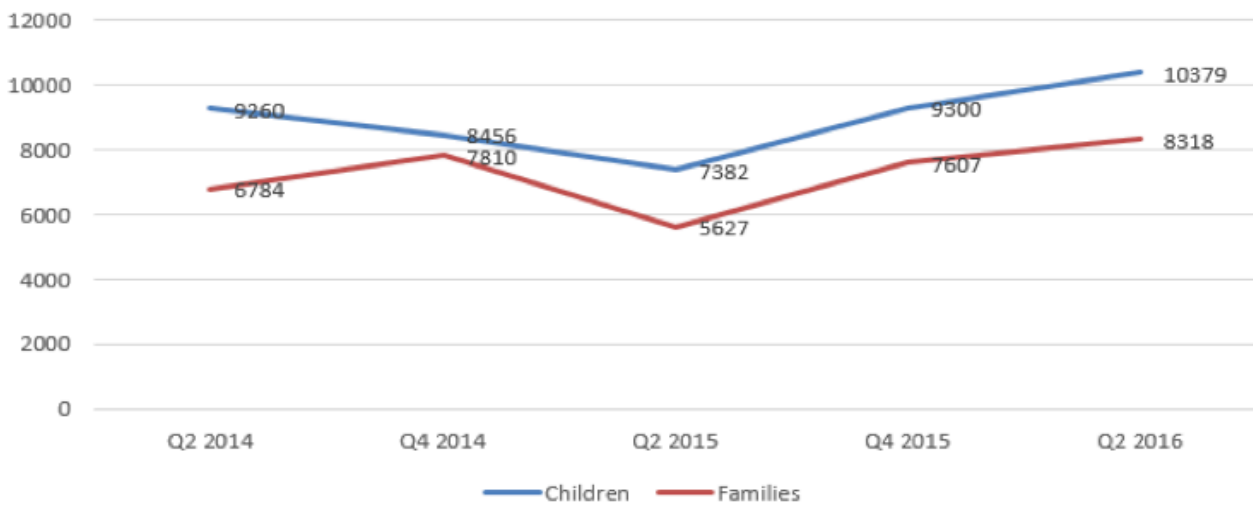Referrals from social work to Family Support Services[25]
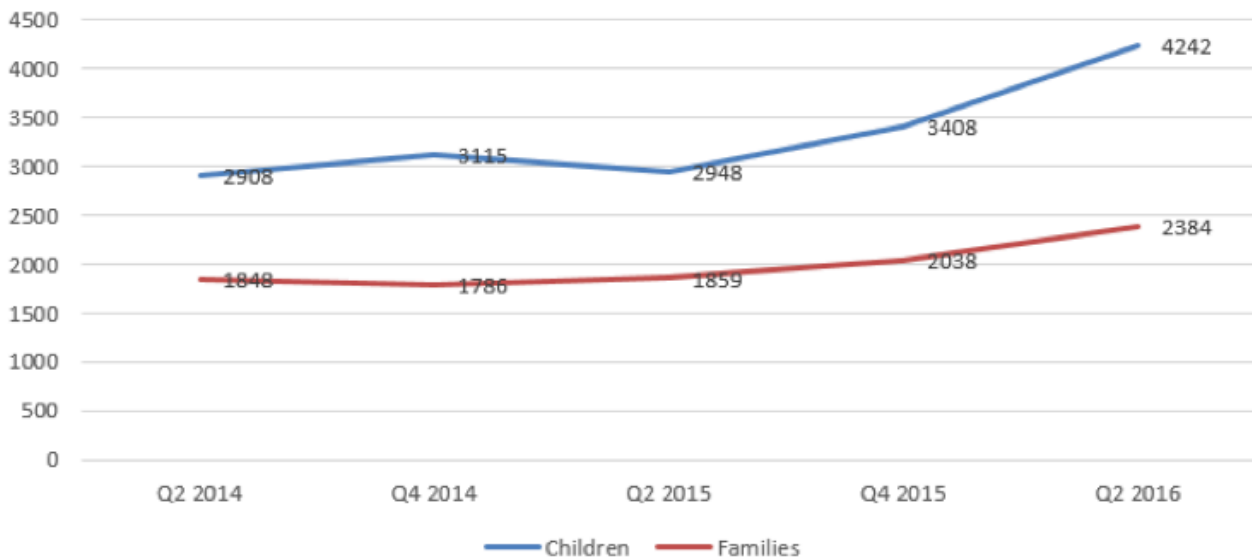
Figure 14: Social Work Referrals to Family Support Services (National)

The number of children and families in receipt of Family Support has increased over time.

[25] Data for Q4 2016 was available but incomplete, and therefore excluded.

Referrals from other sources to Family Support Services[26]

Figure 15: Referrals by other Sources to Family Support Services (National)

The number of children referred to family support services by other sources decreased between Q2 2014 and Q2 2015. The number of families and children referred to family support services by other sources increased between Q2 2015 and Q2 2016.

5.3.7 Families in Receipt of Family Support (National)[27]

The increase in the number of referrals to family support services consequently increased the number of children and families in receipt of Family Support between Q2 2014 and Q2 2016. There was a decrease in the number of children and families in receipt of Family Support in Q2 2015. The number of families in receipt of Family Support increased between Q4 2015 and Q2 2016. The number of children increased by 5342 between Q2 2015 and Q4 2015 but decreased in Q2 2016.
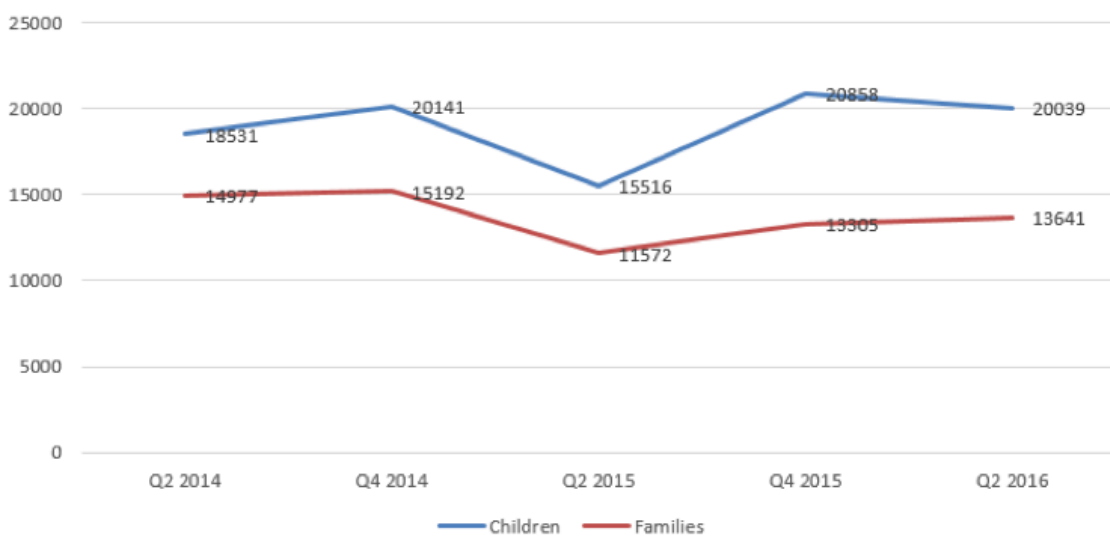
Figure 16: Families in Receipt of Family Support Services (National)

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[26] Data for Q4 2016 was available but incomplete, and therefore excluded.
[27] This data is reported every six months.

5.4 Meitheal

5.4.1 Meitheals Initiated (National)

The number of Meitheals initiated has increased over time from a total of 303 in Q3/Q4 2015 to 390 in Q1/Q2 2016 and 469 in Q3/Q4 2016.
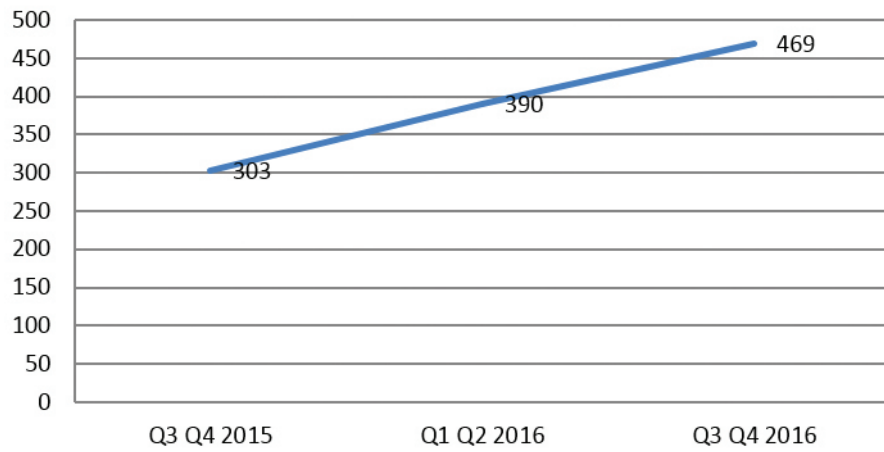

Figure 17: Meitheals Initiated in 2015–2016[28]

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[28] Meitheal information is missing for Carlow, Kerry, Dublin North, Dublin South Central and Dublin South West Kildare West Wicklow as data collection was ongoing at the time of the release of this report.
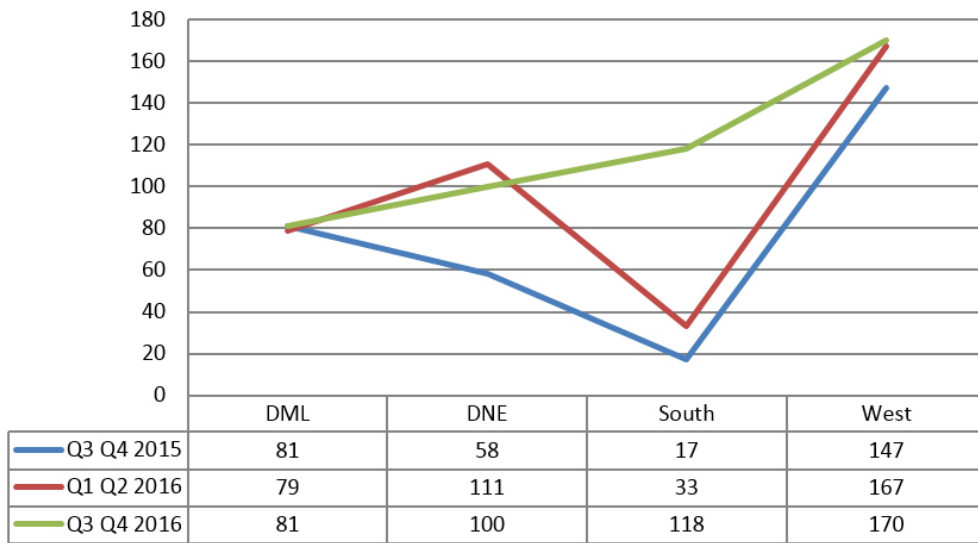
5.4.2 Meitheals Initiated (Regional)

	DML	DNE	South	West
Q3 Q4 2015	81	58	17	147
Q1 Q2 2016	79	111	33	167
Q3 Q4 2016	81	100	118	170

Figure 18: Meitheals Initiated per Region

	Q3/Q4 2015			2016		
	Direct Access	SW Diversion	SW Step-down	Direct Access	SW Diversion	SW Step-down
National	182	80	41	493	258	108
DML	76	1	4	118	17	25
DNE	39	14	5	172	27	12
South	9	6	2	71	65	15
West	58	59	30	132	149	56

Table 15: Meitheal Initiation Pathways 2015–2016

In 2015 the majority of Meitheals initiated came from the direct access pathway. In 2016 the majority of Meitheals initiated arose from a social work diversion, except in the West and South, where direct access was still the most common pathway.

5.4.3 Reasons for Meitheal Initiation

Information on reasons for initiating a Meitheal is available from Q3 and Q4 2016. This data shows that the majority of Meitheals were initiated due to behavioural and emotional problems.
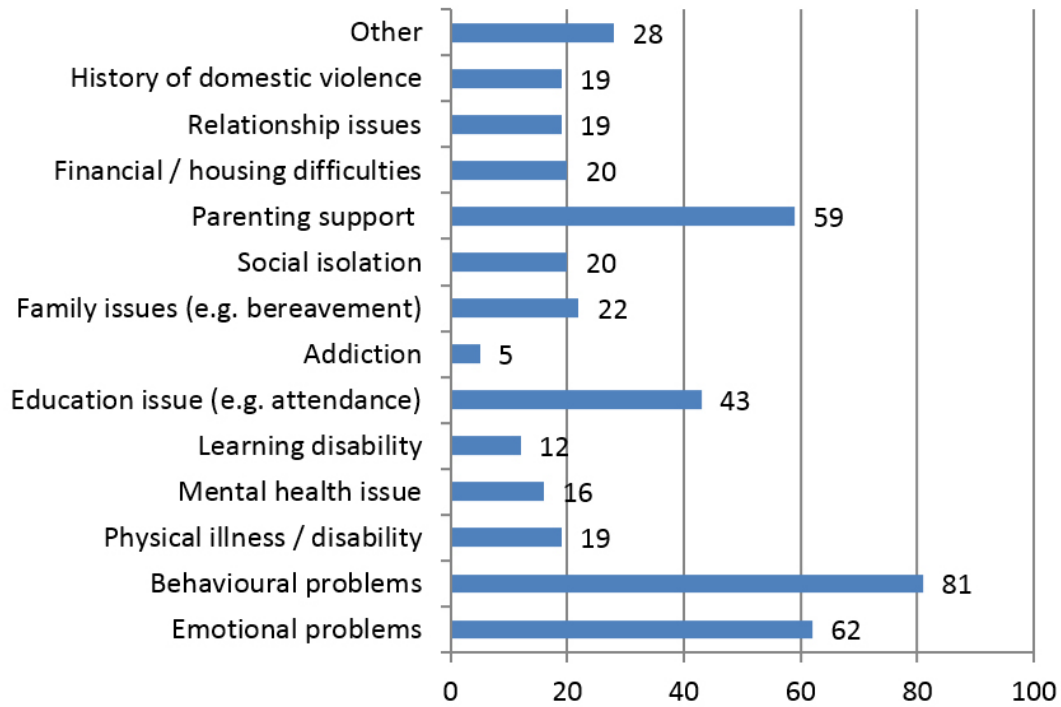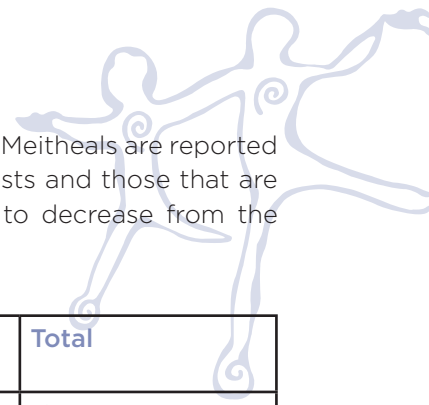

Figure 19: Primary Reasons for Initiation of Meitheal (Q3 and Q4 2016)

Table 16: Primary Reasons for Meitheal Initiation per Region

	Emotional problems	Behavioural problems	Physical illness / disability	Mental health issue	Learning disability	Education issue (e.g. attendance)	Addiction	Family issues (e.g. bereavement)	Social isolation	Parenting support	Financial / housing difficulties	Relationship issues	History of domestic violence	Other
DML	18	19	2	5	4	9	0	2	7	9	1	2	0	2
DNE	13	18	7	4	5	13	1	1	2	12	6	3	1	9
South	9	18	5	3	2	10	3	2	5	19	8	9	2	8
West	22	26	5	4	1	11	2	17	6	19	5	5	16	9

Meitheal data from Q1 and partially for Q2 2017[29] is included. The metrics by which Meitheals are reported have also been improved: a differentiation is now made between Meitheal requests and those that are actually initiated. This is another reason why the number of Meitheals seems to decrease from the previous quarter.

	Direct access	Social work diversion	Social work step-down	Total
National	146	42	10	198
DML	32	5	1	38
DNE	21	15	1	37
South	36	19	3	58
West	57	3	5	65

Table 17: Meitheal Data Q1 and Q2 2017

5.5 Overall Findings: Meitheal and the Help-Seeking and Help-Provision Context

- **The number of children in care has generally decreased over time, and there has been an increase in the number of foster carers; this may suggest a possible change in the provision of help for children and young people in Ireland. At the beginning of 2017, however, there was a slight increase, which needs to be tracked over time.**

- **There is no clear pattern in the number of referrals nationally over time, as it decreased and increased in certain time periods. It is clear from the data that the number of referrals in 2016 was higher than in 2014 and 2015. More cases were reported to social work. The South was the region that reported the highest number of referrals, and the West was the only region that decreased its level of referrals between 2014 and 2016.**

- **There is an increase in the total number of referrals in the under 18 population between 2014 and 2016.**

- **Although the number of referrals increased over time, the number of open cases nationally has been decreasing, which suggests that more children, young people and families are seeking support but also that more families are being provided with that support.**

- **Waiting times, particularly for cases with high-priority levels, has decreased for children and young people waiting for over three months, and the number of cases allocated within one week has increased over time, suggesting that responses are happening faster. Meitheal does not target this level of need, so this cannot necessarily be attributed to Meitheal, but the inclusion of prevention and early intervention pathways may have helped to ease demand on support services and channel people towards the correct levels of support to target their needs more efficiently. However, this is not happening at low-priority levels; the number of cases allocated between one and three weeks has increased, but so too have those allocated between one and three months or more.**

- **The number of children, young people and families referred from social work and other sources to family support services has increased, which may suggest that the thresholds of need are working effectively and families that do not require the intervention of social work are being assigned to the supports they require according to their level of need.**

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[29] Meitheal information is missing for Carlow, Kerry, Dublin North, Dublin South Central and Dublin South West Kildare West Wicklow as data collection was ongoing at the time of the release of this report.

- **The number of Meitheals has increased between 2015 and 2016. The West is the area where more Meitheals have been initiated, followed by DNE.**

- **The majority of Meitheals initiated in Q3 and Q4 2016 were due to emotional and behavioural issues.**

5.6 Conclusion

This chapter provided a descriptive analysis of the Tusla support system between 2014 and 2017. There are no major changes evident in the support system. Slight patterns were identified, as the number of children in care seems to have decreased over time and the number of foster carers increased. The number of referrals increased in 2016 and the West has the most referrals. Even if there seems to be more referrals, there are fewer open cases, which may suggest an improvement in the speed of service provision, particularly at higher levels of need as waiting times have decreased. This could also be due to the fact that one child can have multiple referrals while still being counted as one open case.

The increase in the total number of referrals in the under 18 population between 2014 and 2016 may be due to an increase in the number of child welfare and child protection concerns nationally. Even though it cannot be confirmed by the data it could also be due to an increased awareness among service users regarding the supports available and how to access them. Another important aspect to consider is that Tusla was established in 2014 and this means that the introduction of the agency as such may have improved the processes to systematically and efficiently identify children and young people in vulnerable situations and provide them with the services and supports they require in a more efficient and focused way.

The introduction of Meitheal to the system has made evident the continuum of support that Tusla can provide for children, youth and families at different levels of need. Meitheal has highlighted, and quantifies, work at lower levels of need that were not accounted for before and were excluded from Tusla's performance activity. The number of Meitheals increased between 2015 and 2016, suggesting that more children, young people and families are receiving the help they need, and this does not take into account the fact that the data is incomplete. The majority of children seem to have behavioural and emotional needs, while parenting support is also an issue. All of this will contribute to responses to the complex needs of children, young people and families becoming more tailored. It is expected that the final report on the Meitheal Process and Outcomes Study will provide a longitudinal understanding of the impact of Meitheal on the help provision system. As has been evidenced in this chapter, change can be small and can take a longer period of time to happen than can be accounted for within the scope of this. Nevertheless, the final report will contain a detailed description of Tusla's continuum of support and the institutional capacity to provide for different levels of need among children, young people and families in Ireland.

6

Chapter Six: Discussion, Conclusions and Recommendations for Practice

6.1 Introduction

This interim report on the Meitheal and CFSNs Process and Outcomes study provided an understanding of the preliminary impact of the Meitheal model on the outcomes of children, young people and families. It also presented a comprehensive understanding of the process of implementing the model and how this new model of intervention fits into the overall help-seeking and help-provision systems in Ireland.

This chapter aims to interpret the results obtained from data collected with children, young people and families at the early stages of their involvement in the Meitheal process and to determine their experience and perceptions in detail. Lead Practitioners also provided their perspectives on the model and its overall implementation at a local and national level. These findings are placed in the context of local and international research, which can provide a deeper understanding of the Meitheal model, its uniqueness and its similarities with other prevention and early intervention systems and programmes. This study is the first of its kind in Ireland to be carried out nationwide and is therefore crucial to evaluate the state of Family Support in Ireland and to highlight relevant findings that can improve practice and the provision of help for families.

Overall, the findings have identified that Meitheal, notwithstanding the issues, which emerged, for example, in relation to participation is a largely positive experience for children, young people and families. Lead Practitioners also have a positive attitude towards the model and see the value and potential it has to provide for the needs of families early on in the process. Evidence was provided to further understand the crucial role of family–practitioner relationships and participation by children, young people and parents in shaping and determining the success of Meitheal. Strengths and challenges were identified and will be further analysed in this chapter. Results also supported the importance of taking a holistic approach to understand needs and also to provide for the needs of Meitheal children, young people and families, justifying the need and essential role of inter-agency collaboration for best practice. Additional information was included about Meitheal and the thresholds of need, and the impact of Meitheal on the overall help-provision system. It is not possible to say at this early stage the extent to which Meitheal has changed the help and support system; however it can be suggested that it has made visible the work that Tusla carries out with families at lower levels of need. It also demonstrates its potential for targeting and responding to children and young people in an effective and appropriate manner, irrespective of their level of need at a particular time, thus helping to make the continuum of support a reality.

This chapter also considers the limitations and challenges to the Meitheal model and its implementation and the difficulties experienced during the design and implementation of the research study, such as having a small sample of participants, which limited the quantity and quality of the analysis carried out from a quantitative perspective. The chapter concludes with recommendations for practice.

6.2 Discussion

The Meitheal process was positively received by almost all of the participants. This was due to the progress that had already been made towards meeting families' unmet needs. These improvements included improved parent–child interactions, greater parental self-confidence, reductions in familial conflict, and positive changes to school attendance on the part of the children and young people. Parents who had prior contact with services viewed Meitheal as a significant improvement compared to their previous experiences of help provision, for example, in relation to parent and child participation, the coordination of services and the promptness and accountability of responses to their needs. Lead Practitioners saw Meitheal as a very beneficial approach to working with families, especially in the improvements to how services were provided and the impact it could have on outcomes.

The process of help provision in Meitheal was also perceived to be positive. Parents in particular were engaged and responsive, and there was extensive evidence of their collaborative participation in the process, including in decision-making, identifying needs, and creating the Meitheal action plan. This led to a sense of empowerment and confidence in the process. Children and young people were relatively satisfied with their experience of the Meitheal process to date, including how they were listened to and their engagement with the Lead Practitioner. However, although Lead Practitioners were supportive of family participation in Meitheal and actively sought to include them where possible, there were some issues with children and young people's participation, as outlined below.

The perceived strengths of the Meitheal model include its multi-agency approach, which facilitates greater coordination of services and the development of more tailored action plans to meet families' needs, reductions in the duplication of interventions, strengthening of communication between families and service providers and between practitioners and professionals who are supporting the family. Its holistic, strengths-based approach was welcomed as a means of working with families and identifying specific unmet needs that can be resolved through the provision of targeted support.

Both the quantitative and qualitative findings of this study support the need for a holistic approach to understanding the needs of children, young people and families. Families reported an appreciation for services provided to children and also the supports made available to parents from an early stage of the process. The quantitative findings identified that the largest predictor of family outcomes was maternal well-being. This emphasises the importance of having a comprehensive and holistic approach towards the needs and strengths of children, young people and families (Kyle and Kellerman, 1998). While the Meitheal principles emphasise the need for a child-centred approach to be taken, in practice this is not always fully adhered to. However, where a process is child-centred it enables the issues that affect children and young people to be focused on. Nevertheless, it is important to consider their families and contexts to fully understand the complexity of their needs and consequently to be able to provide an appropriate response to those needs. Previous research has suggested that parental support is an essential part of improving children's outcomes (Rochford et al., 2014; McClenaghan, 2012). Children and young people's outcomes are influenced by several factors, such as the child, the environment and the interaction between them (Corman & Devaney, 2011). Therefore, evaluating outcomes and the context is important. It is also relevant to consider that well-being is a vast and complex concept, and defining it can be challenging. Maternal well-being was measured using the General Health Questionnaire only, and this may pose challenges and limitations to the interplay between well-being and outcomes (Pollard & Lee, 2003). It is also important to consider these findings from the Feminist Ethics of Care perspective, where care is described as central to everyone, not only to women and mothers. From this perspective, it is fundamental to listen to women to able to understand and communicate with them as part of ethical practice and the care provided to them (Parton, 2003). This Ethics of Care practice can eventually lead to changes in embedded social gender values and stereotypes that may still associate care with a female role. This can put great pressure on women and negatively impact on their well-being as was highlighted in the study.
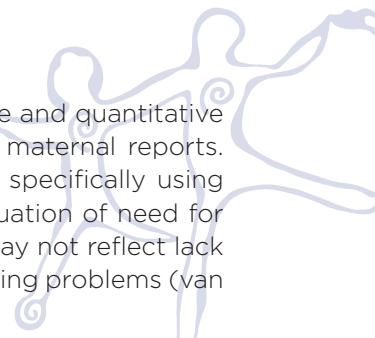
The need for a holistic approach is further supported by the fact that both qualitative and quantitative findings identified discrepancies between child and young person self-reports and maternal reports. Previous research has also found low to moderate agreement between informants, specifically using the Strengths and Difficulties Questionnaire; these discrepancies can affect the evaluation of need for services and are therefore very relevant (Van Roy et al., 2010). These discrepancies may not reflect lack of validity but can represent unique differences and needs and predict future internalising problems (van de Looji-Jansen et al., 2011; Van Roy et al., 2010) that need to be targeted early on.

A holistic approach to family needs also requires and implies an emphasis on inter-agency work, as individual members of a family may have different needs, with the majority of children and young people in this study reporting a combination of reasons to initiate a Meitheal, including behavioural, educational, health and financial/housing issues. This complexity and variety of needs cannot be provided for by a single-agency response. Inter-agency collaboration is part of Tusla's vision included in the Child Protection and Welfare Strategy (2017: 4): 'To provide an appropriate, proportionate, timely response to children "at risk/in need", sharing responsibility and control with families and communities through co-created solutions and interagency collaboration'. Dolan et al. (2006), emphasise the need for reflective practice to ensure that children and families are receiving tailored supports that are realistic, attainable and needs-focused.

A key strength of the model is the Lead Practitioners, who appear to have strong relationships with families and are viewed as empathetic, non-judgemental and trustworthy. In this relationship, how Lead Practitioners work with families and the importance they place on listening, for example, is in line with best practice in this area. Lorié et al. (2017) point to the importance of nonverbal cues (for example, listening) in how the relationship develops, while Roter et al. (2006) note that positive nonverbal empathetic cues can improve service-user perceptions of the practitioner's capacities and improve their engagement with the service. However, it is important to note that not all children and young people felt engaged in the process or had a strong relationship with the Lead Practitioner. This was causing some issues in relation to children and young people's participation in Meitheal.

Lead Practitioners have a crucial role not only in the direct services they provide to families but also in how they encourage and facilitate participation, coordinate the overall process, and support families in their engagement with the community and voluntary sector and statutory agencies. This finding reflects the literature, which demonstrates the importance of the relationship between the service provider and user (Munro, 2011) and its potential impact. Trevithick (2003) argued that the relationship between service-users and providers can become the basis of capacity-building and empowerment. Howe (2008) stated that where parents felt understood, their stress levels were reduced, which in turn decreased risks for their children. Lead Practitioners also play an important role in the provision of services to families through the support they can gain from a wider range of services to help meet unresolved needs. This demonstrates in a practical way the principle of 'No Wrong Door' as espoused in the Meitheal and CFSN model's philosophy, as Lead Practitioners with very specific remits can facilitate interventions connected to unmet needs outside of their area of expertise.

It should be noted that parents generally reported feeling empowered, listened to and respected by the other participants during the Meitheal process. There were examples of best practice in how children and young people are supported to participate in Meitheal, such as collaborating in the identification of needs and attending Meitheal Review Meetings. The study showed that the benefits gained from children and young people participating in the process were clear, as they felt listened to and empowered and had identified needs that they sought support on and in some cases had begun to see impacts on their lives. This echoes findings from an Irish study on sick children and young people in hospitals' participation in decision-making, which demonstrated that knowing professionals well helped to develop feelings of trust in the relationship (Coyne et al., 2006). Where children and young people were facilitated to participate, their actions reflect the findings in Cossar et al.'s (2011) study, based on interviews with children and

young people about their participation in the child protection system, which highlighted that this group wanted to be involved in resolving their issues and to do so with the support of trusted adults.

However, the manner in which children and young people are included in Meitheal is not always as fully participatory as it could be. The kind of relationship that would enable a child or young person to be sufficiently at ease to participate fully had not always been fully developed prior to, for example, their involvement in completing the Strengths and Needs form. This was especially the case where the Lead Practitioner had a previous relationship with the parent(s) and not the child or young person. Concerns also arise regarding the extent to which some of the Meitheal Review Meetings could be called child-centred, as participants noted that children and young people felt uncomfortable and under pressure as a result of how a small number of practitioners and professionals interacted with them at the meeting. This reflects findings in Cossar et al.'s (2011) study, which noted that attendance at child protection meetings can be difficult for children and young people and that professionals and practitioners need to be mindful of how they are engaged with. In addition, issues emerged where parents are unwilling or unable to identify needs of their own that might be a factor in their family's issues: at Meitheal Review Meetings, for example, children and young people's needs may be unduly focused on in isolation. This not only undermines the holistic underpinning of Meitheal but also exacerbates the tendency, as previously noted by Cossar et al. (2011), for this cohort to feel responsible for not only creating but resolving their family's issues. A crucial finding in this research is the need to ensure that children, young people and families are not blamed or burdened but, instead, strengthened and empowered in the Meitheal process.

Although generally Lead Practitioners, and to a lesser extent parents, demonstrated good understanding of the Meitheal process, this was not uniform across the research cohort. Some parents appeared to be confused about their role in the process and how much information they should expect to have access to regarding their children. There appeared to be significant issues with how Meitheal was understood by children and young people, particularly in comprehending its role and the extent to which they could or should be involved. While Meitheal appears to have led to parents taking on an active role in their engagement with service providers, children and young people (taking into account age and capacity) seem to, with some exceptions, play a relatively passive role as recipients of services rather than as active co-creators of solutions to their issues. This can in part be traced back to their understanding of Meitheal, as without a clear understanding of the process and their rights within it, it is more difficult for them to exercise these rights and be confident in doing so. This can potentially be linked to findings by Coyne et al. (2006), who noted that this cohort needs to be given time to take in information, which in turn improves their participation in processes, as they can ask questions and seek clarification.

Concerns emerged from the data about the lack of public awareness about the existence of Meitheal, including among service providers and potential users. This finding is in line with current research in the field, where the lack of awareness of the Meitheal model was evidenced in a nationwide population survey (McGregor and Nic Gabhain, 2016). Although awareness was beginning to spread, and parents were supporting this by recommending the model within their social networks, at present access continues to depend largely on the knowledge of particular individuals rather than because of systemic awareness. This reduces the possibility that Meitheal could become a resource for families with no previous contact with services, since access depends on already having contact with someone who is familiar with the programme. This issue echoes Kyle and Kellerman's (1998) systematic evaluation of family resource programmes in Canada, which found that one of the limiting factors of the possible benefits of interventions was a lack of public awareness of what services were available and how they worked.

A challenge to the implementation is the availability of services to participate in Meitheal. This is particularly the case where acute services are needed, such as disability, housing supports and mental health professionals. These issues are caused by a combination of factors, including lack of engagement
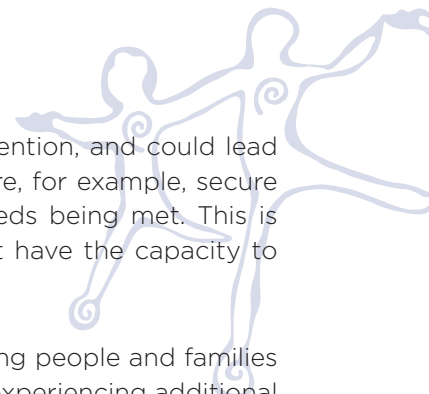
and under-resourcing. This threatens the model's stated premise of early intervention, and could lead to Meitheal acting as a 'holding' service to prevent the escalation of issues where, for example, secure housing is not available for families, or to the closure of Meitheals without needs being met. This is exacerbated by the influence of socio-economic factors that Meitheal does not have the capacity to influence or control.

Findings of this preliminary report have shown that the majority of children, young people and families report high scores for outcomes, and only a small number may be struggling or experiencing additional needs. This suggests that the initial screening and evaluation processes are effectively identifying the levels of needs that families have and therefore the appropriate intervention they require. This is in line with Tusla's Child Protection and Welfare Strategy (2017: 4) which states that 'children and families will get into the right service at the right time for the right reason'.

The Meitheal toolkit, which includes the essential components of the Meitheal and CFSN model, (Tusla, 2015) stated that the highest level of need that Meitheal can respond to, as determined by the Hardiker model, is level 3, insofar as these needs are not dependent on the resolution of child protection and welfare concerns as contained within Tusla's National Service Delivery Framework (2016). The needs of children and young people at this level are multiple and complex and require a coordinated multi-agency response such as Meitheal or the Initial Assessment Process. This study has identified that families in Meitheal can have low levels or less complex additional needs. A small proportion of families reported outcomes below 50% of the possible total scores obtained. Results on the SDQ suggest a level of need between slightly raised and high, but these are not at the highest level. All children report positive outcomes, and only a few teenagers scored below the median score of the outcomes measures. The reasons for referral, both primary and secondary, are mostly related to emotional and behavioural issues. These reasons correspond to the statistics collated nationwide: the vast majority of Meitheals initiated (Q3 and Q4 2016) were due to emotional and behavioural difficulties.

Maternal well-being seems to stand out over other variables, as the majority of mothers report scores above the cut-off score of the General Health Questionnaire (GHQ); this suggests the importance of continuing to evaluate the impact of maternal well-being even if families are between 1 and 3 in their levels of need. It is significant to note that the majority of parents and guardians in the study are mothers, which may reflect the gender bias in the field of interest and traditional gender roles where mothers are more involved in mothering and caring roles.

Child protection services have experienced a shift towards preventive approaches (Centre for Effective Services, 2013); however, the quantitative and qualitative findings concur that it may be too early to identify major changes in the system of help-seeking and help-provision in Ireland. The introduction of Meitheal, however, has made evident the continuum of support that Meitheal can provide at the different levels of need. Help provision from a prevention and early intervention perspective is now being quantified and validated as part of Tusla's performance data. As Devaney and Mc Gregor (2017) highlight preventative Family Support and child protection often happen at one and the same time. This shows the strengths and added capacity of Tusla to identify and respond to the needs of children, young people and families at different levels of need, which is in line with the Signs of Safety approach being adopted by Tusla as a key component of its Child Protection and Welfare Strategy (2017). As highlighted in the report *Early implementation of Meitheal and the Child and Family Support Networks: Lessons from the field (Cassidy, Devaney and Mc Gregor, 2016)* the interface between Meitheal and the child protection system is a critical area of practice that requires continued attention. It is envisaged that the final research report on Meitheal will provide further clarity on the effectiveness of practices that overlap in these systems.

It is also important to note that the visibility of Tusla's work carried out at lower levels of need and from a prevention and early intervention perspective is increasing. This is evident in the fact that the number of Meitheals initiated increased from 2015 to 2016. This however may also be due to an improvement in the definition of Meitheal and the method by which Meitheal is quantified. In the early stages of Meitheal implementation differences emerged in how Meitheal was defined nationwide and therefore how it was quantified (Cassidy, Devaney and McGregor, 2016). Early and cross-sectional findings do suggest that higher levels of fidelity to the Meitheal model may be related to higher levels of well-being, which require further longitudinal exploration.

6.3 Conclusions

- **Overall, Meitheal is perceived to be a positive experience for both families and Lead Practitioners. This includes the potential impact on outcomes for children and young people, and their participation in it. Although it is still at an early stage, parents were engaged and responsive and felt empowered, while children and young people felt supported and listened to by the Lead Practitioners and that Meitheal could have an impact. Lead Practitioners felt that while it increased their workload, it was a mechanism that could facilitate changes in outcomes and in how services are provided.**

- **Some issues emerged, particularly around the nature of children and young people's participation, resources, and engagement by services and agencies. These have the potential to limit the effectiveness of individual Meitheals and the overall implementation of the model. Of particular interest is the need to ensure that children, young people and families are not blamed or burdened in the Meitheal process as this can be detrimental to the success of the Meitheal process and the actual provision of support for their needs.**

- **Children, young people and families in Meitheal have appropriate levels of need corresponding to the levels of need that Meitheal can respond to. This suggests that an appropriate and efficient evaluation of needs and screening processes and clear responsive pathways are in place.**

- **Meitheal needs to have a holistic approach to children's, young people's and family's needs, as the needs of one family member can have an impact on the whole family.**

- **Inter-agency collaboration can contribute to a holistic response to the complex and varying needs that a single family can have, particularly early on, in order to guarantee better outcomes for children and young people. The high level of emotional and behavioural problems evidenced the necessity for the provision of more specialised services in these areas that can effectively respond to the needs of children and young people.**

- **Even though the help provision system has not significantly changed since the introduction of Meitheal, the introduction of this model of prevention and early intervention has provided visibility to the capacity of Tusla to identify and provide for the needs of children, young people and families in a continuum of support and at all levels of need.**

- **The study shows Tusla's capacity to provide for the different levels of need of children, young people and families in Ireland. However, it is important to consider that the needs of children and families are the responsibility of every agency in the country as was established in the national policy framework for children and young people (BOBF, 2014-2020: 2): '…make Ireland the best small country in the world in which to grow up and raise a family, and where the rights of all children and young people are respected, protected and fulfilled; where their voices are heard and where they are supported to realise their maximum potential now and in the future'.**
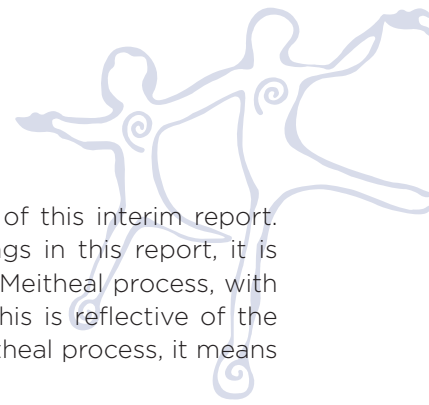
6.4 Limitations

This section emphasises the overall limitations encountered in the preparation of this interim report. Methodological limitations are detailed in section 2.7. In considering the findings in this report, it is important to note that the participant families were at a very early stage in the Meitheal process, with most not yet having attended a Meitheal Review Meeting, or just one. While this is reflective of the study's research design, as it seeks to capture data at different points in the Meitheal process, it means that there was limited data available on some topics.

A limitation of the data collected to date is that it contains the voice of only a small number of male participants. While the study is open to fathers, it was primarily mothers who took part up to the data collection cut off point. Similarly, almost all of the Lead Practitioners who supported the data collection so far were female. By contrast, of the children and young people who agreed to take part in this research, eight were male and two were female.

In most cases the Lead Practitioner worked for a family support service. This means that it is not necessarily possible to link their behaviour to Meitheal, as their attributes of listening, being non-judgemental and providing flexible support could be due to their own prior work experience, the approach of the service they work for, or their own attitude to the work that they have been tasked to carry out.

A possible limitation of the data collected for this study is that because participants self-selected to take part, those families who were dissatisfied with the Meitheal process would be less likely to agree to it. Therefore, the findings here could be skewed in favour of those who had positive experiences of Meitheal.

A limitation of the findings is that no PPFS managers or CFSN Coordinators were interviewed for this report. The role of CFSNs in supporting the implementation of Meitheal was not focused on. This will be included in the next phase of the data collection and presented in the final report.

6.5 Recommendations for Practice

- **Where a Lead Practitioner is only known to one member of the family, care needs to be taken that other relevant family members are included as much as possible throughout the process. This includes supporting participation in discussions about services, providing information and ensuring that relevant individuals are kept informed. This is especially the case where the Lead Practitioner has a prior known relationship only with a parent and not with the child or young person. Co-working arrangements could be put in place so that Lead Practitioner duties are shared between services with remits to work with particular cohorts. This could help to ensure that participation by all relevant parties is supported.**

- **Particular care needs to be taken to increase engagement where possible among essential acute services, such as housing, disability services or mental health. Efforts to increase engagement need to take into account different levels of management at local and national levels, as well as among frontline service providers.**

- **Upholding and encouraging the expression of parents', children's and young people's right to participate should be continually reinforced as the responsibility of all participants in Meitheal, including but not exclusive to the Lead Practitioner or the chairperson. Particular attention needs to be paid to how children and young people are included in the Meitheal Review Meetings, to ensure that they are child-centred. All attendees at the meeting should be made aware of the purpose and nature of children and young people's involvement, and clear guidelines should be established and monitored by the chairperson around how they are included in the meeting.**

- Attention needs to be paid to what needs are identified for inclusion in action plans. Where parents are unwilling or unable to identify needs of their own, attention should be paid to how the needs of others, particularly their children, are framed. This can help to avoid undue stress, blame and/or burden being placed on the child or young person as the cause of a family's issues and/or becoming the sole focus of the Meitheal action plan.

- The introduction of a mentoring process to support Lead Practitioners in their initial Meitheal could be considered. This could improve confidence levels in the capacity to take on this role and increase model fidelity, especially where there is a lengthy gap between completion of the Meitheal standardised training and commencement of the Meitheal itself.

- A public awareness and communications strategy is recommended, as a priority, to raise awareness among professionals and practitioners who could lead a Meitheal and among the wider population. Data performance reports that are in the public domain should be included in these strategies, in order to make Tusla's work visible and accessible to the general population and to encourage reflective practice intra- and inter-agency.

- Data available in Meitheal databases is somewhat limited with no data from the Strengths and Needs forms. To improve the availability of data and to facilitate the analysis it could be useful to have more appropriate software in place. Therefore, the inclusion of a Meitheal and CFSNs section in the National Child Care Information System could be prioritised.

- The importance of having defined, measurable outcomes should be embedded in the culture of Tusla and its partner agencies, as this provides evidence of whether child protection and welfare objectives are being achieved. One of the ways that outcomes can be measured is through research and evaluation. As there was a relatively low level of involvement by practitioners the possibility of gaining a national understanding of outcomes-focused practice nationwide is limited.

- Following on from this outcomes-focused strategic objective, it is important for Tusla to have a congruent and systematic way to record and report performance data. The same vocabulary should be used throughout so that it becomes more accessible, and the same data needs to be tracked over time and clearly reported. Data performance reports are in the public domain, but it is important to include these as part of Tusla's public awareness strategies and campaigns to make Tusla's work visible and accessible to the general population and to encourage reflective practice.

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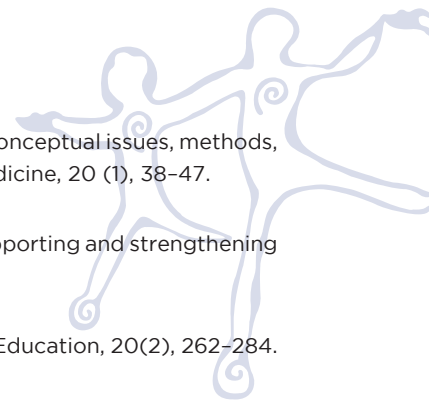
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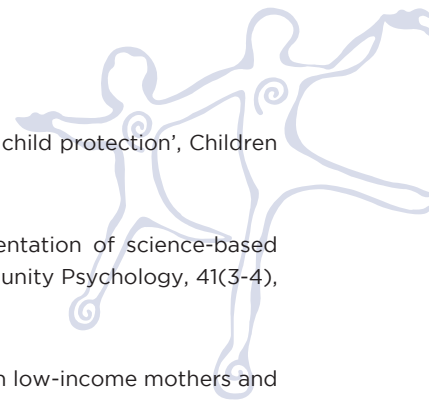
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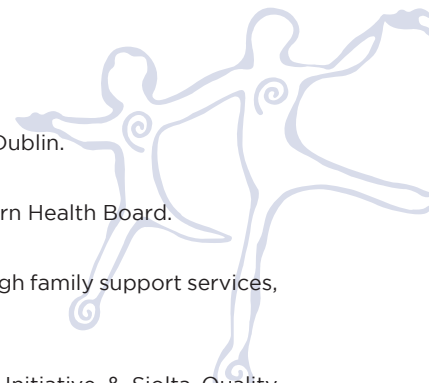
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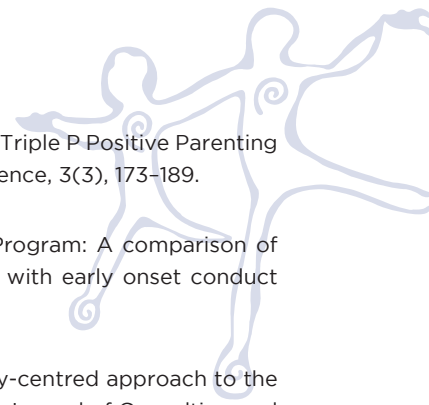
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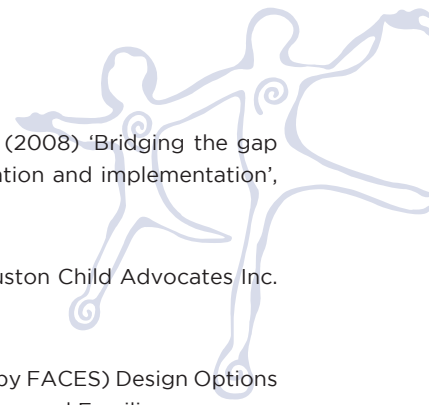
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Appendices

Appendix 1

Scales and Questionnaires
General Health Questionnaire (GHQ 12)

Please read this carefully:
We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

HAVE YOU RECENTLY:

1 -	been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2 -	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3 -	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4 -	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5 -	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6 -	felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7 -	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8 -	been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9 -	been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10 -	been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11 -	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12 -	been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

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Meitheal Fidelity Checklist

Date:
Meitheal no:
Area:
Child and Family Support Network Coordinator (CFSNC):
Lead practitioner (LP):

<u>Please tick</u>✓ the most suitable response to the following questions:

Stage One: Planning

	Yes ✓	Partially ✓	No ✓	Comment
1. Is a lead practitioner who has a prior relationship with the family members leading the Meitheal process?	○	○	○	
2. Has the CFSNC determined that no current child protection concerns exist?	○	○	○	
3. Has the LP considered a single response option to meet needs of child/ young person in advance of considering a Meitheal?	○	○	○	
4. Has a decision to hold a Meitheal been discussed & agreed with the parent(s) and child(ren) as appropriate, and with the CFSNC by the LP?	○	○	○	
5. Is the process complying with the guidelines on the interface with the child protection and welfare system?	○	○	○	

Stage Two: Discussion

	Yes ✓	Partially ✓	No ✓	Comment
1. Has a strengths and needs form including desired outcomes been completed with the parent(s) on each identified child / young person by the LP?	○	○	○	
2. Has a response been planned and agreed with parent(s)?	○	○	○	
3. Has a Meitheal Support Meeting been arranged?	○	○	○	

Stage Three: Delivery

	Yes ✓	Partially ✓	No ✓	Comment
1. Did one / more Meitheal Support Meetings take place?	○	○	○	
2. Were the parent(s) and child/ young person present?	○	○	○	
3. Was a need, outcome, indicator and action plan agreed with the parent, child or young person and recorded for each identified child?	○	○	○	
4. Was this plan(s) reviewed on a regular basis in an outcomes focused way until the child's needs are met or the process ended?	○	○	○	
5. Were the Closure and Feedback forms completed and returned to the CFSNC?	○	○	○	
6. Was there an appropriate information sharing procedure followed throughout the process?	○	○	○	

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name .... Male/Female

Date of Birth...

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Signature .... Date ....

Parent/Teacher/Other (please specify:)

Thank you very much for your help

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Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name .... Male/Female

Date of Birth..

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am usually on my own. I generally play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Your signature ....   Today's date ....

Thank you very much for your help

Outcomes Star

Star Chart

Family Star Plus™

An Outcomes Star for parents

Parent _____

Date of completion _____

First ○ Review ○ Retrospective ○

Completed by Professional and parent ○
Professional ○
Parent ○

Number of children ○
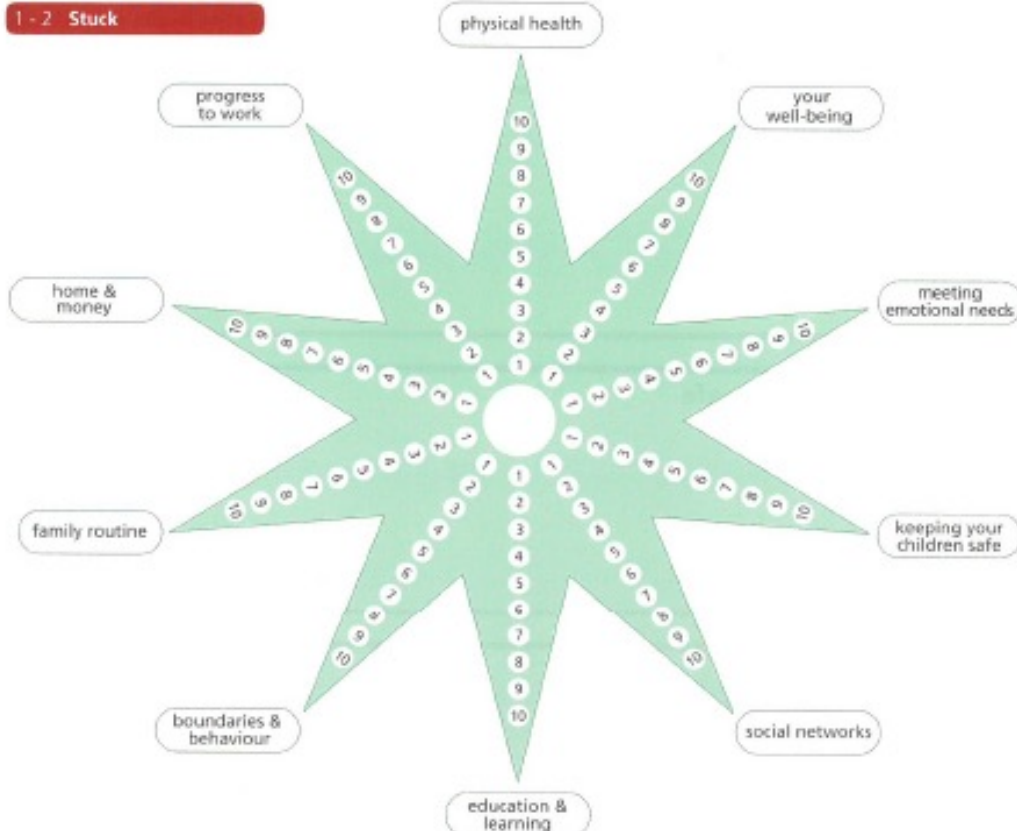
9 - 10	Effective parenting
7 - 8	Finding what works
5 - 6	Trying
3 - 4	Accepting help
1 - 2	Stuck

- physical health
- your well-being
- meeting emotional needs
- keeping your children safe
- social networks
- education & learning
- boundaries & behaviour
- family routine
- home & money
- progress to work

Parent: I was involved in completing this Star Chart _____

Outcomes Star

Family Star Plus™ © Triangle Consulting Social Enterprise Ltd | www.outcomesstar.org.uk
The Star Chart must be used with the User Guide and workers trained by a licensed Star trainer

![Outcomes Star logo]

Star Chart

Youth Star™
The Outcomes Star for youth work

Young person _____

Date of completion _____

First ◯   Review ◯   Retrospective ◯

Completed by   Worker and young person ◯
Worker alone ◯
Young person ◯

making a
difference

5
4
3
2
1

choices and
behaviour

hopes and
dreams

communicating

well-being

education
and work
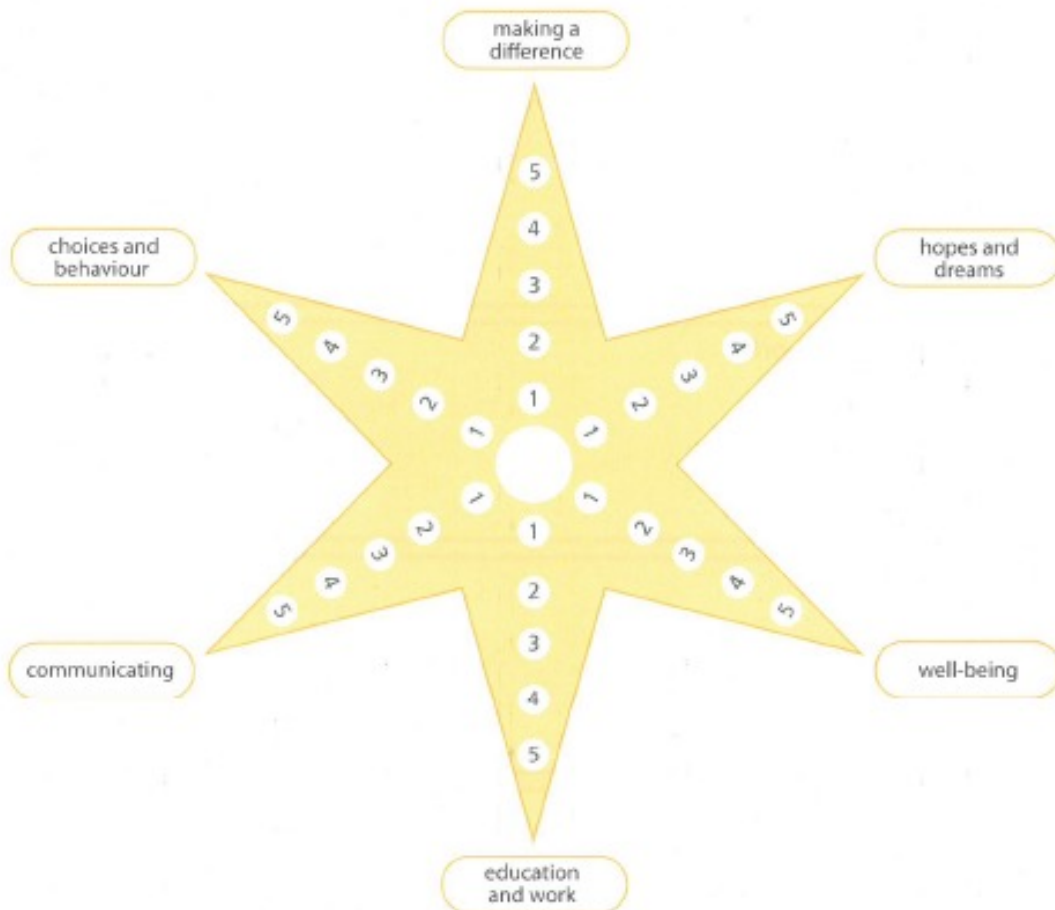
Young person: I was involved in completing this Star Chart _____

Appendix 2

Information Sheets and Consent Forms

Meitheal and Family Support Networks
Process and Outcomes Study
Child/ Young Person Interview Prompt Questions

(Adapted from Brandon et al. 2014 and Brady et al., 2008)

Access to Meitheal[1]

How did you find out about Meitheal?

Were you provided enough and clear information about Meitheal?

Did you know your family was involved in Meitheal?

Were you happy to take part, do you think it will help your family?

What did you think of Meitheal before? What did you expect it would be like?

The Meitheal Process

How did you get on with the practitioner/ people of Meitheal that helped you?

Did you feel that they were fair and you could trust them?

Was the practitioner/ Meitheal person easy to talk to?

Did the practitioner/ Meitheal person help you sort out and understand your problems?

Was there anything they could not help you with?

Was the practitioner/ Meitheal person consistent (did what they said)?

Did the practitioner/ Meitheal person listen carefully to what you said?

What did you do with the practitioner/ Meitheal people?

Did the practitioner/ Meitheal person listen to your views and did something about them?

Did the practitioner/ Meitheal people help you or support you and your family in any

What happened if you were unhappy or upset about something the practitioner/ Meitl persms said or did?

Did you understand the reasons why decisions were taken?

Perception of the future

What help do you feel you and your family need now?

Do you think you will get the help you need?

How do you imagine things will be for you in a year?

What are the best things about Meitheal? What is not so good?

Is there anything that you have not yet ask or discuss?

Meitheal and Family Support Networks

Process and Outcomes Study

Parent/ Guardian Interview Prompt Questions

(Adapted from Brandon et al., 2014 and Brady et al., 2008)

Access to Meitheal

How did you first find out about Meitheal?

Have you been involved with other services before?

Why do you think your family was referred to the service?

What type of help were you looking to obtain? (Was your family having a problem at the time?)

What did you expect of Meitheal before starting, how did you think it would be?

How did you feel about the amount of time you and your family had to spend during the Meitheal process?

How long did you have to wait for the service?

The Meitheal Process

How did you get on with Meitheal practitioners?

Did you feel you could trust Meitheal practitioners?

Do you think practitioners were fair?

Did practitioners explain things clearly?

Were practitioners easy to talk to and listened to you carefully?

How did practitioners help you understand and sort your problems?

Were practitioners consistent (doing what they said they would do)

What sort of help/ support were you provided?

---

[31] These questions will only be asked at the pre-Meitheal stage of the study (Time 0 data collection).

Was there anything Meitheal could not help you with?

What happened if you were unhappy or upset about something the practitioner said or did?

How has Meitheal helped you as a parent/ adult?

How has Meitheal helped your family/ children and young people?

Is your family coping better with problems now than before Meitheal?

Perception of the future

What sort of help do you feel you/ your family need now?

Do you think you will get it?

How do you think things will be for you/ your family in a year's time?

What are the best things about Meitheal? What is not so good?

Would you recommend Meitheal to another family in a similar situation to yours?

Is there anything that you have not yet ask or discuss?

Meitheal and Family Support Networks

Process and Outcomes Study

Regional Managers Interview Prompt Questions

1. How do you feel that the overall implementation of Meitheal and the CFSN model is progressing?

2. How do you feel that the Meitheal and the CFSN model fits into the overall prevention, partnership and Family Support strategy?

3. What are the key challenges facing the implementation of Meitheal?

4. What are the key challenges facing the implementation of the CFSNs?

5. What are the strengths of Meitheal?

6. What are the strengths of the CFSNs?

7. What are the weaknesses of Meitheal?

8. What are the weaknesses of the CFSNs?

9. What do you think are the significant fidelity issues for the implementation of Meitheal? What progress, if any, has been made towards resolving these?

10. Can you tell me a little about how the interface between Meitheal and other parts of the child welfare system such as Child Protection and Welfare are going?

11. How has the implementation of Meitheal and the CFSNs impacted at a system level in Tusla?

12. Is there anything further you would like to discuss that has not been mentioned so far?

Meitheal and Family Support Networks

Process and Outcomes Study

Practitioner Focus Groups Prompt Questions

(Adapted from Brandon et al. 2014 and Brady et al., 2008)

Meitheal General ((pre-post-follow up)

1. What is it like to be a practitioner taking part in a Meitheal?
2. How is Meitheal working in practice?
3. How was the Meitheal training process? Did you require or want different trainings?
4. How many Meitheals are you working with? How long are you working with them?
5. What are the issues that Meitheal families you have worked with have?
6. How do you handle families that want to drop out?
7. Who are you working with? How do you find coordinating meetings? What is your experience with Meitheal partners/ other agencies?
8. How does your work impact on you?
9. Who supports you (formally and informally)?
10. How do you find the supervision process?
11. What might threaten/ limit the success of Meitheal?
12. What control do you have over resources available?
13. What is the impact of Meitheal at a local and national level?
14. Are there any recommendations/ suggestions you would like to make for how Meitheal could work better?

Family Specific (pre-post-follow up PER FAMILY)

1. What is your relationship with this family (Process of establishing the relationship, frequency of visits)
2. How are you engaging with this family?
3. How did you obtain family consent?
4. How did you agree an action plan with this family?
5. How do you ensure that the voices of all family members are heard?
6. How can you make sure you are meeting the needs of all family members?
7. What resources are you using/ find helpful?
8. What kind of support do you find easier or harder to deliver successfully? Can you give me an example of work you have done that worked well and an example of what has not worked so well.
9. How is the closing of a Meitheal process with this family? (follow up/ step up/ step down)
10. Anything else you would like to say?

ALL ABOUT ME

What I like the most

My Future...

People I love

ME

Meitheal Time

My Hardest Time...

My Happiest Time

Emotion Faces

Anxious   Bored   Cold   Confident

Curious   Dissapointed   Disgusted   Exhausted

Happy   Hot   Hysterical   Interested

Lonely   Satisfied   Surprised   Thoughtful
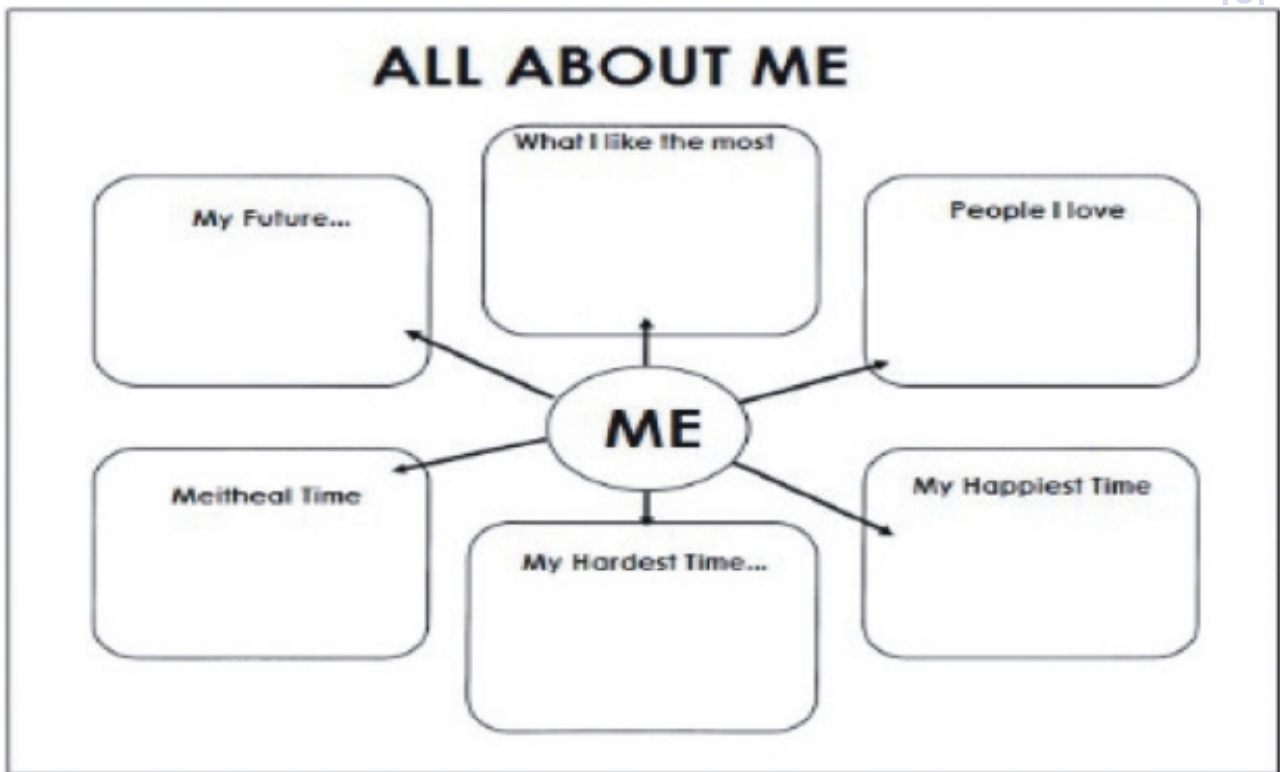
Tell us about a time when you felt....

MY LIFE LADDER

very happy

less happy

LIFE HAS UPS AND DOWNS.....CAN YOU SHARE SOME OF YOURS?

....
....
....
....
....
....

Appendix 3

Participant Information Sheet and Consent Forms
- Child Consent Form

Child Information Sheet

Meitheal

Who are we?

Carmel, Leonor and Anne are researchers from the UNESCO Child and Family Research Centre, at the National University of Ireland, Galway.

This centre works with children and young people to understand their everyday experiences and how to improve children's lives.

What will you have to do if you decide to take part?

We will talk to you about what you feel about being in Meitheal.

We will ask you to draw a picture for us called 'All About Me'. And tell us all about you. We will record you with a voice recorder (only if you agree!) and you can hear yourself on it afterwards

You will complete 'My Star' which has questions to get to know you and your life a bit more.

Do you have to take part?

Not at all! It is up to you. You can also say yes and change your mind later on, all you have to do is let us know or your parent/ guardian or another adult know.

We are not going to be angry at you and you and your family will continue to receive the help you need as normal.

If you have any questions please ask us any time in person, by phone or by email.

Carmel Phone: 091495733

Email: carmel.devaney@nuigalway.ie

What is this study about?

We are trying to understand the experiences of children, young people and families taking part of Meitheal.

This will help adults understand what is good about it, what is not so good and how can it be better so we can help children, young people and families more.

Will anyone know that you are taking part or what you told us?

We are the only ones that will know your name and that you are taking part of the study.

We will never use your real name

The only time we will have to tell someone what you say is if you tell us that someone is hurting you or harming you in any way, as we want this to stop immediately.

Is there anything that will upset you if you take part?

Talking about your experiences, particularly difficult ones, can be a bit sad or upsetting.

If you feel like this please let us know or another adult know immediately. You can stop taking part at this time.

We will also give your parent/ carer names of people you can talk to about how you feel and they will help you feel better.

CHILD

CONSENT FORM

I agree to take part of the study	YES 🙂	NO 🔴
I am happy to have the researcher in my house 3 times (fewer times is okay too)	YES 🙂	NO 🔴
I agree to complete the activities and pictures	YES 🙂	NO 🔴
I am happy to be recorded	YES 🙂	NO 🔴
I know my name will not be used in the report	YES 🙂	NO 🔴
I know I can withdraw from the study at any time	YES 🙂	NO 🔴

My Name is:

_____

(Please sign your name)

Date:

Young Person Information Sheet
Meitheal Study

This gives you information about a research study on the experience of children, young people and families involved in Meitheal. You are invited to take part in the research and it is very important that you know what the project is about and what you are asked to do.

What's the study about?

The UNESCO Child and Family Research Centre, at NUI Galway and TUSLA, the Child and Family Agency are doing a study on children and young people and families involved in Meitheal. We want to know more about the lives of children and families and what happened since you were involved in Meitheal. This is important for improving services for children, young people and families in Ireland. We are asking you to participate in this study that will run from January 2017 to February 2018.

What is the benefit of taking part?

This study allows the Child and Family Agency (TUSLA) and researchers to hear your opinions about things that they do that work for children and young people and things that they could be doing better to improve children's lives and how services can be improved.

What do I do?

If you would like to take part, talk to your parent(s)/ guardian(s) who also received information on the study. If would like to be involved in the research and your parent(s)/caregiver(s) are happy for you to take part, you can sign the consent form.

If you agree to take part, you will be asked to talk with the researchers and complete three activities (All about me, Youth Star and Strengths and Difficulties Questionnaire) to get to know you best and tell us about your experience in Meitheal. We will meet in and your practitioner at a day and time that suits you and your parents/ guardians.

If you agree, researchers will also have access to Tusla records about you and your family. These will help us know a bit more about you but we will never use your real name and we will not share that information with anyone.

Do I have to take part?

No you don't have to take part! And even if you decide you'd like to take part in the research and then change your mind, that's okay! Also taking part or not taking part will not make any difference to the services provided for you.

What are the risks of taking part?

During the process, you might have uncomfortable feelings or emotions. If this happens, you should tell the researcher who will ask you if you wish to continue, or decide not to take part anymore. If you tell us something about you or another child that puts you at risk of harm, then we are required to pass this information on as part of our responsibility.

How will the information be collected?

Our conversation about the activity 'All about me' will be recorded with an electronic recording device. Youth Star and the Strengths and Difficulties Questionnaire are completed on paper. All your information will be stored securely and only the researchers will have access to it. This information will be safely kept for five years and then it will be destroyed.

Will anyone know they were my answers?

No. The information is confidential and anonymous. Nobody will be able to identify and we won't share any information with anyone.

Who are the researchers?

The project researchers are Carmel, Leonor, Anne. They have a lot of experience doing research researching with children and families and they work at the UNESCO Child and Family Research Centre, NUI Galway.

You can contact Carmel about the project by telephone at 091 495733 or you can e-mail her at carmel.devaney@nuigalway.ie. You can also ask your parent(s)/caregiver(s) to do this for you.

Thank you for reading this and taking part of this study!

You will be receive a copy of this Information Sheet and a signed Consent Form to keep.

Young Person Consent Form

Meitheal Study

Please read the Participant Information Sheet before you agree/do not agree to take part in the Meitheal Study. If you agree, researchers will work with you and your practitioner to get to know you better and what Meitheal has been like for you.

This research was approved by the Research Ethics Committee of the National University of Ireland Galway. If you have any questions or concerns about your rights as a participant in this study, please contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of Vice President for Research, NUI Galway. You can also e-mail them at ethics@nuigalway.ie

If you wish to ask any questions or to discuss any concerns about the research, please contact Carmel, Project Researcher at 091 495733 or via e-mail at carmel.devaney@nuigalway.ie

Please tick to indicate whether you agree to take part, or you do not agree;

■I have read the Participant Information Sheet for the study

■I agree to talk with the researcher and complete the three activities she

will ask me to do (All about me, Youth Star and Strengths and Difficulties

Questionnaire).

■I agree to let the researcher obtain information about me and my family

from Meitheal records (date of birth, nationality, sex, address, siblings

and services who are or have supported you).

■I understand that my name will never be revealed and my information

will always be safe and locked away until destroyed.

■I am happy to be recorded and I understand that this information

will always be safely stored away until destroyed.

■I do not agree to be involved in this study

With researchers for the Meitheal Study,

Please sign your name here: **Date:**

Parental/Guardian Consent Form

Meitheal Study

If you agree to take part in the Meitheal Study, you must tick the boxes below. Please read the Participant Information Sheet before you agree/do not agree to take part in the research.

This research was approved by the Research Ethics Committee of the National University of Ireland Galway. If you have any questions or concerns about your rights as a participant in this study, please contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of Vice President for Research, NUI Galway. You can also e-mail them at ethics@nuigalway.ie

If you wish to ask any questions or to discuss any concerns about the research, please contact Carmel, Project Researcher at 091 495733 or via e-mail at carmel.devaney@nuigalway.ie

Please tick the boxes below if you agree to take part in the study;

■ I have read the Participant Information Sheet for the study

■ I have had the opportunity to ask questions

■ My participation in this Study is voluntary

■ I understand that I can withdraw from the study at any time

■ I agree to let the researchers obtain information about me and my

family from Meitheal records (date of birth, nationality, sex,

address, siblings and services who are or have supported me or

my family currently or in the past)

■ I am happy to be recorded and I know this information will be

safely stored for five years until destroyed.

With researchers for the Meitheal Study,

Please sign your name here: **Date:**

Are there any risks involved?

You/your child/ young person might experience some uncomfortable feelings or emotions when researchers are observing your interaction at home. If this happens, you should tell the researcher who will ask you if you wish to continue with the process or not. There won't be any negative consequences to you or your child if you do this.

What happens if a concern about risk to a child is talked about during the research process?

As far as possible, all information will be confidential and there will be no way to link what you tell us directly back to you. The data will be fully anonymised. However, if you or your child/ young person tells us about something that has put your child, or another child, at risk of harm or abuse, we will be obliged to pass this information onto TUSLA as part of our responsibility for child protection under *Children First 2011* Guidelines. This is the ONLY situation when confidentiality will be broken.

How shall the information be collected and stored?

All information with children and parents are recorded on paper and transferred to the researcher computer. Interview recordings will be safely stored. All information will be stored very safely so only the researchers will have access to it. It will be destroyed after five years.

Will someone be able to identify me or what I say in an interview?

No. Details about you or your child/ young person won't be given to anyone else either and it won't be possible for anyone to recognize you or your child.

Who are the researchers?

The project researchers are Dr Carmel Devaney and Dr Leonor Rodriguez and Dr Anne Cassidy. They have a lot of experience researching with children and families and work at the UNESCO Child and Family Research Centre, NUI Galway.

If you and your child/ young person want to take part, we ask that you sign a consent form. Also, if you have any questions or comments, you can contact Carmel Devaney one of the researcher, by phone at 091 495733 or e-mail at carmel.devaney@nuigalway.ie

Yours sincerely,

Carmel, Leonor and Anne

Thank you for reading this and taking part of this study!

You will be receive a copy of this Information Sheet and a signed Consent Form to keep.

Practitioner Information Sheet

Meitheal Study

Dear Participant,

This gives you information about a research study on the experience of children, young people and families involved in Meitheal. You are invited to take part in the research and it is very important that you know what the project is about and what you are asked to do.

What's the study about?

The UNESCO Child and Family Research Centre, at NUI Galway and TUSLA, the Child and Family Agency are doing a study on children and young people and families involved in Meitheal. We want to know more about the lives of children, families and what happened since they were involved in Meitheal, from the point of view of practitioners. We also want to hear practitioner's voices about the impact of Meitheal in Tusla and Ireland and about your experience taking part of Meitheal. This is important for improving services for children, young people and families in Ireland. We are asking you to participate in this study that will run from January 2017 to February 2018.

What will you do?

If you agree to take part of the case study, we will ask you to take part of a focus group with other Meitheal practitioners to discuss your experience in more depth. We will also ask you to complete the Meitheal Fidelity Checklist three times, at the beginning of the study, six months after and then a year later.

Do you have to take part?

Taking part is voluntary. You can decide to take part or not. You can say 'No' at any time and opt out during the process if you wish. Your role in Meitheal won't be affected if you decide not to participate. You don't have to take part and you don't have to talk about anything you don't want to.

Are there any risks involved?

You might experience some uncomfortable feelings or emotions when you share your experience in the Meitheal focus groups, as this may be sensitive information. If this happens, you should tell the researcher who will ask you if you wish to continue with the process or not. There won't be any negative consequences for you if you do this.

How shall the information be collected and stored?

We will coordinate the focus groups at time and place that suits you best. These focus groups will be recorded. You will not be identifiable we will not share any information about you or the family case study with anybody else. If you are concerned about sharing information with other people, you can have a private interview with one of the UCFRC Researchers. All recordings will be safely stored for five years after which they will be destroyed.

Who are the researchers?

The project researchers are Dr Carmel Devaney and Dr Leonor Rodriguez and Dr Anne Cassidy. They have a lot of experience researching with children and families and work at the UNESCO Child and Family Research Centre, NUI Galway.

If you want to take part, we ask that you sign a consent form. Also, if you have any questions or comments, you can contact Carmel Devaney one of the researchers, by phone at 091 495733 or email at carmel.devaney@nuigalway.ie

Yours sincerely,

Carmel, Leonor and Anne

Thank you for reading this and taking part of this study!

You will be receive a copy of this Information Sheet and a signed Consent Form to keep.

Practitioner Consent Form

Meitheal Study

Please read the Participant Information Sheet before you agree/do not agree to take part in the research. If you agree, researchers will coordinate a focus group with you to talk about your experience of Meitheal and complete the Meitheal Fidelity checklist three times. If you do not agree, this data will not be shared.

This research was approved by the Research Ethics Committee of the National University of Ireland Galway. If you have any questions or concerns about your rights as a participant in this study, please contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of Vice President for Research, NUI Galway. You can also e-mail them at ethics@nuigalway.ie

If you wish to ask any questions or to discuss any concerns about the research, please contact Carmel, Project Researcher at 091 495733 or via e-mail at carmel.devaney@nuigalway.ie

Please tick the boxes below if you agree to take part in the study;

• I have read the Participant Information Sheet for the study

• I have had the opportunity to ask questions

• My participation in this Study is voluntary

• I understand that I can withdraw from the study at any time,

• I agree to let the researchers obtain information about me and my

family from Meitheal records (date of birth, nationality, sex,

address, siblings and services who are or have supported me or
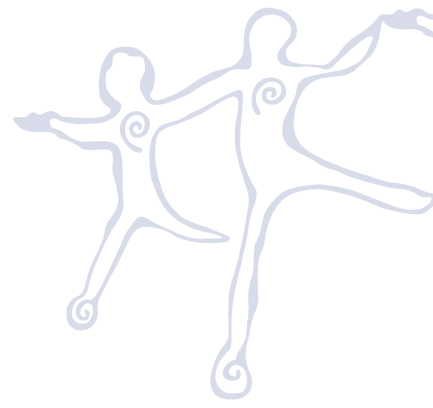
my family currently or in the past)

• I am happy to be recorded and I know this information will be

safely stored for five years until destroyed.

With researchers for the Meitheal Study,

Please sign your name here: Date: