A national review of the COMMUNITY MOTHERS PROGRAMME

Full Report

Susan Brocklesby

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KHF KATHARINE HOWARD FOUNDATION

The Community Foundation for Ireland

Acknowledgements

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- Jim Gibson, Chief Operations Officer
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- Aidan Waterstone, Senior Manager
- Aisling Gillen, Regional Service Director - West and National Lead, Prevention, Partnership and Family Support
- Caroline Jordan, Regional Implementation Manager, Prevention, Partnership and Family Support
- Catherine O'Donoghue, Regional Implementation Manager, Prevention, Partnership and Family Support

Katharine Howard Foundation (also representing Community Foundation for Ireland)

- Noelle Spring, Director
- Francis Chance, Programme Manager
- Marguerite Hanratty, Strategy Implementation Consultant

Foreword: Katharine Howard Foundation and the Community Foundation for Ireland

The Katharine Howard Foundation (KHF) and the Community Foundation for Ireland (CFI) have been aware for many years of the work carried out through the Community Mothers Programme in locations around Ireland. Both Foundations have provided financial supports to a number of these projects on occasions. From our experience, the Community Mothers Programme has been an important resource in providing early and valued support to families in their own homes and communities.

In recent years, CFI and KHF were concerned to hear that a significant number of Community Mothers Programme sites had closed while others had significant fears for their future. As a result, we agreed that it would be beneficial to conduct a review of the current status of the Community Mothers Programme in Ireland with a view to informing the development of a strategic plan for the future of the Programme.

The focus of this review is on the nine remaining sites delivering the Community Mothers Programme or an equivalent and similar programme.

Two key statutory agencies currently provide most of the funding to the Programme, the Health Service Executive and Tusla – The Child and Family Agency. The two Foundations felt that it was imperative that these key funders would actively engage in and support the review process. We were pleased that senior managers in both agencies responded positively to a request to nominate key staff to sit on an Oversight Group and subsequently the Steering Group which have advised and supported this review process.

The review was undertaken by an Independent Consultant, Susan Brocklesby who has worked with thoroughness, professionalism, tact and great attention to detail in gathering the data to develop this report and in framing the recommendations.

The review process has involved:

- Gathering data from the nine identified project sites by email and through meetings with Programme Coordinators, representatives of management structures, Community Mothers and service users as well as obtaining the views of key local stakeholders including key personnel from funding bodies and other local partner agencies.
- Holding a workshop in November 2017 with representatives from the nine sites where the key findings of the review were presented, and potential recommendations were discussed.
- Engaging with a range of key stakeholders to get their input to reality check and fine tune the recommendations in this report and in developing a plan for the first stages of their implementation.

The Katharine Howard Foundation and the Community Foundation for Ireland look forward to the key stakeholders progressing the recommendations contained in this report and clarifying the future strategic direction and potential of the Community Mothers Programme in continuing to meet the needs of children, families and communities.

Noelle Spring,
Director,
Katharine Howard Foundation

Tina Roche,
Chief Executive,
Community Foundation for Ireland

Foreword: Health Service Executive and Tusla, the Child and Family Agency

The Health Service Executive and Tusla are committed to working together to ensure that parents are given the best possible supports in raising their children.

We welcome this review of the Community Mother's Programme undertaken by the Katharine Howard Foundation in conjunction with the Community Foundation for Ireland which has been undertaken in close collaboration with our two agencies.

The Community Mother's Programme in Ireland has its genesis in the early 1980s in the Public Health Nursing service in the Eastern Health Board area. Since the establishment of Tusla in 2014, the Community Mothers Programme sites have been supported separately by both Tusla and the HSE. This review has provided us with the opportunity to explore the development of a joint strategic approach towards the Programme.

The review process has increased the level of awareness of the Programme and its important work locally, within both the HSE and Tusla at all levels. The review has also enabled us to take a national strategic view of the Programme and its future sustainability. We have worked with the foundations who funded this report in order to stabilise the funding for the Programme sites in 2019. We are committed to maintaining our support to the Community Mother's Programme.

This review is timely as it coincides with the publication of First 5: The Whole-of-Government Strategy for Babies, Young Children and Their Families (DCYA, November 2018). First 5 commits to the development of a joined-up approach between Government Departments and State Agencies towards the provision of a continuum of supports to parents.

Specifically, First 5 commits that:

> "…. an approach to home visiting services, across a continuum of need, will be agreed, having regard to Irish evidence on the implementation of prevention and early intervention initiatives."

Tusla and the HSE are committed to working together with the Department of Children and Youth Affairs to support the implementation of this action. We recognise that the Community Mother's Programme, with its over 35 years of experience in delivering a home visiting based family support programme, will have a significant contribution to make in this process.

We look forward to collaborating with the Community Mothers Programme sites along with the wider service environment to develop a national home visiting approach which will address the support needs of young children and their families as a key element of a comprehensive continuum of supports to families.

Aisling Gillen
Regional Service Director - West
Tusla – the Child and Family Agency

Siobhan McArdle,
Head of Operations Primary Care,
Health Service Executive

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Acronyms

ABC	Area Based Childhood
ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BOBF	Better Outcomes Brighter Futures
CCC	City/County Childcare Committee
CDI	Childhood Development Initiative
CDP	Child Development Programme
CE	Community Employment
CES	Centre for Effective Services
CFI	Community Foundation for Ireland
CFSNs	Child and Family Support Networks
CHO	Community Healthcare Organisation
CLG	Company Limited by Guarantee
CM	Community Mother
CMP	Community Mothers Programme
CPC	Child Protection Conference
CPR	Cardio Pulmonary Resuscitation
CRM	Customer Relationship Management
CSO	Central Statistics Office
CYPSC	Children and Young People's Services Committee
DCYA	Department of Children and Youth Affairs
EHB	Eastern Health Board
ELI	Early Learning Initiative
EPIC	European Platform for Investing in Children
FDN	Family Development Nurse
FPHVS	First Parent Health Visitor Scheme
FRC	Family Resource Centre
GP	General Practitioner
HSE	Health Service Executive
KHF	Katharine Howard Foundation
LHO	Local Health Office
MABS	Money Advice and Budgeting Service
NIRN	National Implementation Research Network
PCHP	Parent Child Home Programme
PEIP	Prevention and Early Intervention Programme
PFL	Preparing for Life Programme
PHN	Public Health Nurse
PPET	Parenting Programme Evaluation Tool
PPFS	Prevention, Partnership and Family Support
QQI	Quality and Qualifications Ireland
RCT	Randomised Controlled Trial
SLA	Service Level Agreement
TPSP	Teen Parent Support Programme

Terminology

Community Mothers Programme (CMP) sites: This will be used to describe each Programme location. Each Programme site will have its 'trading name' referenced in table 1 but will thereafter be referred to as a CMP.

Coordinator: This will be used to describe the individual who is responsible for the overall coordination of each CMP. In the first and original CMP this role was described as a Family Development Nurse (FDN), but most of the CMP sites use the term Coordinator.

Community Mother (CM): All volunteers or paid employees who carry out home visits or are involved in the running of groups will be called a CM**.** Again, this is for consistency throughout the document. However, in some CMP sites the terms community parent, volunteer and home visitor are also used.

Original model: The original Eastern Health Board CMP, established by Brenda Molloy, will be referred to as the 'original model'. This will be extended to include Kerry Programme which is also led by a Public Health Nurse in the role of Family Development Nurse. The core governance structure is with the HSE.

Community model: A derivative of the original model supported by the Bernard Van Leer Foundation was adopted outside of the Eastern Health Board Area. This was led by a community worker and governed by a community not for profit company structure and will be referred to as a 'community model'.

Family Development Nurse: The original title established by the original model for a Public Health Nurse who received training in the Walter Baker Child Development Programme and who recruits, trains and supports the educational development of a group of volunteer Community Mothers. The Family Development Nurse is also responsible for the initial meeting with new parents.

Host organisation: The relevant organisation responsible for the governance and day to day management of the CMP will be referred to as the 'host organisation'.

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1. Introduction

This is the full report of a review of the Community Mothers Programme carried out in 2017. This report and the summary report can be accessed on the Katharine Howard Foundation website – links below.

The review represents a snap shot of the status of the Community Mothers Programme (CMP) between the months of June and November 2017. This information was contextualised against the current policy and service delivery framework. It was subsequently shared with key funding and policy stakeholders to develop recommendations culminating in this final full report.

Full report can be accessed here:

www.khf.ie/2019/community-mothers-programme-full -report

Summary report can be accessed here:

www.khf.ie/2019/community-mothers-programme-summary-report

1.1. Background to the review

The Katharine Howard Foundation and the Community Foundation for Ireland have both had a significant history of involvement with and support to the Community Mothers Programme (CMP) in a number of areas of Ireland. Both Foundations value the quality of service that the CMP can offer to parents and their children based on feedback received and on research evidence. Arising from discussions with different interested parties who are concerned about the future of the CMP, the 2 Foundations commissioned this review to support its future direction.

This review of the current status of the CMP nationally was commissioned with the active support and participation of the Health Service Executive (HSE) and Tusla with the hope that it could inform the development of a strategy for the future of the Programme. The review represents a snap shot of the status of the CMP between the months of June and November 2017. This information was subsequently shared with key funding and policy stakeholders to develop recommendations, culminating in the final review report which contextualises this review in the current policy and service delivery framework.

An oversight committee for the review was formed and has representation from Tusla, the HSE and the Katharine Howard Foundation (who also represent the Community Foundation for Ireland).

The original CMP was established in 1983 in the former Eastern Heath Board (EHB) area by Brenda Molloy, a Public Health Nurse (PHN)who was assigned as the Programme Director. Initial funding for a pilot of the Programme came from the Bernard Van Leer Foundation and thereafter funding came from the Health Board. In 2013, an annual report of the CMP within the former EHB region outlined that it was operating in 10 Local Health Office (LHO) areas[1] with a total of 9 Family Development Nurses (FDNs) and 119 Community Mothers (CMs) working with 1,891 families (Molloy & Harper, 2013). This model will be referred to as the **original model** within this document.

[1] This represented 11 sites within the 10 LHO areas.

In 1992, the Bernard Van Leer Foundation funded pilot initiatives in the former Mid-Western, Midlands and North-Eastern Health Board (O'Conner, 1999). These initiatives were established by the Health Board areas under community governance structures. They were coordinated by a community worker, rather than being led by a PHN, and held within the then Health Board, as in the original model. These will be referred to as the **community model**. The origins and development of these early models of the CMP is reflected in table 1 below.

Site	Title of programme	Years operating	Origins and influences	Host Organisation
Clonmel	Clonmel Community Mothers Programme	19	CMP community model; Bernard Van Leer Foundation	Clonmel Community Parents Company
Dublin Docklands	0-2 Programme	3	CMPs nationally; ABC Programmes; Parent Child Home Learning Programme	Early Learning Initiative National College of Ireland
Dublin Finglas	Community Mothers Finglas Programme	29	CMP original model Bernard Van Leer Foundation	HSE
Dublin Loughlinstown	Community Mothers Loughlinstown Programme	25	CMP original model Bernard Van Leer Foundation	HSE
Kerry	Community Parents Programme Kerry	17	CMP original model; Bernard Van Leer Foundation	HSE
Laois / Offaly	Parents First Laois/Offaly	17	Home Start	Parents First Laois/Offaly
Limerick	Limerick Social Services Council Community Mothers Programme	25	CMP community model; Bernard Van Leer Foundation	Limerick Social Services Council
Longford / Westmeath[2]	Longford/Westmeath Community Mothers	10	CMP community model; Bernard Van Leer Foundation	Westmeath Community Development Company
North Tipperary[3]	North Tipperary Community Mothers Programme	18	CMP community model; Limerick CMP	North Tipperary Community Services

Table 1: Outline of all CMP sites participating in the review

[2] The original midlands CMP site was in Athlone, which influenced the development of the Programme in Longford/Westmeath. The Athlone site then merged under the governance and management of the Longford/Westmeath Programme. The '**years operating'** in table 1 for Longford/Westmeath, reflects the start of the programme in Longford/Westmeath and not the start of the Programme in Athlone.

[3] Now Silver Arch Family Resource Centre following a funding and constitutional change and renaming of North Tipperary Community Services.

An additional programme in Kerry had its pilot phase funded under the Bernard Van Leer Foundation and was then established and governed by the then Southern Health Board.

Since the start of these early versions of the CMP, additional home visiting programmes have been established nationally.

One such programme is Parents First in Laois/Offaly. This was originally a Home Start Programme but moved away from this model and developed a greater focus on first-time mothers, nutrition, and parenting. After consideration it was agreed to include Parents First in the review given its similarities to existing CMPs.

Subsequently, the 0-2 Programme was developed in the Dublin Docklands area. The 0-2 Programme was established under the Area Based Childhood (ABC) Programme by the Early Learning Initiative (ELI) and was modelled strongly on the CMP and was supported in its development by the Programme in South Tipperary. It retains close working relationships with existing CMP sites nationally. All CMP sites participating in this review are listed in table 1.

From the start of the first CMP in the 1980s there have been a number of changes impacting on future sustainability of the Programme.

The establishment of Tusla, the Child and Family Agency, in 2014 resulted in the funding for 5 **community model** CMP sites to move from the Health Service Executive (HSE) to Tusla with reductions in the level of funding received. The community model sites never had a national profile or a central coordinating body to support development or advocate and represent the services.

Additionally, in the former EHB area the funding for all **original model** CMPs, was split between both Tusla, and the HSE. The funding for the Programme Director, expenses for the CMs and materials moved to Tusla. However, the funding for the FDN posts remained as part of the PHN team funded by the HSE (see figure 1 below).

2 CMP sites, Kerry and Dublin Docklands, were not affected by the establishment of Tusla. Kerry has continued to receive all its funding directly from the HSE and Dublin Docklands was a newly established site in 2014 with its core funding coming from the ABC Programme.

Concerns about the future sustainability of the EHB area original model CMP sites were raised in an Irish Times article in 2014 (Irish Times, 2014). Since 2015, the Programme Director post and a number of the FDNs employed by the HSE retired and these posts have not been replaced. This left the original model with a lack of clear leadership and direction.

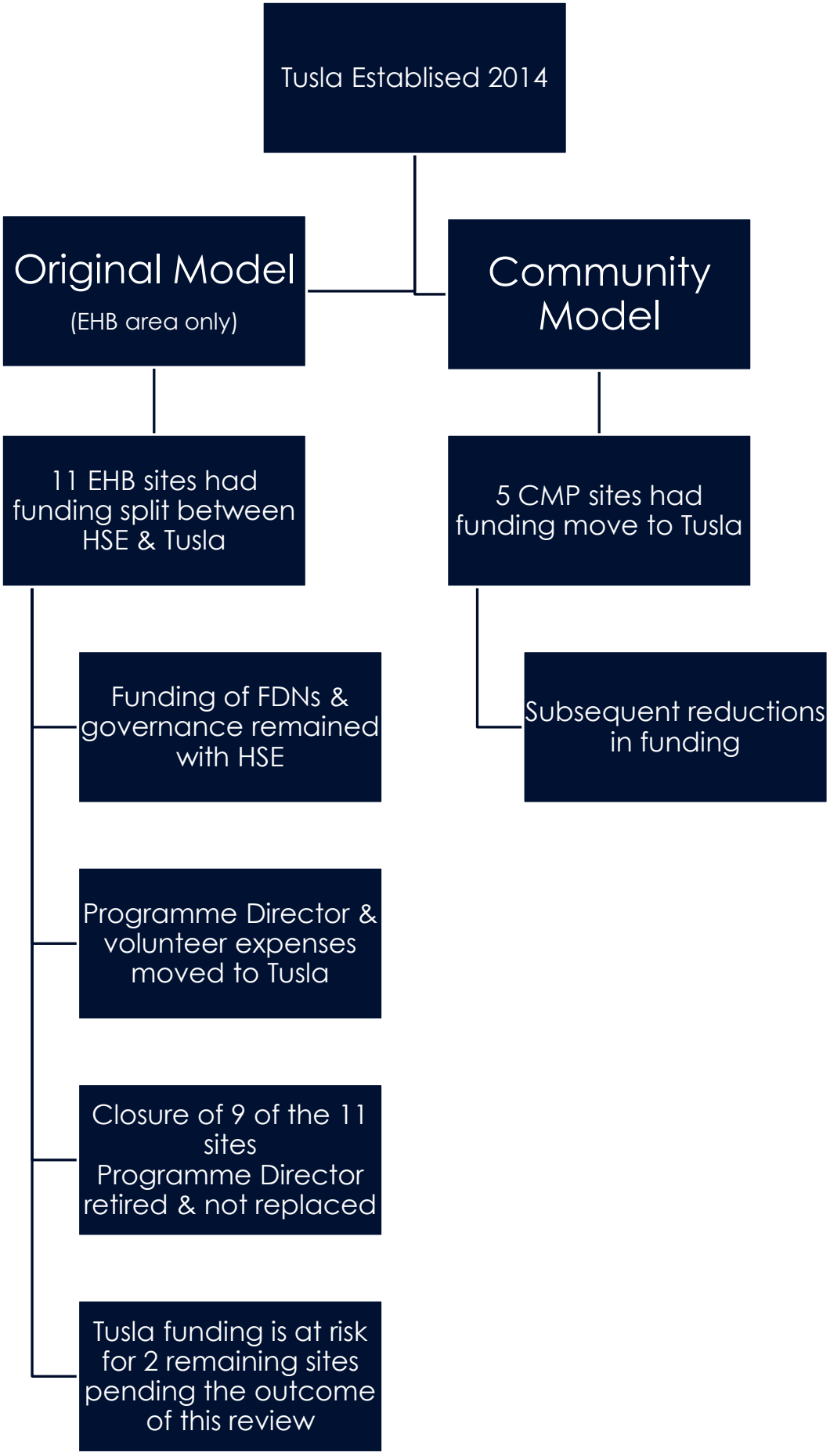


Figure 1: Changes impacting on some of the original and community model sites since the establishment of Tusla from 2014 to 2017

Since the recession in 2008, the PHN services within the HSE have come under considerable pressure. This, aligned with difficulties in recruitment within PHN services and a move to trail more contemporary service models, resulted in a decline of support for the CMP within the HSE. This had a dramatic impact on the EHB sites. Table 2 below summarises the impact of these changes in the last 4 years on the Programme.

In addition to the funding changes outlined above, all the CMP sites have seen significant developments in the past 8 to 10 years as a result of a changing national context in relation to prevention and early intervention programmes.

Many of the areas listed in table 2 presently have an Area Based Childhood (ABC) Programme in operation. Some of these deliver a programme which is very similar to the CMP. For example, Preparing for Life in Darndale, Bray and Finglas and ABC 0-2 Programme in the Docklands are all home visiting programmes targeting parents of children from pre-birth to 2 or 5 years.

There are additional ABC Programmes in some original model sites e.g. Young Ballymun, Tallaght West CDI, Archways Blue Skies, which do not offer a home visiting programme similar to the CMP, but they do target the same parent population through a range of other services and activities.

Local Health Office (LHO) Area	Status in 2013	Status in 2017
Dublin North – Darndale/Coolock	Active – FDN (due to retire)	No longer operating
Dublin North Central – Ballymun	Active – led by Volunteer Coordinator	No longer operating
Dublin North West – Finglas	Active – led by FDN	Active and participating in review
Dublin West – Clondalkin	Active – led by FDN	No longer operating
Dublin West – Neilstown/Ballyfermot	Active – led by FDN	No longer operating
Dublin South City – Ringsend	Active – led by FDN	No longer operating
Dublin South West – Tallaght	Active – jointly led by Volunteer Coordinator + FDN	No longer operating
Dublin South East – Ballinteer	Active – led by FDN	No longer operating
Dun Laoghaire – Loughlinstown	Active – led by FDN	Active and participating in review
Kildare/ West Wicklow – Newbridge	Active – led by Volunteer Coordinator	No longer operating
Wicklow – Bray	Active – led by FDN	No longer operating
Summary		
Programme Director	1	0
Catchment areas	11	2
Family Development Nurses	9	2
Volunteer Coordinators	3	0
Community Mothers	119	18
Families availing of the Programme	1891	205

Table 2: Changes to the CMP in the former Eastern Health Board area[4] (2013- 2017)

[4] Information on 2013 status based on Annual CMP report for the Eastern Health Board region (Molloy & Harper, 2013) and information on 2017 status based on data gathered as part of review process.

1.2. National policy context

The development of prevention and early intervention services in Ireland and relevance for the CMP

Figure 3 outlines the timeline of key policy and strategy documents and developments of key structures over the last 19 years which have shaped the development of child and family services nationally. This diagram highlights the incremental growth of interest and activity in developing prevention and early intervention services for children and young people.

This has always been influenced by the role of philanthropy, from the initial role of the Bernard Van Leer Foundation in the establishment of the CMP to the more recent considerable role played by Atlantic Philanthropies, Community Foundation for Ireland, the Katharine Howard Foundation and the Tony Ryan Fund for Tipperary.

Key influential elements of this policy backdrop will be summarised here.

1. National Children's Strategy (Department of Health and Children, 2000)**:** This strategy outlined 3 goals all of which laid the foundation for the many initiatives and service developments which have subsequently occurred, including the increase in research in the lives of children and prevention and early intervention. It also commenced a dialogue on quality service delivery for all children's services.

2. Prevention and Early Intervention Programme (PEIP), Area Based Childhood (ABC) Programmes and the Centre for Effective Services (CES): The initial investment by Atlantic Philanthropies built on the vision in the National Children's Strategy (2000) and established 3 demonstration programmes in Dublin:

a. Preparing for Life – Dublin Northside
b. Childhood Development Initiative – Tallaght West
c. Young Ballymun – Ballymun

Atlantic Philanthropies invested in the establishment of the all-Ireland Centre for Effective Services (CES) in parallel with the PEIP. The primary objective was to promote early intervention and prevention and:

- demonstrate effective practice leading to reform
- inform and influence policy and practice
- develop capacity and infrastructure for the sector

(Paulsell & Pickens Jewell, 2012)

The work of both the PEIP and the CES highlighted the importance of evidence-based outcome-focused practice in children's services. These programmes championed the use of evidence-based programmes e.g. parenting programmes which have been adopted into each CMP site (table 5).

CES also published considerable resources supporting the delivery of effective services. This has brought into focus the need for an analysis of not just the Programme but also how it is run and what organisational components are necessary to make it effective.

The ABC Programme builds on the work of the PEIP by expanding the areas involved. It targets investment in evidence-informed interventions to improve the long-term outcomes for children and families living in areas of disadvantage. Addressing child poverty is a primary aim of the 12 ABC Programmes in operation.

It aims to focus on the implementation of interventions and approaches that have been found to significantly improve child outcomes in an Irish setting (Pobal, 2018)

The Docklands CMP is an ABC funded Programme. Limerick CMP and Finglas CMP both have close working and funding relationships with the ABC Programmes in their local area.

3. Children's and Young People's Services Committees (CYPSCs): Originally established as 4 pilots in 2007, the CYPSCs are now established nationally and have a key aim in the promotion of interagency working at a local level in line with Better Outcomes Brighter Futures (BOBF). The CYPSCs have already had many impacts at a local level and some CMP sites have participated in CYPSC led interagency initiatives e.g. the provision of Infant Mental Health Training and the establishment of Infant Mental Health Network in one area.

4. EU Commission Recommendation – 'Investing in Children' (EU Commission, 2013)**:**
In tandem with the publication of an annual country specific recommendation, the EU Commission launched its recommendations to address child poverty in the EU area. Ireland has had consecutive country specific recommendations in terms of child poverty.

This document reads as a blueprint for how services should be coordinated to address child poverty. Many of these recommendations could be addressed through the current CMP model, in particular:

Responsiveness of health systems: The CMP approach acts as a gateway for many parents and families.

'*Invest in prevention particularly during early childhood years, by putting in place comprehensive policies that combine nutrition, health, education and social measures*' (EU Commission, 2013)

Family Support: The community based universal provision of the CMP can also be a mechanism to

'*Strengthen child protection and social services in the field of prevention; help families develop parenting skills in a non-stigmatising way*' (EU Commission, 2013)

In tandem with the EU Commission recommendations was the establishment of the **European Platform for Investing in Children** (EPIC). This supports policy makers in providing information about evidence-based programmes in Europe. It classifies such programmes in terms of their evidence base and has classed the CMP as a 'promising practice'.

5. Healthy Ireland (Department of Health, 2013): This is a national framework to improve the health and wellbeing of the people of Ireland. Prevention is a key focus within the framework.

The CMP is strongly aligned to the delivery of public health services and could be a vehicle for the delivery of a number of key primary health and health promotion targets. This affords a valuable opportunity to deliver on the indicators outlined within the Healthy Ireland framework e.g.:

- *'Increase the number of adults and children with a healthy weight.*
- *Increase the proportion of adults eating the recommended five or more servings of fruit and vegetables per day.*
- *Increase the wellbeing of the population and increase levels of wellbeing among vulnerable groups.*

- *Reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups and the percentage of low birth-weight babies across socio-economic groups.*
- *Increase the proportion of children reaching a good level of development at age five.*
- *Increase immunisation rates for children'* (Department of Health, 2013)

6. Better Outcomes Brighter Futures (BOBF) (Department of Children and Youth Affairs, 2014):

This national policy framework is to inform the work of government (2014–2020) and its funded stakeholders in delivering better outcomes for children and young people. It aims to '*strengthen the support system around the child and young person'* through the following goals:

a. support parents
b. earlier intervention and prevention
c. listen to and involve children and young people
d. ensure quality services
e. strengthen transitions
f. cross-government and interagency collaboration and coordination

(Department of Children and Youth Affairs, 2014)

It articulates clear outcomes with developed indicators under the headings outlined in figure 2 below.

Figure 2: Better Futures Brighter Outcomes: outcome headings

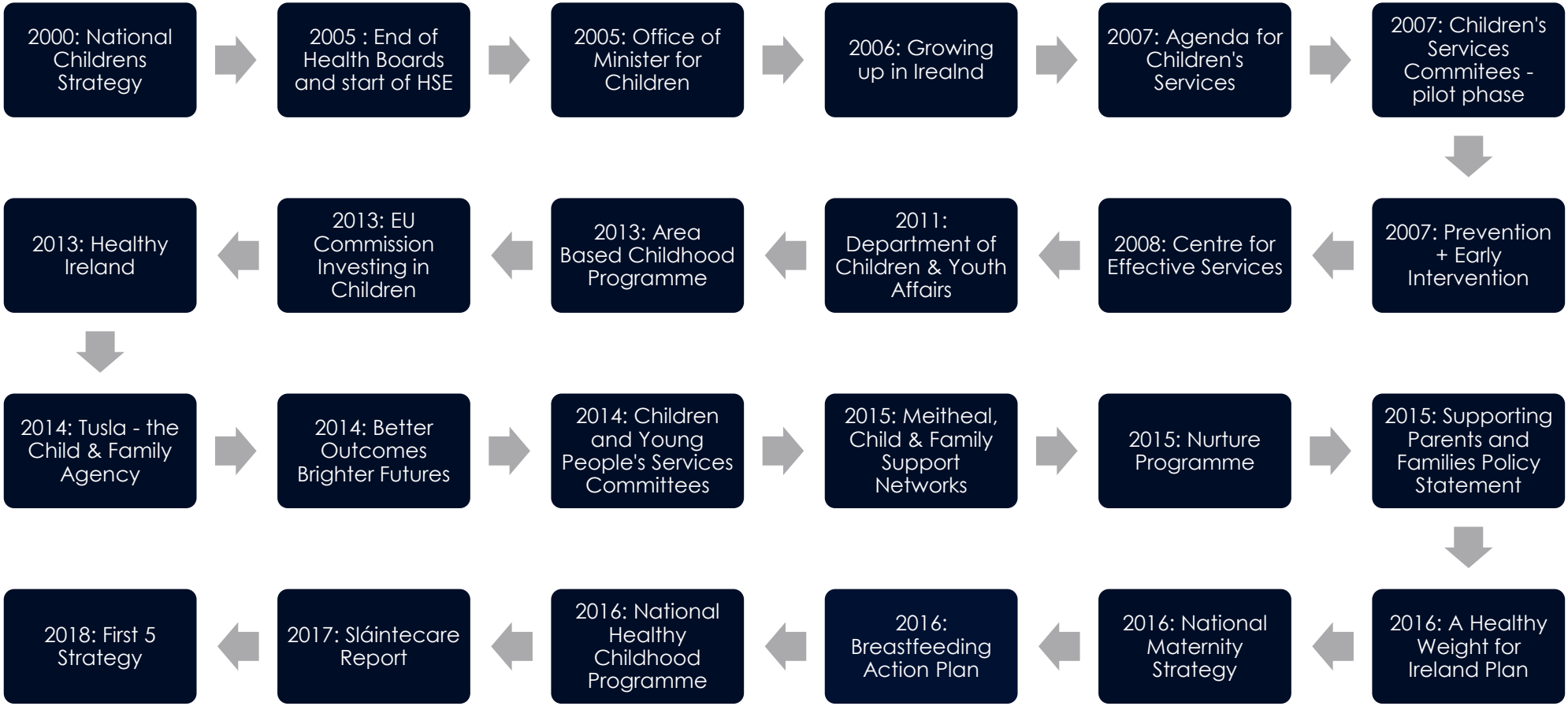


Figure 3 : Key policy, strategic and structural changes in 2000 – 2018

7. Tusla: Prevention, Partnership and Family Support (PPFS) (Tusla, 2013b);

Meitheal (Tusla, 2013d);

Commissioning (Tusla, 2013a);

Child and Family Support Networks (CFSNs) (Tusla, 2017):

Prior to the legislative establishment of Tusla, work had begun in developing new systems of working within what would become Tusla, the Child and Family Agency. Subsequently, these local based mechanisms have been gradually rolled out across the country and aim to engage a wide range of interagency services and supports working with children and young people to come together.

The aim of the **CFSNs** is to establish interagency working relationships including referral pathways to ensure there is 'no wrong door' for families. It comprises all statutory, community and voluntary and statutory funded services to come together. There is a CFSN Coordinator to support this process and oversee the **Meitheal** process (Tusla, 2017).

Meitheal is a child centred process engaging a range of relevant services to come together to put in place a package of support to ensure the needs of the child and their family can be met locally and that these needs do not escalate to higher levels of need (Tusla, 2013).

Both processes are overseen by the senior manager for PPFS who has a role in overseeing the **commissioning** of services, securing the participation of children and young people in services, raising public awareness and parenting. Tusla have received investment from Atlantic Philanthropies to support the development of this new area-based approach to family and community support.

Commissioning will have a substantial impact on the future of all prevention and early intervention programmes, including the CMP, who presently rely on Tusla for their core funding. Commissioning has been defined as:

> *'the use of the total resources available for children and families in the most efficient, equitable, proportionate and sustainable way in order to improve outcomes for children'* (Tusla, 2013).

8. High Level Policy Statement on Supporting Parents and Families (Department of Children and Youth Affairs, 2015)

The 'High Level Policy Statement on Supporting Parents and Families (Supporting Parents and Families) sets out the Governments key commitments through a series of statements on how the state will address the needs of Parents and Families.

It places '**Parent and Family Support'** as a priority under the Governments national policy framework 2014-2020 (BOBF). It sets out the importance of the parening role within the many and varied forms of families. The document outlines many statements and recommendations that all have relevance for the delivery and sustainability of the CMP.

It recognises the importance of prevention and identifies that the method of delivery of these supports to parents and families is important.

The statement outlines the active role that parents, children and young people should take within a support process. It also recognises the ongoing development of services and their workforce in continuous professional development and the strenghtening of evidence based practice.

Finally it acknowledges that while Tusla has a 'pivotal role' in parenting and family support, it is also the 'business' of everyone working with children and families. In particular it highlights the strong relationship between the HSE and Tusla in jointly supporting parenting and family support :

> *'The relationship between the HSE and Tusla is the cornerstone of 'parenting and family support'.*

This document relfects the governance and funding responsibilities that both the HSE and Tusla have given the origins of CMP in Ireland.

9. HSE: National Healthy Childhood Programme 2016 (HSE, 2017b)
Nurture Programme: Infant Health and Wellbeing 2015 (HSE, 2017a)
Breastfeeding in a Healthy Ireland: Health Service Breastfeeding Action Plan 2016–2021 (HSE, 2016a)

There are 9 key components of the National Healthy Childhood Programme ranging from health promotion, infant mental health and maternal mental health assessments and promotion to screening and immunisations (Jennings, 2016).

In line with other developments e.g. National Maternity Strategy and Healthy Ireland, the National Healthy Childhood Programme aims to promote the concept '**make every contact count**'. It has been developed based on the following:

1. acknowledgement that the wider determinants of health play a significant part in child and adult health
2. the benefits of a Child Health Programme based on a model of progressive universalism
3. the impact of the antenatal period on the development of the foetus
4. the importance of maternal mental health on infant mental health and development
5. the pivotal role of the parents in child development
6. early identification of issues can improve the outcome for the child

The Nurture Programme has been funded by Atlantic Philanthropies and managed by the Katharine Howard Foundation. It is an integrated programme of work within the HSE with implementation support provided by the CES. It aims to improve health and wellbeing outcomes for children in pregnancy and up to a child's 3rd birthday.

The 6 key components of the Nurture Programme are:

- knowledge and communications
- antenatal to postnatal
- health and wellbeing promotion and improvement

- infant mental health and supporting parents
- standardised health records for parents and professionals
- training and resources (Jennings, 2016)

Practically, it aims to have developed 8 identified actions over the next 2 to 3 years addressing a range of areas from information dissemination[5] to developing standards of care in relation to antenatal classes; infant mental health; parent held child records. It also aims to develop supports and programmes in the areas of child safety, breastfeeding and parents with additional support needs (Jennings, 2016).

In parallel to the above-mentioned strategies, the HSE strategy to promote breastfeeding was launched and is a document which heavily correlates with the messages of both the Nurture Programme and the Healthy Childhood Programme. It lists 9 priorities, many of which are being delivered in some way presently by the CMP. However, it outlines one primary action which could be addressed by the CMP:

'*Develop a model for breastfeeding support in CHOs*' (HSE, 2016a).

The CMP with additional support, training and oversight can build on an its current role in providing community-based breastfeeding support.

10. Creating a Better Future Together: National Maternity strategy 2016–2026 (Department of Health, 2016a). The National Maternity Strategy outlines 4 key strategic pillars which advocate for changes in the current service provision to become more parent led and provide services that are less medically, and more midwifery led. It promotes a greater level of accessible and community-based working.

A number of key recommendations which have relevance for the CMP are:

- opportunities to support pregnant women focus on their health and wellbeing and make positive health choices
- provision of women led care and the development of 'Alongside Birth Centres'
- opportunity to make 'every contact count' and ensure sufficient information and supports for all women when they present at maternity and antenatal services
- advocating 'continuity of care' where maternity services continue to support mothers in the community alongside multidisciplinary teams and public health nurse services

This strategy is being implemented under the National Women and Infants' Health Programme.

[5] Information includes parenting and child health website; healthy pregnancy books and development of Caring for your Baby.

11. First 5 – A Whole of Government Strategy for Babies, Young Children and their Families 2019 – 2028 (Department of Children and Youth Affairs, 2018)

First 5 is a comprehensive whole of government 10-year plan to improve the lives of babies, young children and their families. Through its vision for early childhood as a 'critical and distinct' period in a child and family's life, the strategy addresses the following themes:

- a healthy childhood starting from pregnancy
- time together with parents especially in the first year in a nurturing and playful home environment whether children's material needs are met
- high-quality play-based Early Learning and Care experiences
- positive transitions to primary school
- supportive community contexts (Department of Children and Youth Affairs, 2018).

The strategy outlines 5 'Big Steps', three of whom have a particular relevance for the CMP:

1. Access to broader range of options for parents to balance working and caring

2. A new model of parenting support

   Through the establishment of a new Parenting Unit within the DCYA, a continuum of parenting supports will be made available. This includes exploring home visiting and the CMP is listed as one of several home visiting programmes in Ireland. Of specific relevance is a commitment to:

> *'..building on the current PHN home visitation programme, an approach to home visiting services, across a continuum of need, will be agreed, having regard to Irish evidence on the implantation of prevention and early intervention initiatives'* (Department of Children and Youth Affairs, 2018)

3. New developments in child health
   The promotion of positive health behaviours and the physical and mental health of babies, children and their families along with enhancing the National Healthy Childhood Programme, will impact on the CMP. The CMP is uniquely placed to address these actions given its current role in supporting breastfeeding, nutrition and infant and parent mental health.

4. Reform of the Early Learning and Care system

5. A package of supports to tackle early childhood poverty.
   Again, the CMP is uniquely placed given its universal nature to be an access point for families accessing a range of information and supports which might act as a gateway service for those families who are at risk of poverty and the impacts of poverty.

1.3. Review process

The agreed purpose of the review process was '*to undertake a review of the current status of the Community Mothers Programme (CMP) in Ireland with a view to the development of a strategic plan for the future of the Programme'* (Katharine Howard Foundation/Community Foundation for Ireland, 2017).

An oversight group was established which includes representatives from Tusla, the Health Service Executive, and the Katharine Howard Foundation (representing both KHF and CFI). This group has advised on the methodology, supported the review process and was involved in formulating the final recommendations. Following a tendering process, KHF contracted a consultant to undertake the review.

1.4. Methodology

A methodology for the review was outlined in the original commissioning papers and was finalised in conjunction with the oversight committee. It involved a site visit to 9 CMP sites and included:

Site visits: to each of the 9 CMP sites and included pre-visit questionnaires

Interviews: semi structured interviews with the coordinators and the 'host organisation'

Focus groups and paper-based surveys: Carried out with a total of 44 Community Mothers (CMs)

Parent interviews: 18 semi structured recorded interviews with 1 to 2 parents from each CMP site

Stakeholder interviews: 22 semi structured interviews with key local stakeholders including funders[6]

Interviews with other home visiting programmes: Semi structured interviews were carried out for comparison purposes with 3 other home visiting programmes operating in Ireland:

- Preparing for Life (Darndale)
- Home Start (Blanchardstown)
- Lifestart (National model)

Consultation: Once the report was drafted it was presented to a wide number of stakeholders (listed below) and they were consulted on the final recommendations:

- **Representatives of all 9 CMP sites** (participated in a workshop – see section 6.3.)
- **Directors of PHN, HSE**

[6] 27 external stakeholders representing HSE, Tusla (PPFS) and CYPSC Coordinators were contacted as part of the review process, which resulted in 22 stakeholders being available for interview.

- **Representatives from the Department of Health**
- **Representatives from the Department of Children and Youth Affairs**
- **Representatives from Tusla**

1.5. Limitations

Stakeholder interviews: While every attempt was made to contact all stakeholders, there were a small number who were not available or did not feel they were familiar enough with the CMP to participate given that they were new to their role.

Time and logistics: The time available to carry out a range of different interviews in one day in each site was a limiting factor, this was exacerbated by the geographical spread of the projects.

Review and not an evaluation: As this is a review of the status of the CMP nationally it was not possible to explore each CMP site in detail. This review is to provide a broad overview of what is happening nationally in relation to the provision of a CMP. Many sites have already had a number of external evaluations carried out to date and these are referred to herein.

Gathering comparable numerical data: CMP sites have different methods of recording outputs and so data was not easily comparable. In cases where a coordinator had been out sick for a period or there had been a change in staff member, this information was either not available or was not reliable.

1.6. What is a Community Mothers Programme?

The first CMP in Ireland was based on a UK model entitled the First Parent Health Visitor Scheme (FPHVS).

1.6.1. The First Parent Health Visitor Scheme (FPHVS)

Established in 1979 by Professor Walter Barker (Barker, 1984) the FPHVS was a nurse led home visiting approach developed through the Child Development Programme (CDP) at Bristol University and was originally delivered in 3 areas of deprivation in Bristol in the UK. At its peak it was being delivered in 18 health areas across Britain (Emond, et al., 2002). The FPHVS was supported by the Bernard Van Leer Foundation and an internal evaluation of the FPHVS reported substantial improvements in child health.

The FPHVS differed from the standard health visitor service in the following ways:

- there was one visit antenatally
- the number and spacing of visits was different and more intense. They started weekly moving to monthly after 5 months with flexibility to maintain a high frequency of visits should this be necessary
- most families availed of the Programme for 1 year but there was capacity to extend the Programme for 2 years depending on the needs of the family
- there was a structure to each visit with core materials including cartoons to support the information transfer to parents
- FPHVS health visitors generally had greater time to spend in contact with a family, allowing 1 hour per visit which would not usually be afforded in the generic health visitor model

The FPHVS had a strong ethos of parent support through empowerment and focused on maternal health, child health and support for parents in their parenting role. This was evidenced through the language used by the FPHVS visitor and the value they placed on this philosophy (Deave, 2003).

Subsequent external evaluations have not replicated the positive results from the internal evaluation and the original internal evaluation methodology has been critiqued (Emond, et al., 2002).

1.6.2. The original Community Mothers Programme in Ireland

Established in 1983 by Brenda Molloy, the initial intention for the establishment of the CMP was to replicate the FPHVS in an Irish context.

This was trialled in Dublin but was found to be too expensive to sustain and an alternative model was designed using specifically trained local women, who volunteered to provide a peer to peer programme using the training and resource materials from the FPHVS.

The structure involved recruiting mothers who had been identified by the local PHN team. The team of CMs were supported and supervised in their home visiting role by an FDN. The FDN is a PHN who was specifically trained in the original FPHVS approach and seconded to have a coordinating and professional development support role in the CMP.

The ethos of this original model is a peer to peer volunteer support programme to promote parent enablement and empowerment and references the philosophy of World Health Organisation 1978 conference at Alma Ata. It was outlined as follows:

> *'drawing out the potential of parents rather than giving advice and direction; using a behavioural approach in which parents are encouraged to undertake agreed tasks; using illustrated cartoon sequences to show the alternatives available to parents in coping with various child rearing problems'* (Johnson & Molloy, 1995).

Additionally, the role of the FDN is shaped by the World Health Organisation's 'Health for all by the year 2000'. This promoted a community approach to health rather than the traditional medical model:

> *'it is a move away from working for people to working with people…this is a move away from the bio-medical model of health and it fosters in the FDN a commitment to equality of relations'* (Johnson & Molloy, 1995).

Recruitment of CMs was based on personal attributes and values of potential volunteers:

> *'desirable qualities would be a caring, sensitive nature, reasonable literacy and an interest in the community. Undesirable qualities would be a dominant, over confident or judgemental personality, a tendency to gossip and being a perceived leader of the community'* (Johnson & Molloy, 1995).

A comprehensive training programme was delivered once a week for 1.5 hours in the CM's own home for 4 weeks. The design of the training module was to build confidence in the CM and ensure their commitment to the Programme by limiting the time between training and commencing home visits. The ethos of the Programme is reflected in the relationship between the Family Development Nurse and the CM.

Support and supervision sessions are provided on a 1:1 basis monthly in the CM's home and a group of CMs meet on a bimonthly basis.

The original model operated as follows:

- children 0–1 year which could be extended to 2 years
- 1 home visit every month lasting 1 hour
- all children and families within prescribed 'catchment' areas which were originally areas identified as disadvantaged
- targeting first time mothers (more recently this requirement was relaxed)
- each volunteer CM would support up to 20 families

Evidence base:

1. **Community mothers' programme: randomised controlled trial of non-professional intervention in parenting** (Johnson, Howell, Molloy, 1993)

The research behind the establishment of the CMP was one of the first Randomised Controlled Trials (RCTs) of an early intervention programme in Ireland. The results demonstrated positive trends in the following areas:

- higher level of uptake of immunisation
- diet consisting of 'more appropriate' foods as reported by parents
- parents reported increased levels of reading to their child
- parents reported that they engaged in higher level of 'stimulation', nursery rhymes/games (excluding motor games), with their child
- parents were more likely to feel positive and less likely to feel negative (Johnson, Howell, Molloy, 1993)

The original research was followed up 7 years later and was also replicated with a Traveller sample.

2. **Community Mothers Programme: Seven year follow up of a randomised controlled trail of non-professional intervention in parenting**
   (Johnson, et. al., 2000)

Outcomes for the mother were sustained in terms of parenting skills and self-esteem. The results demonstrated some benefits of the Programme extending to subsequent children.

3. **Community Mothers Programme: Extension to the Traveller Community in Ireland** (Fitzpatrick, et al., 1997)

Outcomes noted improved dietary habits, maternal wellbeing and child stimulation when compared with settled control group.

The Programme generated a considerable number of additional publications in peer reviewed journals (Johnson & Molloy, 1995)and other reports/books (Mc Donald, et al., 2013; Brady, 1993; Luker, et al., 2016) and it also influenced other programmes internationally e.g. in 2008 there were up to 10 Community Mother/Parenting Programmes operating in the UK influenced by the original Community Mothers Programme in Dublin (Suppiah C. , 2008).

Methodological approach of the original study:

Although the evaluation was an RCT there were a number of key methodological limitations which do have an impact on the evidence base.

1. The research was carried out by the HSE and co-authored by the founder and coordinator of the Programme. Subsequent research did have an external author on the papers (Johnson, et. al., 2000).
2. Data was collected by the FDN, who was known to the parents.
3. The questionnaires used were not standardised with tests of reliability and validity e.g. positive/negative feelings (taken from internal CDP evaluation). Additionally, they did not have a child outcome focus.

The CMP has received substantial attention both nationally and internationally. It is rated by the European Platform for Investing in Children (EPIC) as a 'promising practice' (EPIC, 2017). It has influenced a number of UK based programmes e.g. Thurrock Community Mothers Programme; Parent's 1st.

1.7. Effective services

There is now a growing body of evidence exploring how we deliver effective quality services and early intervention and prevention programmes. This has been strongly influenced by the work of the CES and many of the PEIP and subsequent ABC Programmes.

Tallaght West Childhood Development Initiative developed training and a publication to support organisations to reflect on the effectiveness of their work (Murphy, Murphy, & Smith, 2011). They highlighted the need for: clarity in programme delivery and outcomes; supporting and building staff competence; delivering the necessary inherent organisational change; the qualities associated with effective leadership; and ongoing evaluation – see figure 4 below.

Figure 4: A quality framework for achieving outcomes (Murphy, Murphy, & Smith, 2011)

The CES have outlined what it takes for organisations to be effective in delivering meaningful outcomes rather than outputs (Centre for Effective Services, 2012). The National Implementation Research Network outlined one framework for delivering outcomes as outlined in figure 5.

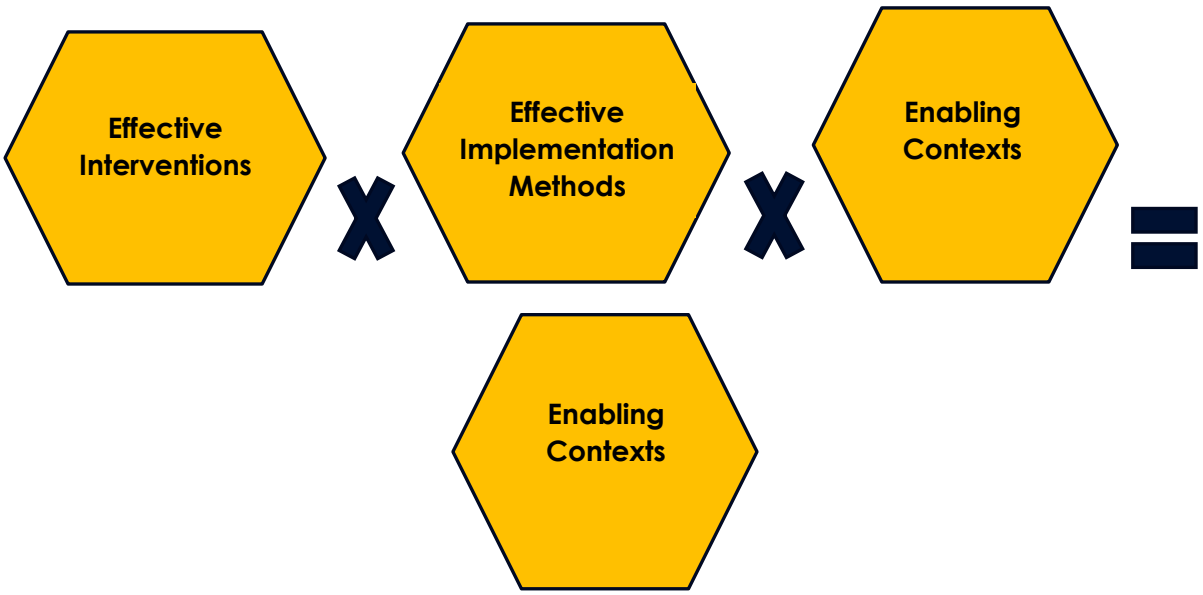


Figure 5 : Formula for successful implementation from the National Implementation Research Network (Van Dyke, 2013)

1. Effective approaches: What are the 'right' or effective programmes or 'what works in early intervention home visiting?

   Section 1.8 explores the evidence supporting the effectiveness of a number of Irish and international home visiting programmes.

2. Effective implementation: Ensuring the successful delivery or implementation of a programme relies on many factors and can be summarised by the Hexagon tool developed by the National Implementation Research Network

   a. Evidence
   b. Usability
   c. Supports
   d. Need
   e. Fit
   f. Capacity
   (National Implementation Research Network, 2018).

3. Enabling contexts: what are the key drivers which ensure an organisation can sustain effective delivery of programmes and ultimately deliver outcomes for children and families? The National Implementation Research Network outline the key drivers for successful implementation within an organisation as outlined in figure 6.

   Understanding these elements of successful implementation contributed to the design of the questionnaire used to gather data from each CMP site and would be important considerations in any future strategic plan for the CMP.

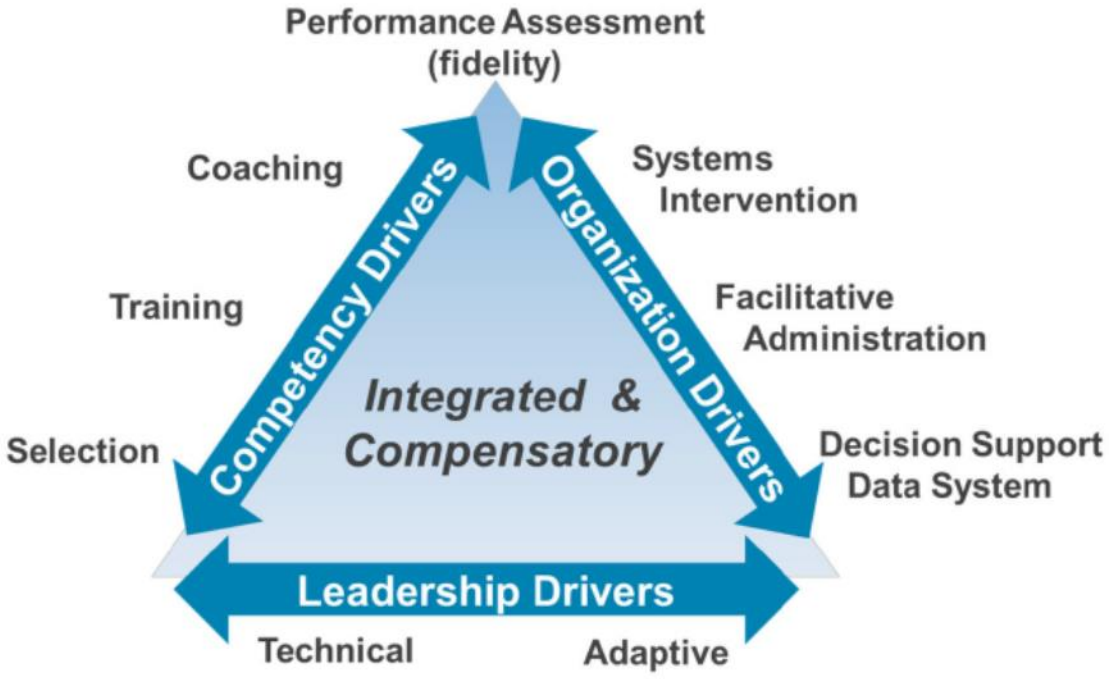


Figure 6: Enabling contexts: Implementation drivers within an organisation to deliver effective practice (Fixsen, Blase, Naoom, & Duda, 2015)

1.8. Home visiting programmes – international and national picture

There has been a gradual increase in the level of review and evaluation of the range of early intervention home visiting programmes both nationally and internationally. This has been primarily driven by organisations in the United States (US) where high levels of scientific evidence are required by state institutions and commissioning agencies before a programme is funded.

The use of repeated and longitudinal RCTs with clear outcomes focus would appear to be the gold standard in the US and only a small number of 'professional' and targeted home visiting programmes have achieved this level of scientific rigour.

Both the UK and Ireland have a strong record of including qualitative evidence in their review of home visiting early intervention programmes (Schrader-McMillan, et al., 2012; Moran, et al., 2004; Mc Keown, 2000).

There are few home-grown Programmes with a rigorous RCT evidence-base and many agencies have had to rely on qualitative research design when evaluating their effectiveness. The use of RCTs in Ireland and the UK is expensive and there can be a negative view in terms of the ethical implications involved i.e. limiting intervention to only one cohort.

However, there is a value attributed to qualitative evaluations to inform the context of what works in programme delivery. RCTs have considerable limitations as they don't explore the process of intervention, explain why things worked and whether some

areas of intervention work better for 1 family over another. RCTs can promote a one size fits all approach (Kortmacher, Kitzman, & Olds, 1998).

This increased attention on reviewing home visiting programmes has been driven by the need to demonstrate cost effectiveness of programmes to state agencies with a growing body of reports being generated by several organisations for example:

- Centre for Effective Services
- Institute of Public Health in Ireland
- Tusla
- Early Intervention Foundation UK
- National Institute for Clinical Effectiveness
- UK Department for Education and Skills

In reviewing the range of home visiting programmes and what the research suggests is effective in home-visiting, it is important to explore a range of questions:

1. **Is the programme led by a 'professional', 'para-professional' or 'volunteer'?**
   To date the evidence suggests that those home visiting programmes led by a professional are the most effective (Kendrick, et al., 2000; Peacock, et al., 2013; Schrader-McMillan, et al., 2012).

   However, there is evidence to suggest that 'para-professional' home visiting is effective when home visitors are sufficiently trained to meet parents needs (Peacock, et al, 2013). This is echoed by Schrader-Mc Millan, et al. (2012), who suggest that these programmes are only effective if there is a structured programme and home visitors receive supervision.

   One para-professional home visiting Programme, 'Health Families America' does have a considerable quantitative evidence-base and is positively rated on the 'Scientific Rating Sale' (California Evidence Based Clearing House for Child Welfare, 2017). The learning from this targeted programme is important and is considered in greater detail in section 1.9.

   There is qualitative evidence supporting the impact of volunteer based home visiting but mixed quantitative evidence. This is explored in section 1.9.

2. **Is the programme multidimensional or specific?**
   This explores whether the Programme addresses one core outcome or is it more responsive to the wider needs of a family and thus addresses a number of outcomes.

   The evidence is mixed in this regard. One systematic review outlined that those with a specific outcome were more effective (Peacock, et al., 2013).

   However, other studies noted that it was important to take on board the many issues that are facing a family (Kortmacher, Kitzman, & Olds, 1998).

This finding was replicated in the UK version of the Nurse Family Partnership and a literature review noted: '*the need for flexible support was highlighted in studies of the Family Nurse Partnership nurse-home visiting programme*' (Schrader-McMillan, et al., 2012)

3. **Does the programme engage antenatally or postnatally?**
   The strongest evidence is for engaging parents in a home visiting programme antenatally (Olds, Sadler, & Kitzman, 2007)

4. **How frequent are the visits to families?**
   Higher frequency of home visits would appear to be more effective with the provision of weekly home visits noted as being most effective (Peacock, et al., 2013).

5. **Is the programme structured and manualised? Is there a strong fidelity to the designed structure? Does the programme have a clear outcome focus?**
   Those programmes with a structure and fidelity to the structure prove to be more effective (Peacock, et al., 2013; Schrader-McMillan, et al., 2012).

6. **What training and professional development support do the home visitors have?** The research indicates that appropriate and ongoing training and professional development for home visitors increases the effectiveness of the programme (Peacock, et al., 2013; Schrader-McMillan, et al., 2012).

7. **What rate of engagement and retention do families have with the programme and what impacts on this?**
   Schrader-McMillan, et al. (2012) suggest the following is important in engaging and retaining families in a home visiting programme:
   - taking time to establish the relationship
   - flexibility to respond to the parent's priorities
   - engaging fathers
   - user-friendly information

   Peacock, et al. (2013), also argue for the provision of a home visiting scheme as one part of a 'bigger systems of supports and services for families at risk'.

   Figure 7 summarises the informaton above which must be considered along with the previous discussion in relation the research in delivering effective services (Murphy, Murphy, & Smith, 2011; Department of Health, 2018; Centre for Effective Services, 2012)

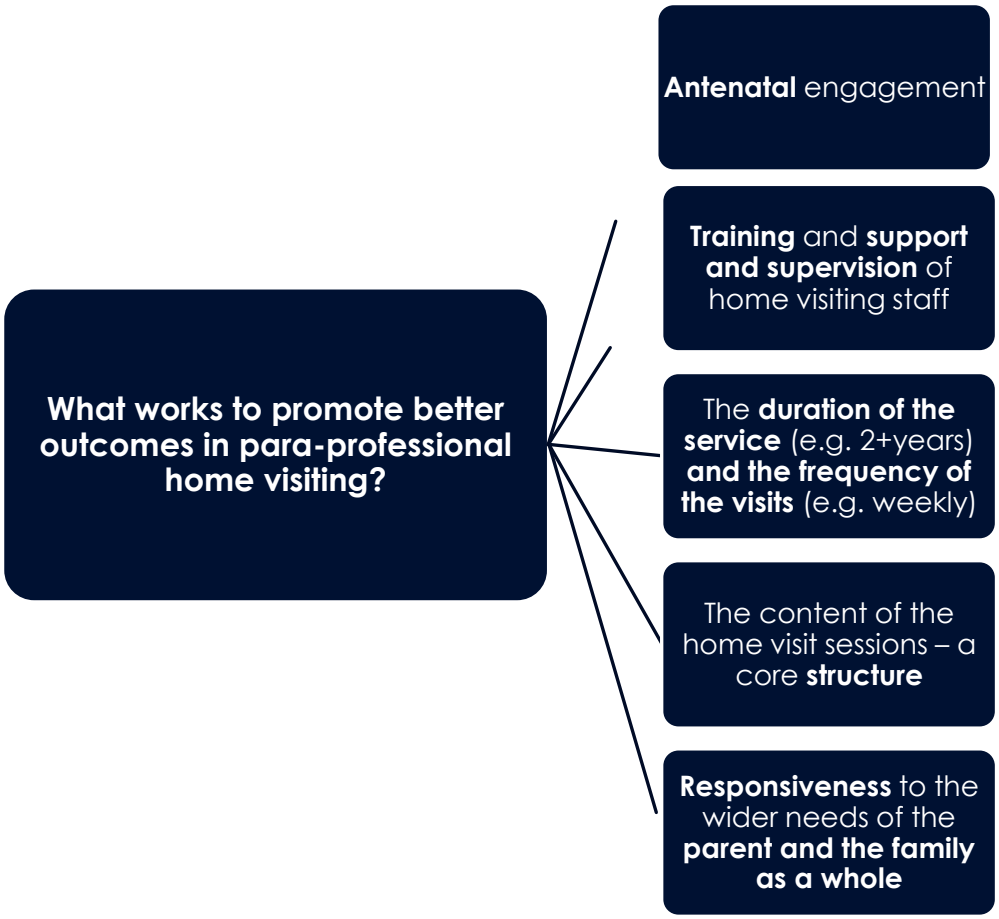


Figure 7: What works in para-professional early years home visiting programmes?

1.9. Professional, para-professional and volunteer programmes

This section defines the differences between professional, para-professional and volunteer-based home visiting programmes. Irish and international programmes will also be explored in this section. While originally described as a 'non-professional' programme, the CMP did operate a model more aligned to a volunteer-based programme. Today, the CMP now presents as a mixed model of para-professional and volunteer programme and it is benchmarked against other para-professional/volunteer home visiting programmes in table 3.

Professional home visiting: The research describes home visiting as professional when each **home visitor** is defined as a professional e.g. a nurse. That is a home visitor who has:

- specific training and qualifications prior to employment
- the need to register or gain a licence with a 'professional' body for both support and oversight in terms of standards of performance within the relevant employment situation

Para-professional home visiting: The research[7] differentiates the term 'para-professional' from professional and defines it as a home visitor who has training in an aligned area but does not have a specific clinical or professional qualification (Moran, et al., 2004; Peacock, et al., 2013). In these situations, they may be in a role where they 'assist' those in a professional role. This review will adopt this definition.

Volunteer home visiting: Those home visitors who are not in a paid role or in a formal employment contract. No prior qualifications are required for volunteer home visitors.

All home visiting programmes, be they professional or volunteer based, have a developed internal induction and training programme for home visitors prior to the commencement of their home visiting role.

1. Professional home visiting: Public Health Nurse (PHN) Service

In Ireland the PHN service is the only universal professionally run home visiting service targeting families and their young children. A PHN is likely to have 6 standard contacts with a child and family:

- 72 hours post discharge from maternity hospital
- 3 months
- 9–11 months
- 12 months (developmental with doctor)
- 2 years
- 3 years – child is discharged unless there is some concern (HSE, 2017a)

In this service provision, most interventions do not take place in the home but in the local health centre with only 1 home visit being prescribed as standard.

The number of home visits can increase depending on the needs and circumstances of the family. This is a statutory service provision with a broad range of aims in relation to young children and families e.g. maternal and child health, child development and public health. It also has a remit in terms of safeguarding children and child welfare. The role of the PHN service is a complex and wide-ranging service from 'cradle to grave' and an oversight of the extent of its role is outlined in Mc Donald, et al. (2013).

2. Professional home visiting: Nurse-Family Partnership

This American model has achieved recognition as a 'Model Programme' in terms of the rigorous evidence base under the 'Blueprints for Healthy Youth Development' (Blueprints for Healthy Youth Development, 2017). It is delivered by nurses and so is classed as a professional home visiting programme for first time mothers and their partners and is targeted at families from disadvantaged backgrounds.

[7] Some research suggests that para-professional home visitors may have a tertiary qualification, making an additional differentiation between them and 'lay health care workers' (Lewin, et al., 2006). However others note that a para-professional may only receive the required training once in post but may have aligned background qualifications.

It engages with families antenatally and continuing until the child is 2 years old. It is a structured programme with the following core practices:

- Preventative health and prenatal practices for the mother – including supporting the parent to improve diet, reduce consumption of cigarettes, alcohol and illegal substances. It also supports parents to prepare emotionally for the baby's birth.
- Health and development education and care for both mother and child – through coaching the nurse promotes parent-child interaction, outlining key child development milestones and supporting a positive approach to parenting.
- Life coaching for the mother and her family – this is involves providing broad supports to the whole family to promote its social and economic outcome including the promotion of maternal education and employment and reducing the frequency of subsequent pregnancies.

It advocates for a strengths-based, client-centred approach which is multidimensional in its support for all members of the family, the wider family environment and the local community. Its key mechanism is through the relationship between the nurse and the family.

It is outcome focused in its delivery rather than trying to address the areas that might influence outcomes. It has a strong data collection mechanism which is supported at a national level.

It reports the following outcomes:

- 48% reduction in child abuse and neglect;
- 56% reduction in emergency room visits for accidents and poisonings;
- 59% reduction in child arrests at age 15;
- 67% reduction in child behavioural and intellectual problems at age 6;
- 35% fewer hypertensive disorders of pregnancy

(Nurse-Family Partnership, 2014)

The Nurse-Family Partnership has been replicated in the UK under the name Family Nurse Partnership and has had promising preliminary results. Further research has been called for in relation to its impact on particularly vulnerable families (Schrader-McMillan, et al., 2012).

It has been significant in influencing a range of both 'professional' and 'para-professional' home visiting programmes.

3. Para-professional home visiting: Healthy Families America [Home visiting for Child Wellbeing]

A US targeted para-professional home visiting programme which is rated on the Scientific Rating Scale (California Evidence Based Clearing House for Child Welfare, 2017) as being 'well supported by research evidence'.

It is 'designed for parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or

previous issues related to substance abuse, mental health issues, and/or domestic violence' (Healthy Families America, 2017).

It has the following characteristics:

- targeted voluntary home visiting programme working with families with children pre-birth to 5 years
- 1 weekly 1 hour, home visit for 6 months, followed by continued home visits at a frequency based on the family's needs
- the programme includes:
    - screening for welfare and maltreatment
    - child development screenings
    - community support groups
    - opportunities to participate in parental education

It aims to:

- reduce child maltreatment
- improve parent-child interactions and children's social-emotional well-being
- increase school readiness
- promote child physical health and development
- promote positive parenting
- promote family self-sufficiency
- increase access to primary care medical and community services
- decrease child injuries and emergency department use

An intensive package of induction and ongoing training is provided to home visitors along with rigorous professional development requirements including weekly support and supervision. Staff must also have a limited caseload depending on the needs of the families.

Research has demonstrated:

- increased birth weight of the infant if parent engages antenatally
- increased performance at school
- reduced adverse childhood experiences[8]
- reduced alcohol use in parents
- increased parental uptake of further education
- increased parental understanding of child development
- reduced parenting stress and stronger parenting efficacy

The Programme has also demonstrated cost benefits to the local community and state.

4. Para-professional home visiting: Parent Child Home Programme

Established in the US in 1965, the Parent Child Home Programme (PCHP) is an evidence-based home visiting programme which aims to support the 'verbal interaction' between parents and their children in their own home. It is a targeted

[8] Adverse Childhood Experiences or 'ACEs' are derived from a study carried out by the Centre for Disease Control and Prevention (Felitti, et al., 1998)

programme working with children and families from lower socio-economic backgrounds with an aim to 'bridge the gap' specifically in the skills necessary for starting school.

Families avail of a 30-minute home visit twice weekly where an 'Early Years Specialist' visits with a book or toy and interacts with the child. The basis of the home visit is to role model the interaction with the child and in this 'light touch' model the parent is supported to develop their own skills, thereby creating a positive home learning environment. Children are between 16 months and 4 years.

The early years specialists are recruited from similar community backgrounds as the families they visit, and desirable criteria for recruitment were listed as being non-judgemental, flexible and patient. They must participate in 16 hours of training before commencing their role and must participate in weekly support and supervision with their coordinator. The coordinator generally has a professional background in either social work or early education. The outcomes outlined are as follows:

- 50% more school ready when compared with their socio-economic peers
- perform above average on standardised US maths tests
- presented with higher socio-emotional skills than a control group
- performed 10 months above their chronological age in school
- were 50% less likely to require special educational supports
- 30% more likely to graduate than their peers

The Early Learning Initiative (ELI) in Dublin Docklands was established by the National College of Ireland as part of its access mission to widen participation in third level education.

In Ireland, Home Visitors receive a 20-hour pre-training course, which is a mandatory part of the application process. Only when applicants have successfully completed the pre-training course, interview, references and Garda vetting process, can they be employed as PCHP Home Visitors. Professional development continues in their role with support, supervision and access to training opportunities including higher level qualifications (Levels 5 (mandatory) to 10 (optional) on the qualifications framework).

The evaluation of PCHP in the Docklands by the Children's Research Centre, Trinity College Dublin (Share, et al., 2011) highlighted the positive impact of this Programme on the families involved, with parents learning a different and more enjoyable approach to reading and playing with their child. According to the evaluation, the children involved developed normally for their age with PCHP benefits extending to brothers, sisters and parents.

From 2007–17, 836 children and their families took part in PCHP in the Docklands. Over 30,000 home visits have taken place. Assessments continue to indicate that the PCHP children's language, literacy and numeracy skills are at levels expected of their age. 10 years on families are continuing to use the skills they learnt through PCHP. They and their children continue to read for fun – using the books and toys with their PCHP and subsequent children.

5. Para-professional home visiting: Lifestart

Lifestart, an all-Ireland organisation, was established in 1986 in 2 areas of socio-economic disadvantage in Connemara and in Derry/Londonderry. It is an early intervention and prevention organisation, founded on the belief that parents create the necessary learning environment for the developing child.

In line with the above approach, Lifestart adopted the Growing Child Programme, originally developed in the University of Purdue, Indiana. The Growing Child Programme is at the core of the work of Lifestart. However, the organisation does deliver a range of other aligned programmes which are predominantly home visiting programmes but also include group-based parenting programmes.

The organisation currently provides different levels of family support across 11 areas, depending on the funding contract e.g. in Sligo Town the organisation delivers wider family support-based services including the provision of an early years setting in addition to the core Growing Child Programme.

The Growing Child Programme is a structured home visiting programme usually delivered once a month in the child and parents' home for children aged 0 to 5 years of age. The average engagement period with a family was reported to be between 2 and 3 years.

The Growing Child curriculum is delivered by home visitors who currently receive a 5-day training programme followed by a probation period of 3 months of shadowing a more experienced home visitor. Home visitors receive group peer support on a weekly basis and clinical supervision on a 6-weekly basis. Many home visitors now have a pre-entry level degree in Community Development, Social Sciences, Early Years, Psychology and related disciplines. However, experience of working in a similar context and the individual characteristics of the home visitor were reported to be key eligibility criteria for recruitment.

The key outcomes reported through a recent longitudinal RCT (Miller, et al., 2015) include:

- improved parental knowledge of child development
- improved parenting efficacy
- reduced parental stress

The research also reported positive changes in: cognitive development, pro-social behaviour, difficult behaviour and referrals to speech and language therapy. However, these results were not statistically significant.

6. Para-professional home visiting: Preparing for Life

Originally established under the PEIP, Preparing for Life (PFL) was one of the first of 3, prevention and early intervention programmes funded by Atlantic Philanthropies. The Programme, established in Darndale, an area of socio-economic disadvantage, received ongoing funding through the ABC Programme.

The Programme was founded to address the concern that children did not demonstrate the necessary school readiness skills when starting school. This led to the development of a grass roots process to develop a plan to address this concern.

With funding under PEIP, the Programme aimed to:

- engage with parents pre-birth
- deliver monthly home visits based on a developed manual and the use of Triple P parenting programme from pre-birth to commencement of school
- deliver group-based parenting supports e.g. parenting programme
- support the quality development of local early years settings, in particular to achieve accreditation in Siolta (Preparing for Life, 2017)

The home visiting programme, developed as a mentoring model, is the cornerstone of the Programme and details of this element of the Programme will be outlined here.

The aim of the mentoring home visits is to support parents and provide them with a range of information to support them as their child grows and develops. It aims to engage families prior to the birth of their child until the child starts school.

A developed manual guides the home visits and draws from HSE information which is packaged into easily accessible tip sheets and is supported by the provision of toys/ books at various stages of the home visiting process.

Although the Programme has a manual, it reported that the home visits are not overly structured and are often response led and directed by the family's needs at that point in time. The importance of this flexible approach was referenced in the final evaluation.

The Programme offers a range of other community-based supports such as baby massage classes, Bosom Buddies information talks, Triple P parenting programme groups and supports the delivering of low-risk maternity clinics in the community.

Criteria for the recruitment of Mentors (home visitors) is primarily based on experience of working in a similar context and individual characteristics. A graduate qualification is desirable but not essential. Mentors have a range of different backgrounds including teaching, youth work and community work.

Mentors have a training period before visiting families independently and this will be dictated by their previous background and experience. A range of professional support and supervision mechanisms are built into the Programme including monthly peer support, with the wider PFL team; fortnightly team meetings; supervision sessions every 6 weeks and quarterly mentor peer learning sessions.

Outcomes of the Programme were outlined in the final evaluation following an RCT and included data gathered from 200 families from 2008 to 2015. Figure 8 below summarises the key outcomes from the Programme evaluation.

	Impacts during the programme	Impacts at School Entry
Cognitive Development	Cognitive improvements from 18 months onwards	10 point IQ gap between children in the high and low treatment groups
Language Development	High treatment children were better at combining words at 24 months	25% of high treatment children had above average verbal ability compared to 8% of low treatment children
Approaches to Learning	High treatment children showed better approaches to learning from 36 months	High treatment children were better able to control their attention than low treatment children
Social & Emotional Development	2% of high treatment children were at risk of behavioural problems compared to 17% of low treatment children at 48 months	25% of high treatment children 'not on track' in their social competence compared to 43% of low treatment children
Physical Wellbeing & Motor Development	24% of high treatment children were classified as overweight compared to 41% of low treatment children at 48 months	High treatment children had better gross and fine motor skills

Figure ES.10 - *Key Results from the PFL Evaluation*

Figure 8: Outcomes reported in the final evaluation of the Preparing for Life Programme (PFL Evaluation team, UCD Geary Insititute for Public Policy, 2016)

7. Volunteer home visiting: Home Start

There is presently only 1 Home Start Programme still in operation in Ireland today in Blanchardstown. Founded in 1988 it continues to provide home visiting, a créche and additional educational and information inputs for families.

It is funded by Tusla having been established under the HSE with funding for a coordinator position. Most of the referrals are from the PHN team and the Programme is being asked to work in a more targeted way through their funding relationship with Tusla.

It is '*a volunteer programme committed to promoting the welfare of families with at least 1 child under 5 years of age. Volunteers offer regular support, friendship and practical help to young families in their own homes helping to prevent family crisis and breakdown*' (Home Start Blanchardstown, 2017).

Originally established in the UK in 1973, there are estimated to be 300 schemes in the UK and it is now operating in 11 countries worldwide. It differs from the CMP in 2 key ways.

1. There is no core material or key information which structures the home visits, i.e. the key aim is support not information dissemination
2. In general, the home visitor can support the parent in many practical ways e.g. assisting the parent to go food shopping which would be beyond the scope of the CMP

Evaluation and evidence for the Programme in Ireland has been predominantly qualitative through case study. One study explored Home Start as a European wide programme working to combat social exclusion amongst families and young children. It found that parents perceived Home Start as being a consistent support on many levels, in terms of stress reduction, building parental confidence and providing much needed hands-on practical support at times (French, 2006).

Many UK and international studies have explored the benefits of Home Start with mixed results. One UK study found that while Home Start was found by parents to be a valuable support in relation to the management of parental stress, quantitative findings did not support this in an assessment of standardised outcomes within an intervention group compared to a control group (Mc Auley, et al., 2004).

A quasi-experimental study in the Netherlands (Hermanns, et al., 2013) found positive long term changes in several domains:

- parental wellbeing, competence and behaviour
- parenting behaviours and child externalising and internalising behavioural problems

8. Volunteer home visiting: Parents 1st UK

Parents 1st is a UK based programme derived from the CMP and it describes its role as community parent peer support. It stated aims are to:

'build on the strengths and skills of parents living in less advantaged communities. Relationships are at the heart of support. Informal early prevention in the heart of local communities empowers parents to cope well from the beginning' (Parents 1st UK, 2017).

It is a universal semi-structured volunteer home visiting programme delivered in a number of sites across the UK. A recent evaluation authored by the coordinator of Parents 1st UK demonstrated positive changes for a wide range of health and parenting issues with significant findings in relation to:

- access to emotional support
- access to information about parenting
- feeling confident about handling children's behaviour
- feeling confident about what foods are right for children
- having time in the day for eating properly
- having time in the day for meeting others
  (Suppiah C. , 2008)

This study used a 'multi-faceted participatory' methodology using qualitative and quantitative methods and argues that the use of RCTs is an inappropriate methodology for evaluating responsive, multifaceted community-based schemes (Suppiah C. , 2008).

1.9.1. Summary of review of home visiting programmes.

A number of other programmes were noted during the research such as:

- AVANCE Parent-Child Education Program (US)
- Starting Well (Scotland)
- Flying Start (Wales)
- Parents as First Teachers (UK/US)
- Play and Learning Strategies (UK/US)

However, it was beyond the scope of this document to comprehensively review all home visiting programmes (Schrader-McMillan, et al., 2012; California Evidence Based Clearing House for Child Welfare, 2018; Early Intervention Foundation, 2018).

Although the original CMP model was one of the first standardised models with a core research basis, it has now significantly changed in line with best practice developments and the changing Irish early years context. Many of the current CMP sites now operate a model which has strong similarities to that of Preparing for Life.

To summarise this review of home visiting programmes, table 3 below lists all known home visiting programmes in Ireland working with families and children aged 0–6 years. Key aspects of programme delivery e.g. frequency of home visit and duration of engagement are set out, along with information about the main approach to evaluating each programme. Section 3 will outline in detail how the 9 CMP sites operate, their similarities and differences.

Programme	Parent Child Home Programme	Lifestart Growing Child	Preparing for Life	Community Mothers Programme	Home Start
Universal/targeted	-Targeted	Universal to all first-time parents	Universal within area of disadvantage	Universal within area of disadvantage	Targeted through referral
Age range of child	**1.5 up to 4 years**	**0–3 years** but can be extended to 0–5 years	**Pre-birth** to school age, **5 years**	**0–2 years** originally Now this varies[9]	**0–5 years**
Frequency of home visit	Twice a week	Monthly	Monthly	Monthly originally Now varies weekly to monthly	Weekly
Duration of engagement	2 years	2 to 3 years	1 to 5 years	2 years originally Now varies, - 2 to 5 years	1 to 5 years
Additional supports	No	Can increase frequency of home visits	Wraparound community-based activities provided	Wraparound community-based activities provided now	Limited provision of community-based activities
Structured or response led	Structured	Structured with manual and flexible at point of delivery	Response led with structure and manual	Response led with structure and manual[10]	Response led, no manual
Pre-recruitment training required	No pre-recruitment training required	Not specific to role but graduate qualification requirement	Not specific to role but graduate qualification desirable	No pre-recruitment training required Experience of parenting is desirable	None – value-based attributes
Professional development mechanisms in place	Support and supervision	Support and supervision with mixed training opportunities	Support and supervision with mixed training opportunities	Support and supervision with mixed training opportunities	Support and supervision

[9] Now this varies between pre-birth in some settings, up to a maximum of 5 years.
[10] This is the original model; today there are different practices and the manual is only used in 2 sites, with a third site using some aspects of the manual.

Programme	Parent Child Home Programme	Lifestart Growing Child	Preparing for Life	Community Mothers Programme	Home Start
Professional /para-professional or volunteer home visiting	Para-professional	Para-professional	Para-professional	Volunteer originally Now mixed profile Volunteer/ Para-professional	Volunteer
Paid/ non-paid	Paid	Paid	Paid	Mixed paid/ stipend/ not paid	Not paid
Main evaluation approach	RCT Longitudinal	RCT	RCT	RCT Longitudinal[11]	Quasi- experimental longitudinal research
Child health evidence	No evidence	No evidence	Significant improvement	Significant improvement	No evidence
Parenting evidence	Significant improvement	Significant improvement	Significant improvement	Positive trend	Positive trend in one study
Behaviour evidence	Significant improvement	Positive trend	Significant improvement	No evidence	Inconsistent evidence[12]
Child learning evidence	Significant improvement	Positive trend	Significant improvement	No evidence[13]	No evidence
Specific/ Multidimensional	Specific	Multidimensional with limitations	Multidimensional with limitations	Multidimensional with limitations	Multidimensional

Table 3: List of early intervention home visiting programmes in Ireland

[11] This refers to the original model. There have been no subsequent RCTs carried out within any of the other CMP sites.
[12] The study by Mc Auley,et al. (2004) demonstrated no quantitative outcomes; however, the Netherlands study by Hermanns, et al. (2013) did have postive trend findings.
[13] While there were some findings that the Programme increased the level of parental reading/ interacting with child, this was not assessed using a standardised tool and there were no child outcome measures used as part of the methodology.

2. Overview of Community Mothers Programmes in Ireland

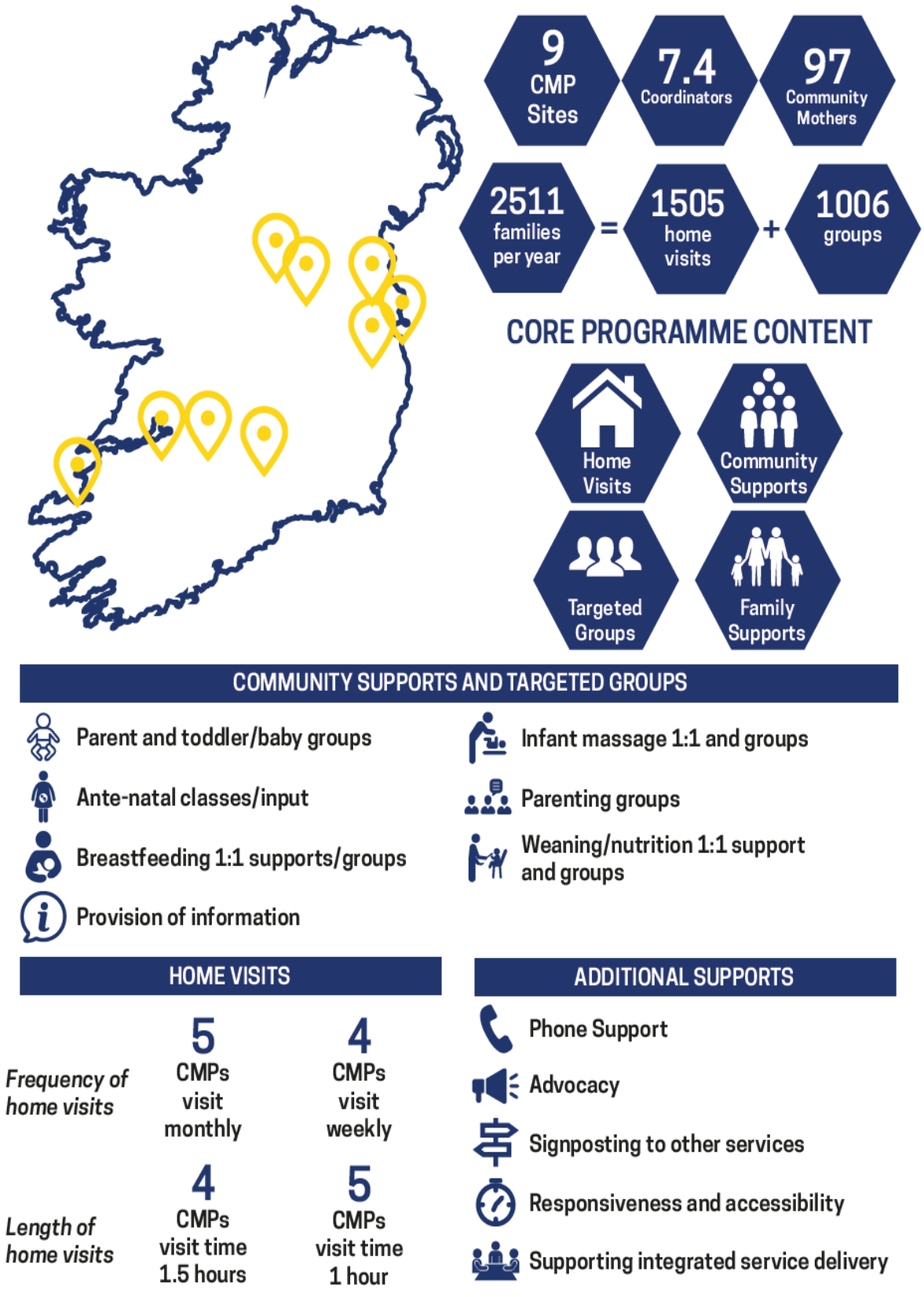


Figure 9: Overview of the 9 Community Mothers Programme in Ireland

2.1. Aims and ethos of the Community Mothers Programme

The current aims and ethos of the CMP was determined by carrying out interviews with coordinators and board members, as well as conducting focus groups carried out at each site with a selection of Community Mothers. Across the 9 sites focus groups were held with a total of 44 (46%) Community Mothers.

Overall the most striking trend across all focus groups was the similarity of ethos and commonality of core aims of the Programme. An analysis of common themes and clustering of words and phrases was carried out and is outlined below.

2.1.1. Programme aims

Focus group discussion outlined a range of key programme aims. All programmes identified the primary aim of promoting better child outcomes being at their core. Additional and most frequently noted aims are represented in figure 10 and are expanded upon below through the use of quotes and material gathered from interviews and focus group discussions

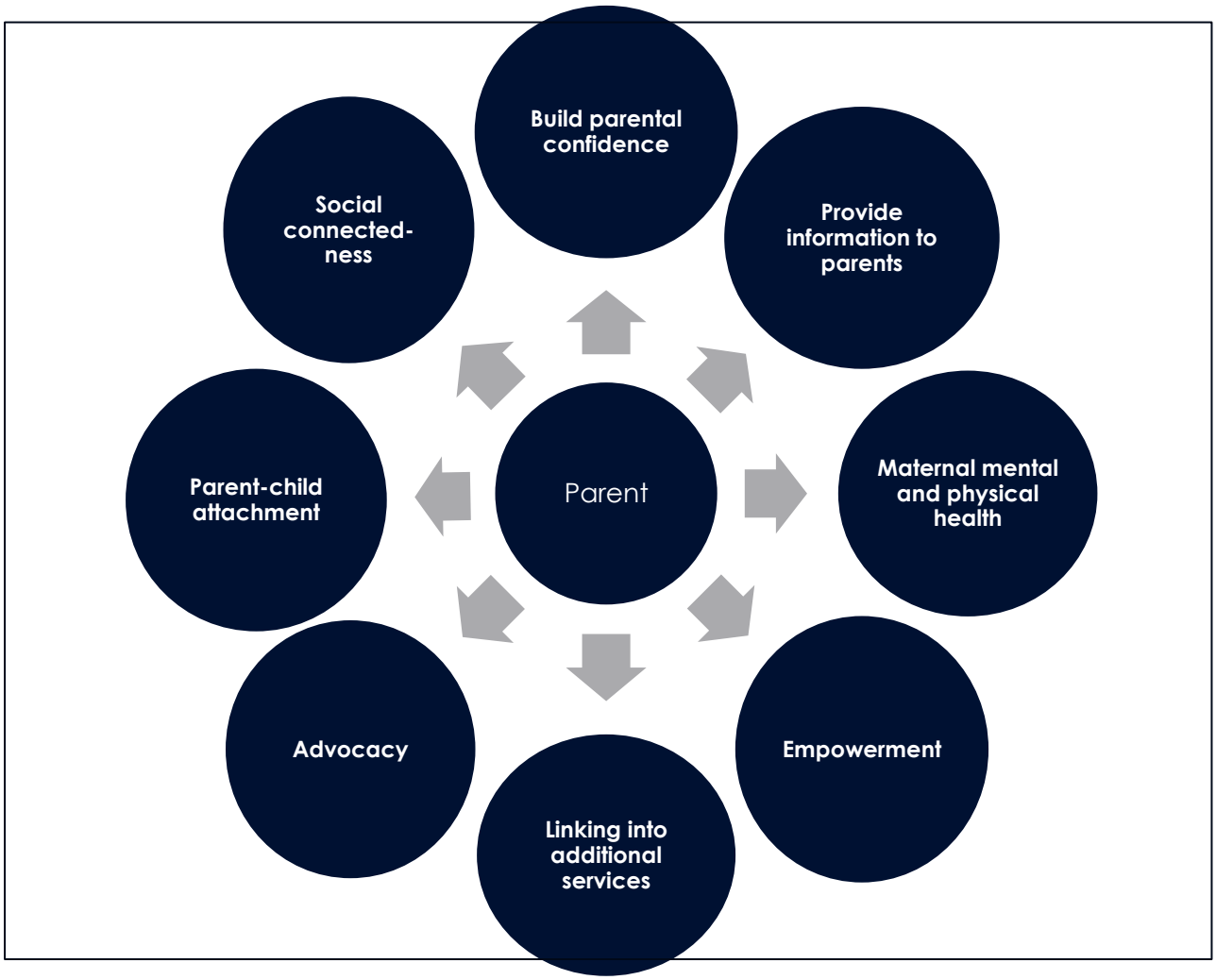


Figure 10: Programme aims most frequent programme aims raised in focus groups

Additional aims noted by the focus groups are listed below.

- support for meetings/appointments
- role modelling
- parental education and employment
- promoting greater awareness of child development
- transition to preschool
- preventative role

Social connectedness

The groups outlined their key aim was to provide social contact through the visits, but also to link parents into the Programme's own groups or other community groups so that they can reduce their dependency on the Programme and establish their own informal support network.

'The isolation is huge and is not addressed by professionals. Parents often feel trapped in the 4 walls, especially parents who are new to the town with a small child [they] can feel very isolated and they say it's great to see a friendly face' **Community Mother**

'It is really important to start building links with the community and using community resources, they really become integrated into the community…they make friends for life' **Community Mother**

'..she said to me, "I just wake up and say thank God, it's Tuesday, as I know that's when you are coming, and I'll get to chat to someone' **Community Mother**

'..they all make friends, sometimes you bump into them in Costa having a coffee and another time they told me they were meeting together to go swimming' **Community Mother**

'..they've now set up their own What's App group and established a regular 'buggy exercise' morning and the word is spreading' **Community Mother**

Provide information to parents

There were some differences across CMP sites in relation to the provision of information, with some CMPs providing standardised manual-based information at key stages of the relationship with the family. Other sites used HSE materials along with additional materials sourced through the range of their training backgrounds e.g. infant mental health/ relevant parenting programme – see table 6.

In all sites, Community Mothers and parents outlined how Community Mothers went out of their way to source additional information which may be important to the needs of the family they were visiting.

Build parental confidence

There was a considerable acknowledgement of the anxiety and pressure on new parents. The aim of building parental confidence was often addressed through the ongoing approach and ethos of the Programme which was consistent within all CMPs. That of praise, encouraging parents' own problem solving and being non-directive, all contributed to the building of confidence.

Additionally, this aim was achieved through practical support in being there. One CM relayed the following experience:

> *'She was starting to wean him, and she was so anxious in getting started she said to me, "can I do it in front of you, will you just stay here with me while I try it"'*
> **Community Mother**

Maternal mental and physical health

There was considerable discussion within the focus groups on maternal health, specifically mental health. The aim of promoting positive mental health as well as physical health in terms of sleep, nutrition, physical exercise and getting out of the house were all consistent across the CMPs. One CM noted:

> *'They're often surprised to learn that we are there for the mother as well and they often say, "gosh I hadn't thought of myself"'* **Community Mother**

Empowerment of parents

All groups used the word empowerment when discussing the aims of the Programme. They expanded on this with clarity as they saw their role to support the parents' growth, confidence and independence.

Support parent-child attachment

Again, parent-child attachment and bonding is a key aim for all CMPs and many noted the ripple effect in that it had benefits for all the children in the home.

Many noted that baby/infant massage was a really helpful and practical tool to introduce the topic of tuning in and spending time with your baby. They stated that baby massage was a real ice breaker at the start of building a relationship with a parent.

'It [baby massage] *really hooks mams in'* **Community Mother**

'I find using tummy time is a great way to start focusing on the attachment and bonding, it's a great way to connect with the child and we talked about spending 15 minutes a day just really tuning in to your child. It can actually transfer to other kids in the house with all kids getting a real period of 1:1 attention' **Community Mother**

Advocacy

This was raised as a recurring aim, with many CMs outlining that '*you're on their side'*. It was very striking that many CMs, including those in a volunteer role, would go to considerable lengths in their role as advocate for the parent. One CM supported her parent through a court case arising out of domestic violence. Many coordinators supported their families through legal custody battles or were an advocate for families during Tusla Child Protection Conferences (CPCs).

Others report supporting parents where there are literacy or language barriers as they navigate through systems and paperwork, always with the provision that they were not doing it for them but supporting them.

Linking into additional services

In some cases, this overlapped with the provision of information in the case of providing information about local community supports and activities. However, it also involved onward referral for specific supports.

Community Mothers all noted that they work closely with their coordinator in this regard and do not act independently. Additionally, many related that they don't have a high rate of official referrals as they frequently support the parent to self-refer. One CM had sourced a counselling support for a parent in conjunction with the coordinator:

'..the parent wanted me to be with her when she made the phone call to book the appointment, me just being there gave her the confidence to do it' **Community Mother**

Community Mothers re-iterated a key value system in this regard of respect and honesty with the family and some noted that if an open and honest relationship was established that this would survive the necessity to make a child protection/welfare referral to Tusla. However, many felt that this was a complicated process and on occasions the relationship did not survive such a referral.

2.1.2. Ethos of the Programme and role of the Community Mother

The learning from the focus groups outlines the skilful role of CMs in the balancing of informality and trust whilst maintaining professional boundaries. The role of the CM is underpinned by a clear ethos that was enshrined in the original former EHB model but has grown in line with both societal and practice-base changes e.g. the inclusion of fathers.

The ethos behind the role of CMs is outlined in figure 11 below and represents the most frequent recurring themes from the focus group discussions.

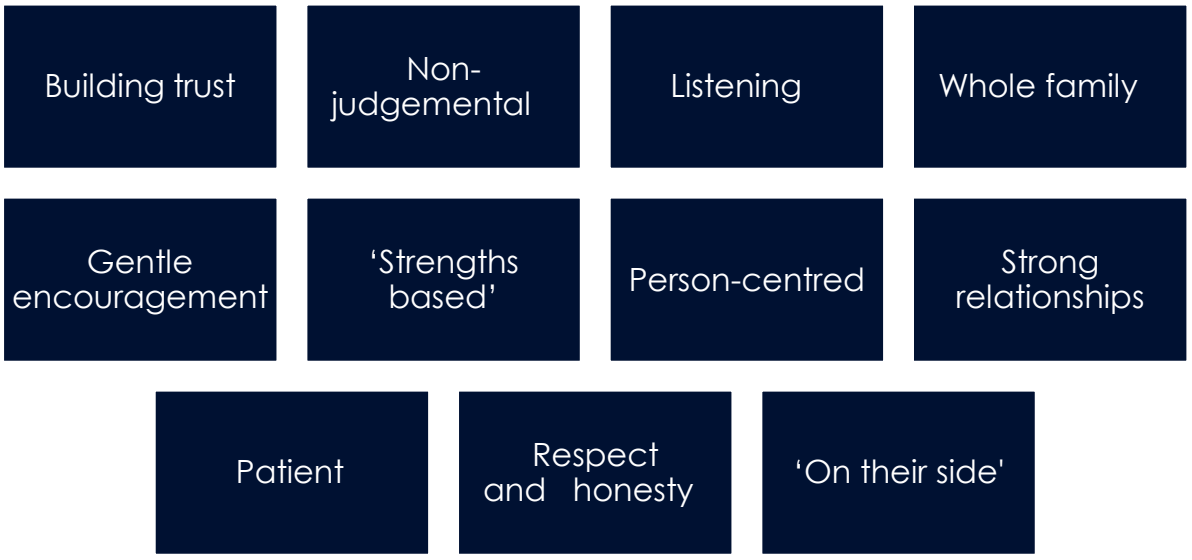


Figure 11: CMP ethos as reported through focus group discussion/interviews

2.2. How the Programme operates within the 9 sites

The CMP sites have many variations in how they deliver the Programme locally. However, there is considerable similarity in the core ethos of the programmes and there would appear to be very little difference between sites in terms of the parental reported experience.

2.2.1. Universal/ targeted/ progressive universalism

While the original model was targeted to areas of disadvantage but was universal within these catchment areas, all CMP sites have moved away from this original model.

The majority of CMP sites are universal, but many also offer a targeted provision within this universal service i.e. progressive universalism – see figure 12 below.

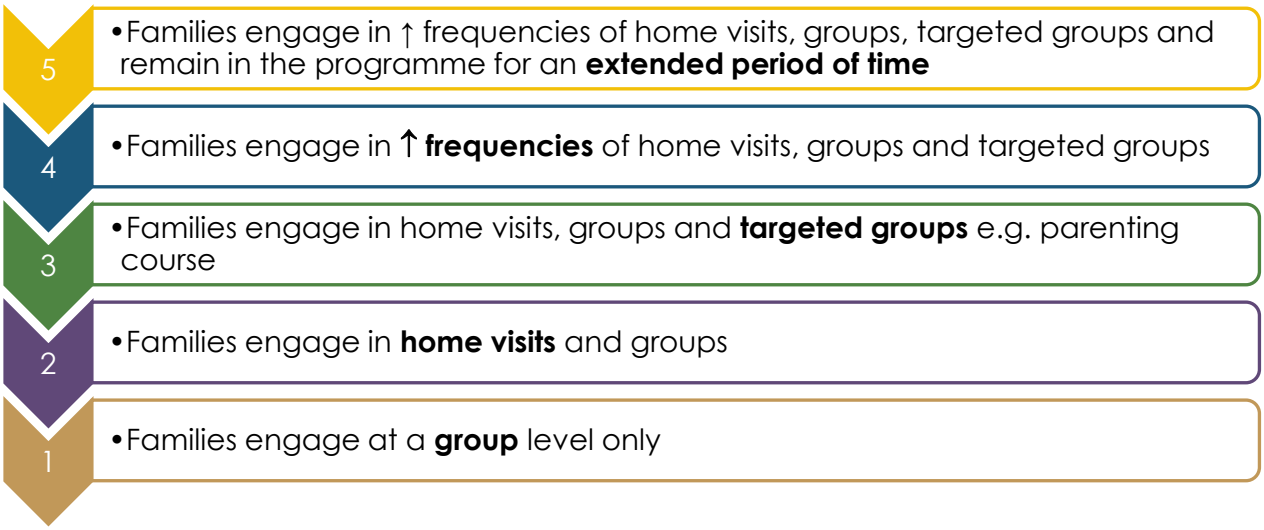


Figure 12: Scale of levels of support available within the CMP

Figure 12 outlines the CMP sites response to addressing different levels of need. Tusla have adopted the Hardiker model (Hardiker, et al., 1991), see figure 13, as a methodology for describing an integrated continuum of preventative support (Tusla, 2013).

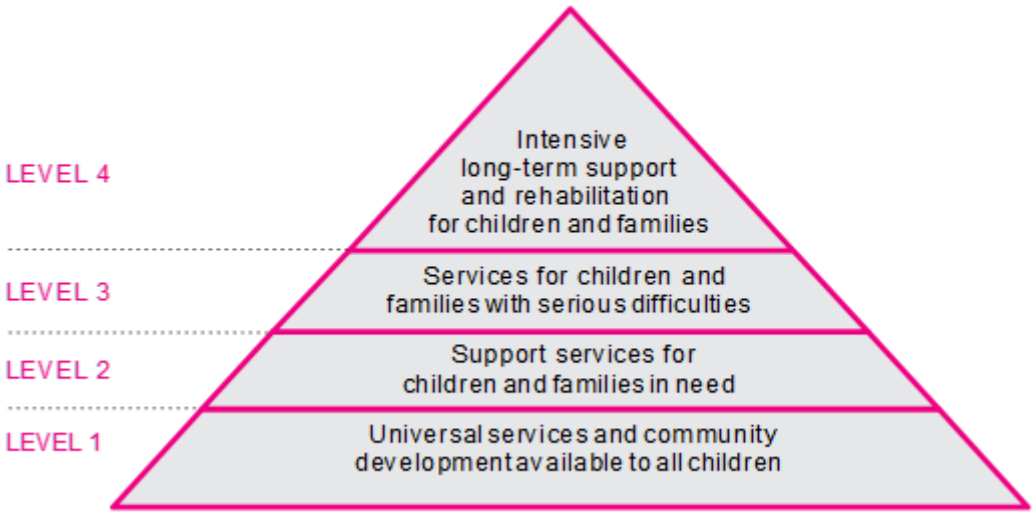


Figure 13: Hardiker levels of need (Tusla, 2013)

The majority of CMP sites would be working at:

- level 1
- level 2
- level 3 within an integrated package of support

The frequency at which CMP sites are working at an 'integrated level 3' varies with some programmes supporting a relatively high number of children and families and some only a limited number.

The review outlined that 7 out of the 9 sites supported at least 1 family at this 'integrated level 3' with 1 site supporting up to 20 families.

It is clear from the interviews carried out or case studies outlined during the course of this review that all CMP sites have some experience of working at this higher need level and all frequently work at the higher end of level 2.

All CMP sites reported working in direct provision services and/or homelessness accommodation supports.

Additionally, CMP sites worked with families who would in general always present at a level 1, however due to an acute ill health experience post the birth of a child or a child presenting with high health or developmental needs, these families present with acute needs at this crucial early stage of a child's life. CMP sites often reported that these families did require high levels of intervention at this actue phase however as these families have the resources or wider supports available to them, this phase remains an acute phase from which they quickly 'bounce back'.

2.2.2. Criteria for availing of a CMP

While the majority of CMPs prioritise first time parents, they do not limit participation to only first-time parents. Many noted that any family can avail of the Programme once they have at least 1 child within the specified age range (see table 4 below).

All families must live within the specified geographic catchment area.

2.2.3. Home visits

Home visiting is at the core of all the CMP sites. Table 4 outlines the approach each CMP takes to home visiting.

In one area it was noted that '*some people will just not take a home visit'*. In these cases, families can still avail of support through the groups offered.

Frequency of visits

The majority (5) of CMPs visit weekly, especially at the start of the engagement with a family as outlined in table 4. In many cases CMs will visit more frequently if required in exceptional circumstances. 1 focus group noted that if there is a crisis it could be more than twice a week for a home visit.

Additional features of the Programme:

Responsiveness and accessibility

The Programme was considerably valued by parents given that it was delivered within the family home, making it extremely accessible.

'They sent me on her number, and I got in touch with her and she called out and did a home visit. It's really handy like if you've a good few children like' **Parent**

'The fact that it's a home visiting service is vital – I wouldn't have been able to engage in those early days if it wasn't delivered through the home' **Parent**

'The home visiting is crucial – all services should be based in the home and the community' **Parent**

As is noted below the average home visit can last 1.5 hours per family. However, this can vary depending on need. Additionally, many families have higher needs in the early days of having a new baby and these reduce as parents gain confidence and increase their network of local supports.

'Probably wouldn't have felt the same approaching a PHN with the queries and concerns, I was lucky with the PHNs I had, but,..like, my Community Mother stayed with me for 3 hours one day and she didn't make me feel like I was taking her time' **Parent**

'Sure they're [PHN] only there 5 minutes whereas at the group or when X [Community Mother] calls around you're there for 1 hour and ½ talking about all the problems your kids could have' **Parent**

Supporting integrated service delivery

The CMP repeatedly demonstrated strong interagency working and this was evidenced at all levels of the review both from within the CMP sites and from all stakeholders. This would appear to have been a considerable strength of the Programme in many CMP sites.

Those families with additional needs also require additional interagency working. In 2016, 1 CMP site attended 15 Tusla case conferences. This required considerable time in terms of preparing documents and in any follow up actions after each conference.

Accessing additional supports for families also requires additional time. This issue was noted in many of the focus groups as CMs noted their frustration with the lack of services, particularly those for children with additional needs. This placed additional time and resource burdens on the CMP to secure the necessary supports for the family they are working with.

Phone support

Throughout the review it became very clear from speaking with CMs, coordinators and parents that over-the-phone advice and support was readily available.

'Every 2 to 3 weeks initially and then monthly after that and if I needed her I could text or ring – she's always at the other end of a phone' **Parent**

'They sent me on her number, and I got in touch with her and she called out and did a home visit. It's really handy like if you've a good few children like' **Parent**

'Like even this morning I was upset about something and I was able to call my CM about it. Cause family just can't, family's too close' **Parent**

'Initially a couple of times a month, certainly at the start it was twice or more a month. She answered the phone the first time I called and that was great. I could pick up the phone and ring her at any time' **Parent**

'She visited once a month, but…you could always ring her. You had your visit once a month, but if you needed her in between you could just pick up the phone' **Parent**

Advocacy and additional supports

Many Community Mothers noted that they also extend their supports to going with a mum to appointments if they were feeling anxious or shy. This was consistent across

many of the CMPs. Additionally, Community Mothers will accompany a parent when visiting or exploring a preschool and putting their child's name down.

'Sometimes it's necessary to role model the interactions you might have with other services, like I went to the school with one parent and once she saw how I spoke and interacted with the school she then had the confidence to do it herself' **Community Mother**

'I sometimes meet them and walk them down to the playgroup, but walking down with them can sometimes give them the courage to join in and makes it less daunting' **Community Mother**

It is very hard to quantify and measure this level of support and yet, as seen above, it is one of the most invaluable elements of the Programme, distinguishing it from services perceived as being more formal and led by professionals.

Programme site	Frequency of home visit	Ability to increase frequency in response to need	Typical length of home visit time	Average length of engagement with a family	Max. engagement	Age range of child
Clonmel	Weekly	2 to 3 times a week	1 hr.	2 yrs.	Once youngest child is within age range	Pre-birth – 5 yrs.
Dublin Docklands	Monthly	Initially weekly and moves to monthly	1.5 hrs.	6 mths. to 1 yr.	2 yrs. Refers directly onto PCHP	0 – 2 yrs.
Dublin Finglas	Monthly	Monthly	1 hr.	1 yr.	2 yrs.	0 – 2 yrs.
Dublin Loughlinstown	Monthly	Initial 2 visits more frequent	1 hr.	6 mths. to 1 yr.	2 yrs.	0 – 2 yrs.
Kerry	Weekly moving to monthly	2 to 3 times a week	1.5 hrs.	1 yr.	3 yrs. Once youngest child is within age range	Pre-birth – 3 yrs.
Laois/Offaly	Weekly	Weekly	1.5 hrs.	2 yrs.	5 yrs. Once youngest child is within age range	0 – 5 yrs.
Limerick	Monthly	2 to 3 times a week	1 hr.	1 to 1 yr. 6 mths.	3 yrs. Once youngest child is within age range[14]	0 – 3yrs.
Longford/ Westmeath	Weekly	Weekly	1.5 hrs.	6 mths. to 2 yrs.	5 yrs.	0 – 5 yrs.
North Tipperary	Weekly	2 to 3 times a week	1.5 hrs.	1 yr. 6 mths.	3yrs. Once youngest child is within age range	Pre-birth – 3 yrs.

Table 4: How home visits are delivered in each CMP

[14] Family can avail of ongoing supports from the Incredible Years Parenting Programme up to the child is 8 years.

2.2.4. Range of community-based supports

A majority of CMPs offer a range of additional community-based wraparound supports – see figure 14 below. Many of these are in response to local need; however, they also reflect the core ethos of the community-based model of parent and child support.

Baby-Parent/ Toddler-Parent are a key element of the Programme in supporting the establishment of social networks for parents and addressing the feeling of social isolation and loneliness.

Being an open and universal group is not to suggest that they are unstructured.

> 'It *might seem unstructured to the parents, but we [me and another CM] work together and go around the room just subtly checking in with each parent. We don't discuss anything in the group but if we pick up that someone is struggling, we will talk to them after the group or ask if they'd like us to come and visit at home'* **Community Mother**

Additionally, most of the CMP sites have a strong educational component:

- baby massage and infant mental health practices during groups
- weaning/ Cook It classes
- role modelling of play and responsiveness to child's developmental stage

> *'We use the playgroups to role model interaction and play with each child '* **Community Mother**

> *'They ran courses like personal development and goal setting and really good things. We did this home management course, and I still use it – and it is really simple recipes but not processed food – it's really good'* **Parent**

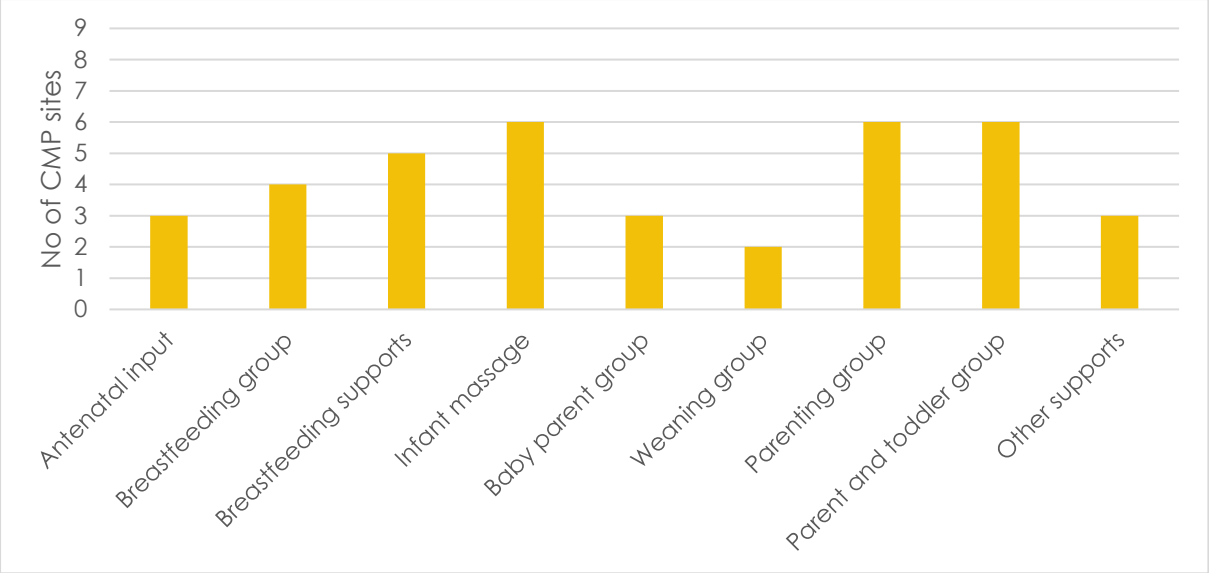


Figure 14: Range of wraparound community supports offered by the CMP sites

Other supports include:

- 'Baby and Me' talk
- home management course
- storytelling group
- summer activities
- talk and play group – co-facilitated with a speech and language therapist
- parent fitness class

2.2.5. Parenting

All CMP sites have adopted a parenting programme which is used either within a group context or to support advice/information sharing during home visits (table 5). In many sites the delivery of a parenting programme is done in an interagency context.

Programme site	Parenting programme (used in either group or 1:1 context)
Clonmel	Parents Plus
Dublin Docklands	Parents Plus
Dublin Finglas	Triple P
Dublin Loughlinstown	Parents Plus
Kerry	Parents Plus
Laois/Offaly	Triple P
Limerick	Incredible Years
Longford/ Westmeath	Triple P
North Tipperary	Incredible Years

Table 5: Parenting programmes used within each CMP site

2.2.6. Materials used

Only 2 Programmes still used the original model materials as was used in the original research base with updates from current HSE Public Health Nurse practice and 1 site utilises some elements of the original material. Given the absence of a national programme structure and an absence of funding, this original material and structure has not been possible to update and subsequently evaluate a new 'manual' based on contemporary research and evidence-based practice.

7 of the existing sites have updated their material in line with both HSE Public Health Nurse guidance and best practice in early intervention and prevention but no longer use the original materials. Table 6 below summarises the range of materials used to underpin both the home visits and the group-based work for each CMP.

Programme	Materials used
Clonmel	Infant Mental Health[15] (Michigan Association of Infant Mental Health) HSE materials[16] Parents Plus Signs of Safety (Turnell, 2012)
Dublin Docklands	HSE materials Aistear/ Siolta Parents Plus
Dublin Finglas	Original CMP manual and materials
Dublin Loughlinstown	Original CMP manual and materials Parents Plus
Kerry	Infant Mental Health HSE materials Parents Plus
Laois/Offaly	Locally developed training programme Triple P Parenting
Limerick	Locally developed manual influenced by the original CMP manual Incredible Years HSE materials

[15] Hayes, et al., 2015

[16] HSE materials refers to 'Caring for your Baby' and 'Caring for your Child' (HSE & Healthy Ireland, 2015a). It also refers to HSE materials provided to the CMP by local health services e.g. speech and language therapists.

Longford/ Westmeath	HSE materials Triple P Parenting
North Tipperary	Incredible Years Tusla's 50 key messages HSE materials Infant Mental Health

Table 6: Materials used within each CMP

2.2.7. Local evaluations and reports

Many sites have, over the years, initiated external evaluations to review their work. These have been summarised within table 7 below.

CMP site	Evaluations	Type	Outcomes
Clonmel	Horgan & Duggan, 2002	Qualitative: documentary analysis and a qualitative evaluation involving recipients and providers	It noted the most useful elements of the CMP as: • Combat isolation, source of empathy and support • Information • Opportunity for children to socialise with peers It found parents reported positive effects in the following areas: • Increased confidence • Developing a wider social network • Reduction in stress levels • Access to information • Better parent-child relationship: managing behaviour; enjoying, understanding; and bonding with their children • Improved coping abilities
Clonmel/ North Tipperary	Morton, 2015	Quantitative, qualitative and outcome data. A questionnaire was designed to assess the self reported outcomes from a sample of 58 service users	Summarised in table in appendix 8 The results demonstrate significant satisfaction amongst service users that needs and outcomes in parenting, play and community safety, networking with families and community were strongly met through participating in the Programme
Clonmel	Curran, 2017	Strategic review	Range of strategic recommendations to secure the sustainability of the Programme

Table 7 : Reviews and evaluations carried out on various CMP sites in Ireland – table continued overleaf.

CMP site	Evaluations	Type	Outcomes
Laois/ Offaly	Wrafter, 2013	Internal qualitative evaluation carried out by coordinator	Service users had increased: • confidence • independence • emotional wellbeing This was attributed to the emotional, practical, esteem, advice and support received through the Programme. It suggested that: • parents could attribute their increased coping capacity to having an impact on their child's social and emotional development • the trusting relationship formed between the Home Visitor and parent was a key strength of the Programme • the Programme supported the establishment of social networks which reduced social isolation
Limerick	O Conner, 1999	Qualitative evaluation including review of documentary material; interviews with CMs and with recipients	82% of recipients of the Programme outlined 3 positive impacts including: • more knowledge • improved self esteem • improved parenting • felt calmer • increased their social contacts 'Fine tuning' of the delivery mechanism was recommended
Limerick	O Sullivan, 2008	Qualitative internal and external including the gathering of case studies	Self-reported benefits for first time mothers in relation to social isolation Recommended some internal systems change
Limerick	O Dwyer, 2010	Internal evaluation using Parenting Programme Evaluation Tool (PPET)(National Academy for Parenting Practitioners, 2008); external interviews with stakeholders	The PPET has a scoring mechanism from 0 (lowest) to 4 (highest) The Programme was assessed at a score of 2.4 including a 5% margin of error Process, training and sustainability recommendations were made One recommendation was for the Programme not to compromise on its core ethos

Table 8 : Continuation of table outlining the reviews and evaluations carried out on various CMP sites in Ireland

2.3. Governance

The CMP sites are governed by a range of different structures.

Some have the additional requirement of reporting to and supporting a board, which given the developments over the last number of years in governance and accountability has become more challenging.

Other 'host organisations' deliver a continuum of complementary supports and work in a community development context in terms of engaging families – see figure 15. Families can be internally referred for additional 'in house' supports. It also enables a greater presence of the CMP at interagency structures as more staff within the organisation can take on this representative brief.

The governance structures of all CMP sites were outlined in table 1. It is worth noting that 6 of the 9 sites are governed by community and voluntary structures of varying size and financial security.

While many small structures in the community and voluntary sector report a great number of challenges due to greater corporate governance and charity regulations, these are greater for those companies with:

- only 1 core funding line
- low levels of funding and a financial turnover less than €100,000
- limited administration and finance to support the work of a board

As noted above, there is increasing pressure on the boards of community and voluntary structures with no acknowledgement of the cost of 'good governance' from funders.

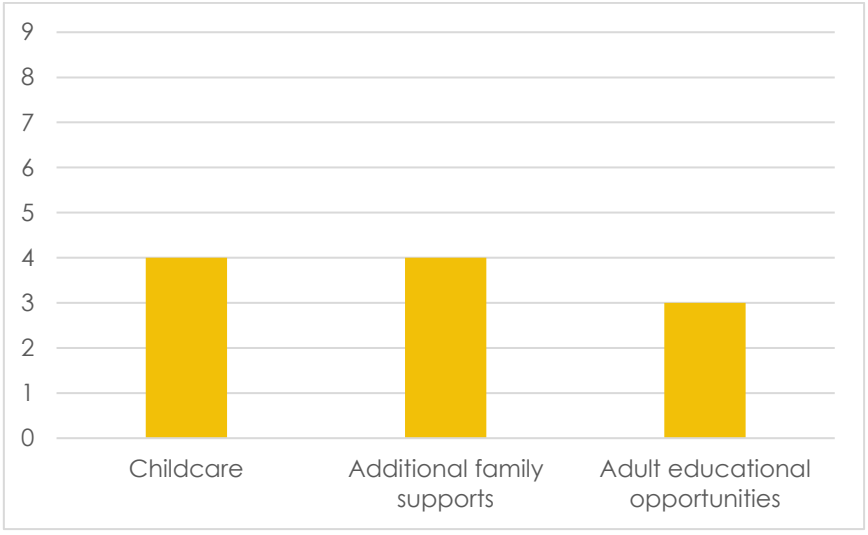


Figure 15: Provision of wider community child and family supports by host structures

There are 3 CMP sites under the governance of the HSE with a PHN in the role of coordinator. The coordinators of all HSE CMP sites work part time within the Programme and so still retain a PHN role within their local PHN team. This has many

benefits in terms of ensuring up to date information and practices and in liaising with the key referral source on a day to day basis.

While the challenges of operating within a small community and voluntary structure were noted above, there are also challenges inherent in being governed by a larger structure. It was noted that unless the CMP is clearly integrated into the strategic plan of a larger organisation it can be overlooked in terms of ongoing development and support.

2.4. Funding and future sustainability

The funding for the 2 Dublin HSE CMP sites is now split between the HSE and Tusla, and this has presented a considerable number of challenges for the logistical day to day running of the Programme. This has been exacerbated by the uncertainty of continued Tusla funding.

Both of the 2 Dublin sites are not permitted to recruit new CMs and are running out of core materials. Tusla have in the short term suspended the withdrawal of funding from these 2 CMP sites to allow for this review to be completed.

In 2016, the CMP sites reported a total income of **€973,232**[17]. Funding sources for all 9 CMP sites is represented in table 9 and figure 16.

All CMP sites reported several pressing concerns in relation to their current funding including the:

- level of funding
- insecurity of funding
- frequent lack of consistency in terms of communication in relation to funding provision for the contract period e.g. not aware of approved funding levels until mid-way through the contract year

Many board members and Coordinators report that operating under these funding insecurities places considerable pressure on management and detracts from the delivery of services. Concerns were raised regarding the low pay of staff, the implementation of pay freezes and cuts and at times the concern that there was insufficient funding to cover basic costs including staff salaries or travel expenses for volunteers.

Board members and management have reported that working in this insecure funding environment limits the progression of services in terms of:

- expanding services
- replacing staff who leave

[17] This figure must be interpreted cautiously. While accurate for all standalone CMP sites, it has not been possible to fully cost out the overheads or supports provided by being within a larger organisation e.g. the HSE or larger community organisations. Being under the umbrella of a larger organisation affords 'economies of scale'. As such it has been difficult to extrapolate the benefits of being managed and hosted by such an organisation to give a 'true-cost' of programme delivery.

- developing the range of services and supports available in response to local need
- accessing additional training and professional development supports for all the staff team.

Total income received	Tusla	ABC *(now Tusla)*	HSE	CCC	Tony Ryan Tipperary Fund	Other
100%	48%	13%	32%	0%	4%	3%
€973,232	€465,657	€125,526	€308,908	€4,370	€41,764	€27,007

Table 9: Income and funding sources for all CMPs 2016[18]

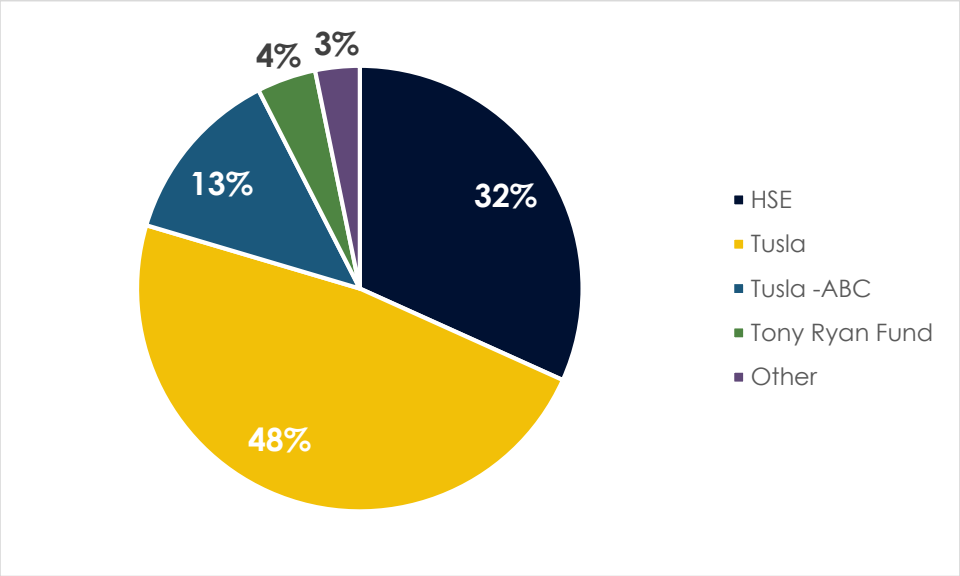


Figure 16: Funding sources for the CMP sites 2016[19]

All the CMP sites expressed concerns regarding the situation in relation to the future sustainability and funding.

[18] **CCC**: City/County Childcare Committee - parent and toddler grant;
ABC: Area Based Childhood Programme now transferred to Tusla;
Tony Ryan Tipperary Fund: Managed through the Community Foundation for Ireland, this Tipperary Fund saw an investment into the expansion of the CMP into additional areas in Tipperary. This funding closed at the end of 2018;
Other: This represented a small grant from supporting Community Employment participants and small income from parent toddler groups or delivering a training output.
[19] Funding sources outlined in figure 16 excludes donations and funding received from CCCs as this was <1%

The projects noted increased costs on an annual basis which are not reflected in funding levels received. Additionally, CMP sites noted concerns regarding how they would navigate the forthcoming Tusla commissioning process.

The 2 Dublin HSE CMPs 'at risk' funding situation was outlined in the introduction and identified that the Tusla funding for these programmes is due to cease and was only extended in light of this review.

2 CMP sites received HSE National Lottery Funding in 2015 which is once off and not a core or secure funding line.

2 CMP sites are in receipt of ABC funding which had a level of uncertainty attached to it at the time of the review. This has now been transferred to Tusla and while there has been reassurances regarding the funding for 2019, there will remain some concerns locally about the security and longer term commitment of this funding.

2 CMP sites are in receipt of philanthropic donations which are time limited grants. Again, these have been extended for 2019 with the commitment that Tusla continue this into the future.

At the time of the review the total of this imminent 'at-risk' funding was **€199,438 (20% of total funding).** However, negotiations during 2018 have resulted in maintaining the currently level of funding until the end of 2019. There has been no commitment to increase the current level of funding to address many of the financial and longer-term sustainability needs of the CMP sites. These needs should be addressed at local level funding discussions.

In summary all CMP funding has a high level of uncertainty attached to it, and this uncertainty is likely to increase in the context of the development of commissioning processes in Tusla and across the wider public sector.

This is not a sustainable way of funding the service. While existing staff members have demonstrated a strong commitment and loyalty to the Programme, there is a considerable risk that it will not be possible to replace the same skill sets at current salary levels and funding uncertainty. Focus group discussion and interviews with coordinators revealed:

'The coordinator role is part-time and when you look at those figures there, you'll quickly see the salary for the position. Who is going to take this role on when I retire?' **Coordinator**

'It's embarrassing as a board, we feel like we are taking advantage of the staff and we don't know what we can do about it' **Board Member**

2.5. Cost of delivering the Programme

It was not possible to fully extrapolate a 'true' cost of each CMP site as 7 of the 9 sites are part of a wider organisation with shared overheads. For all CMP sites funding received matched the cost of running the Programme itself, as is the case for many small community and voluntary projects.

Working out a unit cost for a family per year is also difficult for many reasons. Firstly, many CMPs provide a level of progressive universalism so each family does not receive the same input. The data gathering mechanisms currently in place do not allow for the level of accuracy required to establish such a unit cost, especially for those accessing groups only.

Finally, the Programme as it is run nationally, is a mix of voluntary and paid CMs. Those who are paid are on low pay scales and have had pay reductions in the last number of years. The commitment and loyalty of all the staff teams is such that it extends beyond pay and most CMP sites are funded on an unsustainable cost model which is overly reliant on low wages and voluntary commitment. This is not a viable way to fund such a vital service and many sites report the pay is not commensurate with the work and level of responsibility undertaken.

These elements make it very hard to quantify a single unit cost per family and while not impossible it would place considerable administrative burdens in establishing new methods for data collection.

Trying to establish a standard unit cost based on current levels of funding would also not be sustainable nor acceptable. It does require a full review of the '**real**' costs of running the Programme.

What is clear, however, is that in comparison to many other services it is a low-cost service provision and would remain so even if funding levels accurately reflected 'real' costs. Curran (2017) reported one model of an annual cost per family which considered those families with low and high support. This model proposed:

- low/medium support: €40 per visit with an average of 35 visits per year giving an annual cost per family of €1,400
- high support: €60 per visit with an average of 52 visits per year giving an annual cost per family of €3,120 (Curran, 2017)

2.6. Profile of Community Mothers

Today the profile of Community Mothers (CMs) involved in the former Eastern Health Board **original model**[20] has diminished considerably from **119** in 2013 to **18** in 2017 actively visiting families.

Combining the 18 Community Mothers from the original EHB areas with all other CMP sites there were a total of 97 Community Mothers delivering home visits and community wraparound supports.

2.6.1. Number of Community Mothers within each Community Mother Programme site

Table 10, below, shows the total number of Community Mothers in the participating CMP sites.

Site/Programme	Number of CMs in total	Number of CMs participating in the review
Clonmel	3	3
Dublin Docklands	6	3
Dublin Finglas	8	4
Dublin Loughlinstown	10	6
Kerry	6	4
Laois / Offaly	14	5
Limerick	8	7
Longford/ Westmeath	29	9
North Tipperary	13	3
Total	97	44

Table 10 Current numbers of Community Mothers in all participating CMP sites

Through the course of the review 44 Community Mothers engaged in focus group discussions and completed a brief paper survey. This represents 46% of all Community Mothers. The following data is based on the 44 Community Mothers who participated in the survey and focus groups.

[20] Former EHB region CMP sites.

2.6.2. Age and length of service

The average length of service for a Community Mother is 9 years, ranging from ½ a year to 21 years. The average age of the Community Mothers is 54 years. Youngest Community Mothers were 38 and 39 years and there were 3 Community Mothers in their 70s (70, 71 and 71 years respectively).

2.6.3. The professional and educational background of Community Mothers

Table 11 below outlines the range of roles each Community Mother had prior to recruitment within a CMP.

Role before becoming a CM	% of CMs
At work	30%
Bringing up family	45%
Student	16%
Retired/family reared	7%
Working and studying	2%

Table 11: Backgrounds of Community Mothers before they were recruited into the CMP

Community Mothers were asked to describe their past education and or training as outlined in figure 17 below. This indicated that a majority of Community Mothers had a third level qualification with 56% holding a diploma, degree or professional qualification.

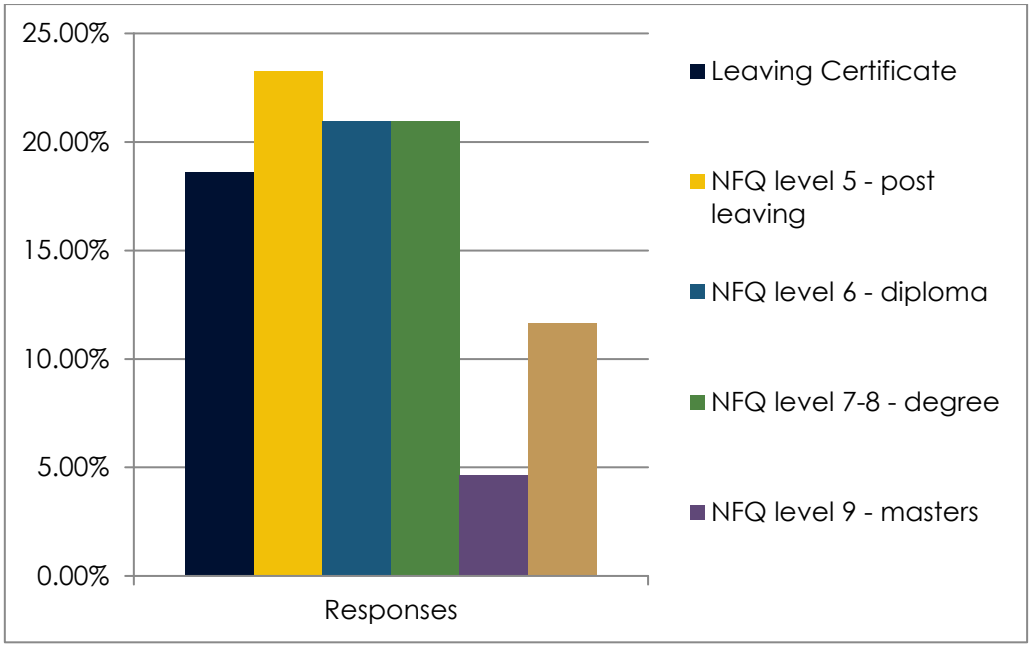


Figure 17: Educational background of Community Mothers

Community Mothers listed their previous professional backgrounds, and this is represented in figure 18 below.

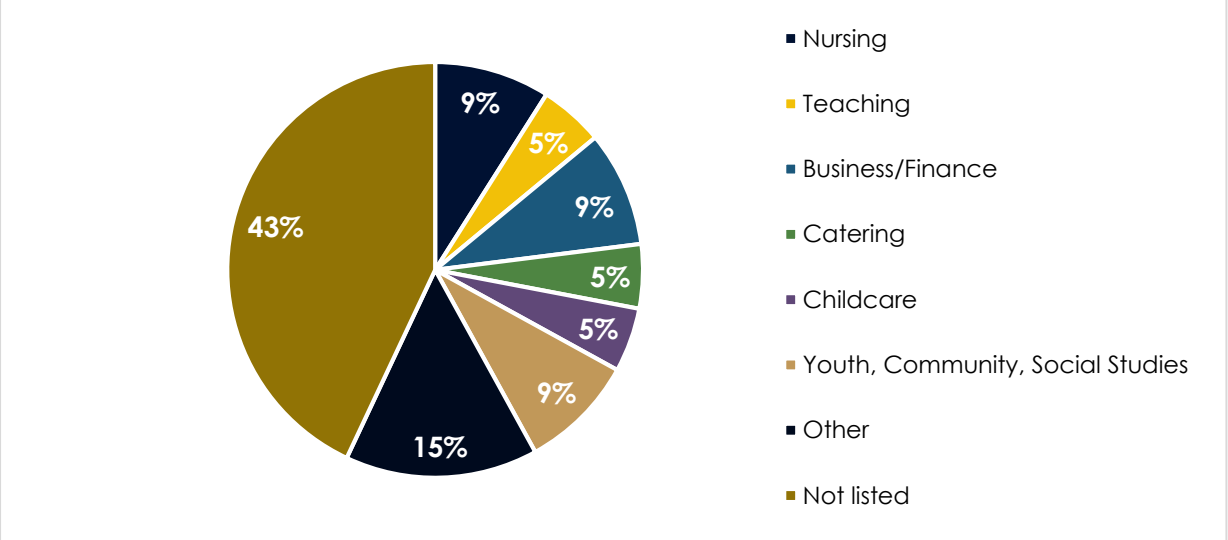


Figure 18: Work experience background of Community Mothers[21]

[21] The 'other' included: special needs assistants; play therapists; energy consultant; hairdresser.

2.6.4. Recruitment, induction, training and professional development supports

Recruitment, induction, training and professional development supports have all been identified by the research as being a key element in a successful para-professional home visiting programme.

Recruitment: The recruitment criteria for all sites remained like that in the original model, which is based on personal attributes, being from the local area, having experience of parenting or being a mother. Some sites have noted that a QQI level 5 in Childcare was a desirable qualification during the recruitment process.

Induction training: Once recruited, all Community Mothers undergo a period of induction and training. This varied across the CMPs as did the training material but was on average 16 hours long, ranging from 6 hours to 33 hours. All CMPs had their own in-house training developed and the majority had moved away from the original Barker materials from the CDP (Barker, 1984).

Support and supervision for Community Mothers: Additionally, all CMP sites had a rigorous support and supervision mechanism in place to support each Community Mother, both on an individual and a peer basis. This was on average twice a month but ranged from weekly to monthly. Those CMP sites with many Community Mothers pose a considerable challenge for the coordinator to ensure adequate support and supervision for each Community Mother. This was one finding that was unique to those remaining volunteer-based CMP sites.

Additional/external training: Many sites noted that it was difficult to secure funding to provide the relevant training for the CMP team as a whole. In some areas CMPs have availed of training opportunities through local Children and Young Peoples Services Committees (CYPSCs), Tusla or ABC programmes as relevant. Others noted that in the past it was possible to secure in-house training from health care professionals from the HSE, however this was now more difficult to access. The most common and consistent training across CMP sites is listed below. However, many Community Mothers had availed of quite extensive training giving them a high level of expertise in relation to the work they do, this additional training is outlined in table 12.

All **Coordinators** had external training in the following:

- Parenting programmes (in 5 sites this was extended to all Community Mothers)
- Meitheal (in 3 sites this training was extended to all Community Mothers)
- Child protection (in all sites Community Mothers have child protection training)

The most common training within **Community Mothers Teams**[22] is listed below:

- Infant mental health
- Infant massage

[22] Including the Coordinator. In some cases, this was all the team and in other cases it was 1-2 representativeS from the team who availed of the training

- Breastfeeding – both lactation consultancy[23] and breastfeeding counselling
- QQI level 5 childcare
- Paediatric first aid

Baby yoga	Circle of security
Home visiting QQI level 5	Counselling skills
Signs of safety	Drugs and alcohol training
Play therapy	Marte Meo
Nutrition	Safe Talk – suicide prevention
Hanen – language development	Facilitation and group skills
Highscope	Supporting refugees and understanding trauma

Table 12 : List of all training received by Community Mothers

2.6.5. Self-identified training needs for Community Mothers

The majority of Community Mothers indicated that they would like to continue to attend ongoing training opportunities relevant to their role, including progressing on to degree level training in family support. Figure 19 outlines the most commonly requested training needs from the focus groups ranked in order with maternal mental health the highest reported training need.

Figure 19: Community Mother training needs identified in focus group

[23] Lactation consultancy was only within a small number of CMPs and only 1-2 members per team

2.6.6. Rationale for becoming a Community Mother

Why did you become a Community Mother? This was an open-ended question and key recurring phrases, or concepts were clustered. The majority of Community Mothers indicated that it was because they understood the complexity of parenting and believed passionately in supporting parents (see figure 20).

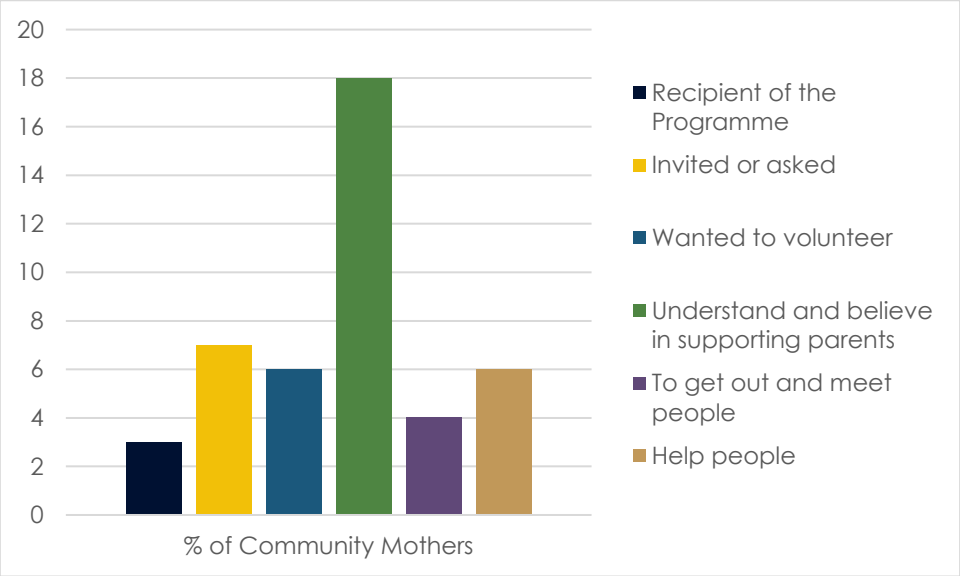


Figure 20 : Why did you become a Community Mother?

2.6.7. Likes, dislikes and job satisfaction

Community Mothers were asked to list 3 things they liked and 3 they disliked. Analysis of these outlined the following results.

Overall there was unanimous positivity towards working in a CMP. 100% of Community Mothers each outlined an average of 2.5 likes and the most frequent likes are outlined in figure 21 below.

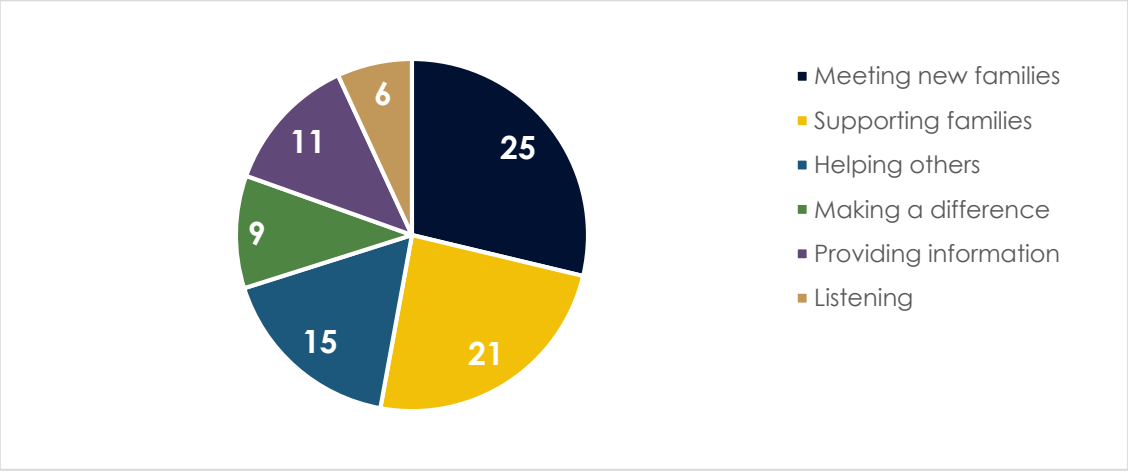


Figure 21: Frequency/number of areas of the Programme 'liked' by CMs.

Additional 'likes' listed by fewer Community Mothers are outlined in table 13.

• Flexibility	• Own personal development
• Meeting families from diverse cultures	• Building relationships of trust and support
• Diversity of whole role	• Empowering and encouraging
• Team work	• Being useful, feeling valued
• Linking parents into local supports/activities	

Table 13 Additional areas of the Programme which were liked by Community Mothers

Figure 22 below outlines the most frequent dislikes from Community Mothers. Although 100% of Community Mothers listed more than 1 area they liked, less than 50% listed a minimum of 1 dislike. The most common area of dissatisfaction outlined by Community Mothers in answering this question was the issue around pay and job insecurity.

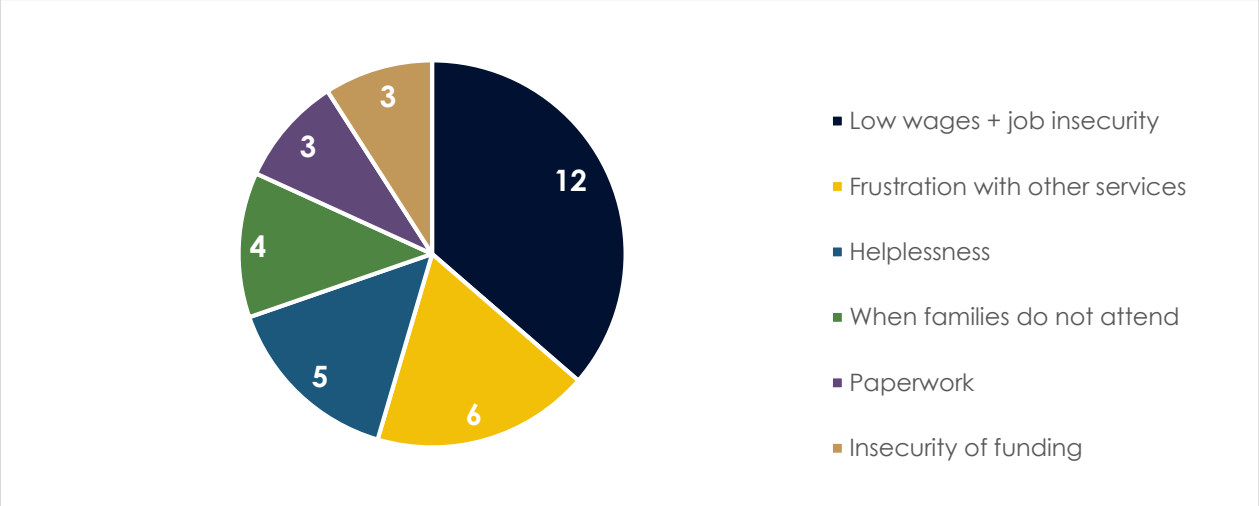


Figure 22 : Frequency/number of areas of the Programme 'disliked' by Community Mothers [24]

The area of 'frustration' or 'helplessness' was the second highest area of dislike expressed by the Community Mothers. This captured one of the key challenges in the role of Community Mothers: you can't do things for the family you are working with, rather you must support them to do it for themselves or rely/wait on other services to become involved.

[24] **Low wages and job insecurity** reflect concerns regarding the low hourly rate of pay and the current practice of Community Mothers being contracted per hour per home visit. This could result in a CM having inconsistent hours of service on a weekly basis depending on the number of families requiring a visit in a particular area. **Funding insecurity** represented Communit Mothers overall concerns about the sustainability of the project in the future, cash flow related issues and lack of ability to plan or develop new supports, services or access training.

It reflects the importance of being non-judgemental and of respecting the concept of 'good enough' parenting. Balancing this difficult role explained the high levels of responsibility that many Community Mothers feel. Additional 'dislikes' outlined by fewer individual Community Mothers are outlined in table 14.

• My own knowledge/ training is limited	• Community Mothers are female only
• Not enough Community Mothers	• Find the Programme is limited
• Limited opportunities to develop	• Traveling in winter months

Table 14: Additional areas of the Programme which were disliked by Community Mothers

Overall there was considerable job satisfaction noted in the open feedback comments:

'Love all the support, I get as much out of it as I give' **Community Mother**

'This is a very rewarding job with great job satisfaction' **Community Mother**

'I love doing this work it is very rewarding' **Community Mother**

2.7. Employment profile of Community Mother Programme sites

4 CMP sites have a part time coordinator in post with hours allocated to the CMP ranging from 16 to 31 hours per week – see table 15 below.

Site/ Programme	Number of coordinators	CE[25]	Number of home visitors
Clonmel	1	2	3
Dublin Docklands	1	0	6
Dublin Finglas	0.8	0	8
Dublin Loughlinstown	0.6	0	10
Kerry	0.4	0	6
Laois/Offaly	0.6	2	14
Limerick	1	0	8
Longford/ Westmeath	1	0	29
North Tipperary	1	2	13
Totals	7.40	6	97

Table 15 Employment profile of each CMP site[26]

- 5 CMP sites have employment contracts for all Community Mothers with some on a salaried contract and some on an hourly sessional contract. The sessional contract in some cases is often dependent on need and so there is no guarantee of set hours each week, although this is not the case in other sites. The range of pay is between **€11 and €16.5 per hour**

- 4 CMP sites have volunteer agreements with their Community Mothers.

  In 3 of these CMP sites, a stipend is paid between **€8 and €10 per hour**.
  In 1 CMP site only travel expenses are paid

- 3 CMP sites support Community Employment (CE) placements

[25] Those staff in a CE role are predominantly in an administrative role or supporting the delivery of groups under the supervision of a staff member.
[26] Administration was not included in this. Only 2 CMP sites have a dedicated administrator. Other CMP sites access finance/ HR and other supports from the wider host organisation. It was not clarified by the reviewer how much support these sites have with day to day administration and data management of the Programme and so it is not reported here.

3. Stakeholders: Families availing of the Community Mothers Programme

3.1. Referrals

Referrals received for a 12-month period in 2016 are outlined in figure 23 below. The category of HSE includes all referrals from PHN, GP, maternity services and healthcare professionals.

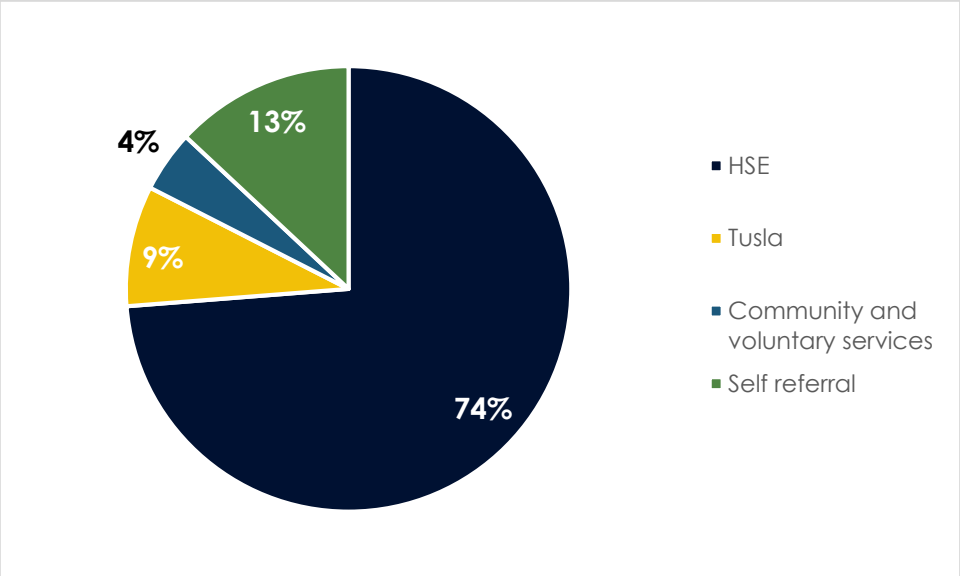


Figure 23: Referral sources to CMP sites in 2016

While the HSE is the primary referral source[27], this was not the case in 1 CMP site where the primary referral sources were self-referral and Tusla. In this CMP site there was a strong antenatal input at the local maternity hospital antenatal class and so many parents self-referred.

Overall 71% of all referrals were from the PHN services (74% from the HSE) with self-referral and Tusla Child Protection/ Family Support being the next most frequent source of referral.

3.2. Number of families availing of the Community Mothers Programme in 1 year

The number of families availing of home visits is outlined below (table 16). There was considerable variation in how many families availed of the Programme amongst different sites and the factors which influenced this are listed below.

- Did families supported require high or low levels of support?

[27] 97% of all HSE referrals came from PHN services. 3% represents referrals from maternity services, GP and other health care professionals.

- Were home visits monthly or weekly?
- Was the service supported by volunteers who may only support 1 to 2 families at a time or salaried Community Mothers who may be able to take a caseload of families?
- Did the service have a breast-feeding support element where a high number of parents would only avail of short time-limited breast feeding supports and not regular home visits? This would increase numbers of parents within such projects.

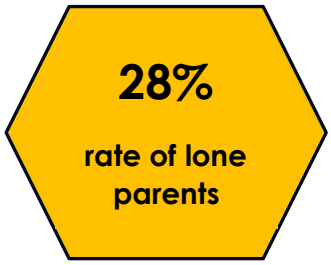
	Number of families availing of home visits 2016	Number of families availing of groups only 2016[28]	Total number of families in receipt of a CMP support[29]
Total	1,505	1,006	2,511

Table 16: Number of families availing of the CMP in 2016

3.3. Profile of families attending

Figure 24 below outlines the range of families availing of a service in 2016.

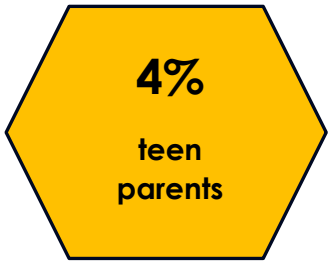
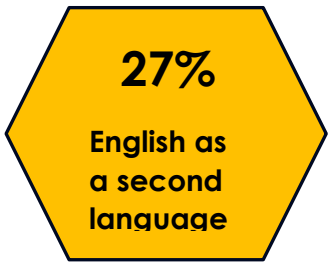
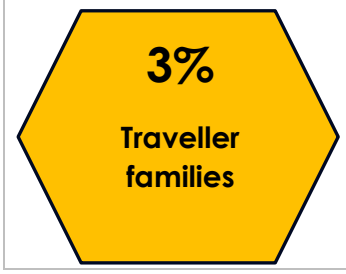
In viewing the profile of families, it must be noted that the CMP is a universal programme, however, many of the rates outlined in figure 24 are above national averages.



The rate of lone parents in Ireland is 18%.
The overall rate from the review was 28% ranging from 11%-57%.
National statistics have indicated that children from a lone parent household have a high rate of 'at risk of poverty' at 33% substantially higher than the EU average of 21% (Department of Children and Youth Affairs, 2016).

[28] The number of those attending groups was extremely difficult to extrapolate within many CMP sites. The actual rate for those attending groups is higher than this as many families receiving a home visit also attend for groups.

[29] This total number of those availing of home visits plus those only availing of 'groups only', was used to capture the reach of the CMP either by home visits or by groups i.e. how many families availed of any CMP support in one year.

	The official **national rate** of homelessness in Ireland in November 2017 was **0.18%** and while it is a national issue, it is more pronounced in the Dublin urban area. The review identified a rate of 6% of CMP families experiencing homelessness and this ranged from **0%-22%** across the CMP sites.
	It should be noted that in 3[30] CMP site 'catchment areas' there is a Teen Parent Support Programme (TPSP) operating and this will have impacted on the numbers of teen parents availing of the CMP. The **national rate** of teen parents is just under **1%,** and the review identified an overall rate of 4% which ranged from **0%** in 2 areas, where there is a TPSP, to the highest rate which was **10%.**
	The **national average rate** for whom English is a second language is **13%.** The range of families attending CMP sites for whom English was a second language was **13%-57%.** This measure was used as opposed to an indicator of non-Irish nationals as a substantial number of UK citizens are resident in Ireland for whom there are less cultural and language barriers impacting.
	The number of Irish Travellers outlined in the 2016 census (Central Statistics Office, 2017) is **0.7%** of the population. The average number of families availing of a CMP was 3%, therefore the CMP is 3 times more likely to have a Traveller family availing of the Programme. Attendance ranged from **0%-10%**

The maternal mental health rate was 12% which is below the national average of 15% of postnatal depression; however, 2 large CMP sites could not report on this statistic. The rate of maternal mental health within the review ranged from 11% to 29% of parents with 4 CMP sites reporting rates higher than the national average for post-natal depression. However, it must also be noted that it wasn't specified what mental health issue was to be categorised and some parents may have had pre-existing mental health issues.

[30] Limerick, Finglas and South Tipperary (Carlow/Kilkenny/ South Tipperary) have a Teen Parent Support Programme.

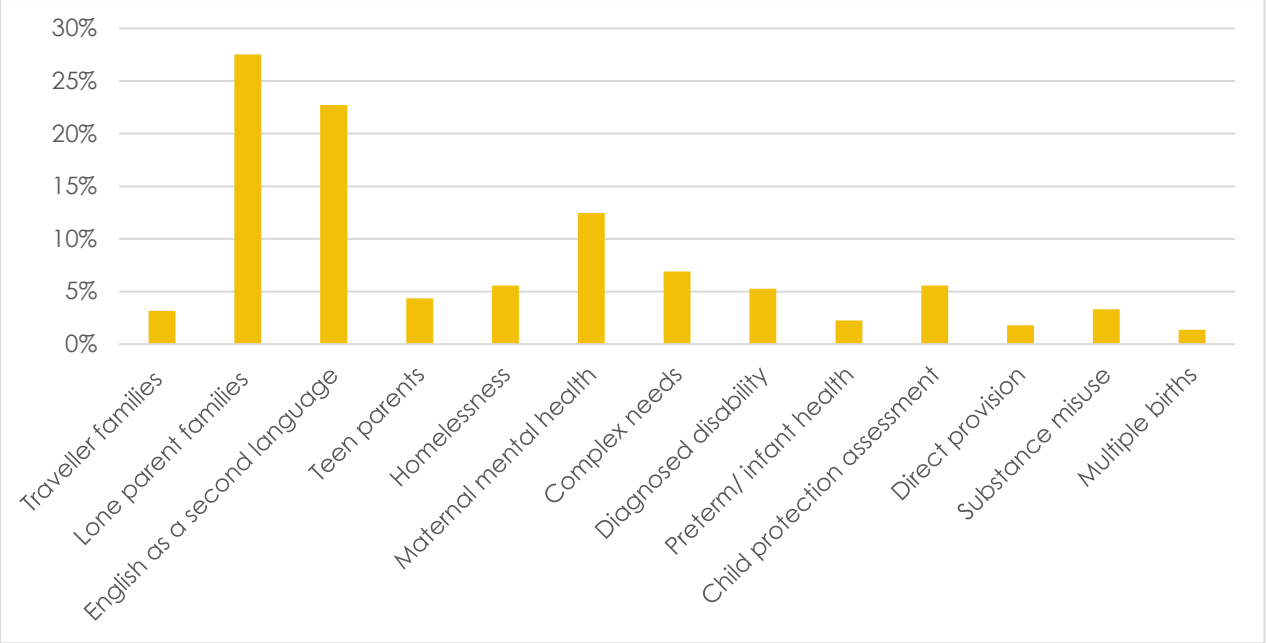


Figure 24: Profile of families availing of CMP in 2016[31]

The rate of families presenting at level 3 of the Hardiker as part of an integrated package of care ranged from 0% to 22%.

It can be confidently stated that these rates would be an underestimate of the range of needs presenting within each service. 3 CMP sites were unable to outline specific details from their families as the present coordinator was on sick leave or was relatively new in post. These sites relied on gathering information from the CMs but this was not always possible within the time frame of the review.

Additionally, as this review was a 'snapshot' in time, it was not possible to establish clearly how to determine categories, specifically regarding maternal mental health or substance misuse. Did this refer to the present time or if a family had experienced it in the past? Did it require a medical diagnosis or was it based on parental self-reporting?

This reinforces the need for greater clarity and standardisation in data gathering. However, these preliminary rates do indicate that the CMP does support a considerable number (above the national average) of vulnerable, at risk or high need families.

[31] Complex needs category refers to: marriage breakdown/separation; parent in prison; sibling with disability and/or complex needs; parent with a learning need; parent who presents as being particularly vulnerable; parents with a physical health need.

3.4. Feedback from parents: interviews

Each site arranged for a minimum of 1 parent/family to come and meet the consultant during the site visit and 18 interviews were completed.

2 detailed interviews are outlined in appendix 7. The interviews outlined a number of areas of need where parents identified the support of the Community Mothers had an impact. These are outlined below.

Needs/themes raised by families from the interviews

1. **Breastfeeding**

'I breastfed and that's where it came in really useful, I had a difficult labour and my daughter was in hospital for 2 weeks after with bacterial meningitis. When I came home, I had a fabulous Community Mothers, and it's so much more relaxed in your own home. She advised me in terms of my posture and that made a huge difference and I breast fed for over a year' **Parent**

'I was having some difficulties with breast feeding and was under a lot of pressure from the local PHN team as my baby wasn't meeting their milestones in terms of weight. It was really stressful. So, a friend gave me the number of the coordinator. I called her, and she came that day' **Parent**

'Well it was so different to other services; she took a real holistic point of view. The more pressure I was under the harder it was to feed. The coordinator instantly gave me reassurance and confidence. It was so much more different, and she taught me how to trust my own instincts. I knew my baby was going to be ok' **Parent**

2. Supporting families where there is a child with an additional need

'When I found out that my eldest had autism and ADHD at 18 months, I just went down with post-natal depression as my baby was only 6 weeks at the time. My CM would bend over backwards to help him in any way. My CM got me an appointment with occupational therapy I know there is a massive waiting list, but I was desperate in my situation. She explained my situation to them. She speeded up a lot of things for me '**Parent**

'The youngest lad stops breathing, he had to be resuscitated 6 times when he was born. I have to take him up to hospital with me when I go in now to have my third baby. She [my CM] has really supported me. My confidence has been the biggest change, I go to groups 4 times a week now just to get out of the house' **Parent**

'She (my baby) was always a little bit slower to develop, and it was my CM who in a very gentle way suggested maybe we need to address these things. So, from an early stage I was aware I needed to have a heightened sense of her needs '**Parent**

'She helped me through the diagnosis process when we got support for my son who has ASD. No support from the HSE during this. He was diagnosed at 2 years of age and both the coordinator and my CM supported me and even came to some of the appointments if I wanted it' **Parent**

'She (my baby) was discharged from hospital and it was a big thing for me, as she was born at 23 weeks. Last minute they taught me CPR in case she stops breathing and still my CM was there for me. She visited 3 days a week. My baby was so tiny, I was so scared of holding her, that I would hurt her, and my CM said, "no be confident". The way she explained I still can't forget, now I am not scared of most things' **Parent**

'It's stressful, and it's hard to accept it and you just say to yourself, there's some days I wish he was normal. But you can't change him. At least with my Community Mother I feel you're not on your own' **Parent**

3. Supporting parent/child bond and parental confidence

'I was really stressed out and couldn't relax. I didn't get to enjoy him and watch his development. Once I became involved with the CMP I started to relax and enjoy him. I had missed out on his development. However, my CM started talking to me about all the stages of development and drew me back in and I really engaged and enjoyed watching him grow and develop' **Parent**

'She (the CM) asked me one day, "do you sing to your baby?" and I was like "oh god I really don't have a good voice" and she said, "that's ok cause babies just really like the sound of your voice". And I still sing to him and you know it totally calms him down. If I'm out doing a bit of shopping and he is getting agitated in the buggy I sing to him in Penneys and he loves it' **Parent**

'My favourite part is the book she has about development. It will have what to expect for the different milestones. I love that because it's great to see what he's at and what he's doing' **Parent**

'I really, I feel like it nearly trained me as a parent because I didn't have my mother by my side' **Parent**

'It's made a big difference you know just the space for yourself to relax and for me tis enjoying my time with my baby, cause it's a busy house it's hard to pick time for each child. It's been really helpful for bonding with your child, I have 8 kids and for us to have the time for the smaller ones is important as the bigger ones demand more time' **Parent**

4. **Supporting parents and families undergoing social work assessment or custody situations**

'I thought they were like social workers or something. At the time I met my CM, I mean I didn't speak to my mother and father and she came out to me I was really rough, I was coming off drink and drugs, I mean the whole lot, like I was really low, really down in the dumps and she was able to link me into all these different things, I mean looking back now what 3 ½ years ago like you know, it's a big, big change like…' **Parent**

'That's what you need though, someone who is down to earth but you know they also need to be someone who is not going to sugar coat it for you either. If you were in the wrong, you know you need someone to tell you' **Parent**

'I didn't know they had any links with social work and they, it turned out, they ended up being a voice for me with social work. I mean it was so invaluable to me, so invaluable I mean I made a really strong bond with the CM' **Parent**

'It's made such a difference to my kids and even to myself, now I'm more confident in myself, she was very supportive. I can't praise them enough. The boys are in proper routines, they are eating more, they are getting on better with other kids. You know she really knows what I am going through. She came with me to every Child Protection Conference (CPC) meeting and she was sitting beside me and reminding me to keep calm, stay cool. CPCs are the most horrible intimidating things going' **Parent**

5. Supporting maternal mental health issues

'Especially with girls who have depression, like if you're depressed or have anxiety and stuff like that its great like as, they really put you on the right path to other places and make sure you get the right support' **Parent**

'In the prevention of post-natal depression, I do believe that having a few visits from a CM versus going on anti-depressants is huge' **Parent**

'I was kinda struggling a bit with anxiety after having my baby and I still am actually, so I was a little bit apprehensive, but she was so understanding and said I'm just here to support you and it really gave me something to look forward to every week and helped me focus on my week ahead' **Parent**

'She'd ask are you getting on ok? And really encouraging things like do you want to bring the baby out for a walk and that's a really nervous thing for me to do, so she helped me get the baby ready and she came with me. It sounds really stupid, but it was really nerve-wracking…' **Parent**

6. **Supporting good nutrition and healthy eating**

'He eats salmon and all. You just have to mash up an avocado and he eats it up. I was really scared about weaning but she taught me it all' **Parent**

'We did a home management course and I still use it – it's really simple cook book from Bord Bia and it's really simple recipes but not processed food – it's really good' **Parent**

7. **Breaking the cycle of parenting behaviours both within a family and across generations**

'She taught me about tummy time, and I was like what if I don't do it right and he was absolutely fine. I was worried about the littlest things and she learned me literally everything, things that my Mam and my Nanny wouldn't have done with me. And I'm like to them, "no you [my family] don't do it like that now"' **Parent**

'Like me Nanny and all that, they'd have given the kids anything, they spoon fed them and all at 3 months, and I like waiting the whole 6 months. And my CM would say, "just take your time" and she gave me the pots and everything' **Parent**

'Our younger one has just gone so clever and you'd never have seen that in the older kids comparing them to when they were her age and it's the same for the baby. Our younger one is well able to start preschool, well able to draw and hold a pencil, none of our others were like that as they didn't get the chance' **Parent**

8. **Supporting parents who do not have a social support network or are parenting alone**

'Or just like people who have no support I mean there are so many people out there with no support, who have broken away from their families or whatever. if they [the CMP] weren't there. I don't know… it would be, oh God, it would be mental 'Parent

'I was feeling isolated after having my first baby, my family didn't support me, I knew no one in the town and so that was it – for my first child I thought I am going to be doing this on my own until my husband comes home from work. I think it was great to have someone to talk with, great to have her come once a week. I did try and go out and leave the house and then through the Programme I got involved in the parent and toddler group' **Parent**

'I really like the contact with other people through the groups, I made really good friends through the Programme. I have fond memories now coming back here today and the coordinator of the Programme is an absolute dote. One of the nicest human beings you could ever meet. It's like coming back to see your mam' **Parent**

3.5. What Families valued about the Programme?

The interview scripts were analysed in detail and all references to the Programme, contact with the Programme team or engagement in any groups were coded. The feedback was overwhelmingly positive and reflected a range of sub headings which Parents attributed a value to. The frequency of these statements are reflected in figure 25.

As was the case in another Irish home visiting Programme, Preparing for Life (Doyle, O., & PFL Evaluation Team, UCD Geary Institue for Public Policy, 2016), the most important factor outlined indirectly by Parents was the relationship they had with their home visitor.

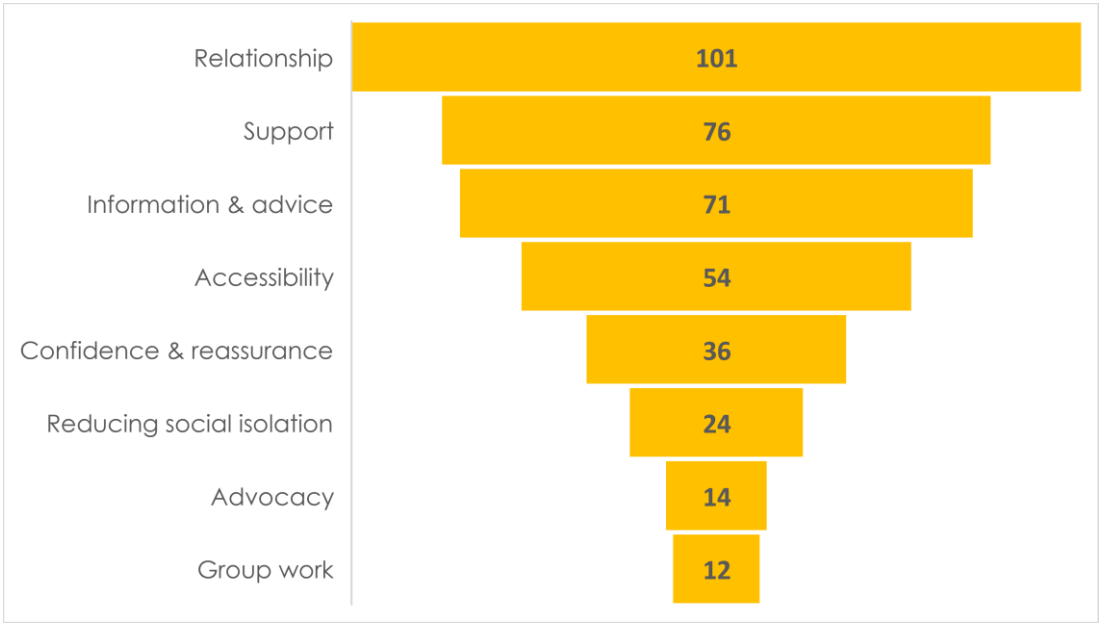


Figure 25: The frequency of positive statements about the Programme made by parents during the interviews

Figure 25 illustrates that the relationship between the parent and the community mother was the most common area mentioned by parents during the interview process. This was explored further to see what were the key elements of the relationship that parents mentioned during the interviews – this is outlined in figure 26.

Figure 26: What Parents valued when describing their relationship with their CM

4. Stakeholders: Interagency partners and funders

20 interviews in total were carried out with the following key local stakeholders and recurring themes from the interviews were collated and are outlined below:

- Tusla (PPFS Coordinator)
- HSE (Director or Assistant Director of Public Health Nursing)
- CYPSC coordinators
- ABC Programme Coordinator if there was one operating in the same area as a CMP

1. Highly regarded programme

Overall, stakeholders spoke extremely positively about the Programme, with many stakeholders involved in co-facilitating local actions with the Programme.

'It's really practical and it adapts to the needs of the mothers and the community' **Stakeholder**

'Feedback from the mothers is great' Stakeholder

'She's really good at engaging parents' **Stakeholder**

'She [the coordinator] reinforces what is said in the Programme [run by the PHN' **Stakeholder**

'Competent, capable and professional' **Stakeholder**

'They are really respectful of families and that's what works' **Stakeholder**

2. Positive working relationships

In many cases the stakeholder spoke positively of the specific working relationship they have with the coordinator. They noted the professionalism of the coordinator.

'The interagency working is excellent, very good through X [coordinator]. She feeds back regularly to the PHNs' **Stakeholder**

'Very good working relationship with the nurses, it's very organic, fantastic' **Stakeholder**

3. Limited, if any, duplication of services

Most stakeholders reported no duplication of services in the areas they were based in.

'There's no service they duplicate, and they are very responsive' **Stakeholder**

'We've a high number of family support workers now based in the FRCs [Family Resource Centres] and they work really well together, they complement each other' **Stakerholder**

A limited number of stakeholders, however, noted possible duplication of services in their area. They identified an uncertainty about the CMP which they felt required a greater level of role clarity.

'They don't seem to duplicate any service, maybe family support. You know I'm not actually clear about the role differences between the two' **Stakeholder**

4. Some need for updating, reviewing and clarifying CMP model

Some stakeholders were unclear at what level of need the Programme supported. In some cases, they only referred high need families, in other cases they felt the Programme wasn't sufficiently equipped to support high need families.

'I have to keep reminding them [the PHN team] that it's not only a family in crisis who can be referred' **Stakeholder**

'

One stakeholder fed back her perception that the CMP model she was familiar with needed up-dating and revision to bring it in line with current practices within healthcare and the innovations of the ABC Programme.

5. **Can provide key supports to high need families**

Many stakeholders noted the role that the CMPs play in relation to high need families. It was referenced by a number of stakeholders as a vital service in working with vulnerable families given its non-threatening and supportive approach.

'They are very wary of social workers, but they needed support and the CMP was just so accessible and acceptable' **Stakeholder**

'It's more targeted, inclusive of other groups and migrant populations, it was a key service with X [local refugee population in a direct provision service]. They worked really closely with Barnardos and were involved in addressing key concerns' **Stakeholder**

6. **Strong interagency working with varying levels of engagement with local CYPSCs, CFSNs and Meitheal**

CMP coordinators were seen by many stakeholders as being key potential Lead Practitioners for Meitheals. However, the need to strengthen links with the CFSNs and Meitheal was raised amongst a considerable number of stakeholders. While it was acknowledged that on the ground the CMPs demonstrated strong interagency working relationships, there was a concern that this wasn't consistently evident across all CMP sites at the level of CFSNs or Meitheal.

This is further complicated by an industrial relations dispute impacting on the participation of PHNs within the Meitheal process.

7. **Identified vulnerability of funding and need to secure additional funding particularly from Health, specifically the HSE.**

There was consistent local commitment from Tusla stakeholders regarding the current levels of funding received by CMP sites. However, they did raise uncertainty regarding Tusla's national priorities with the introduction of a commissioning strategy.

It did appear clear that the funding resources at level 3 and 4 were a high priority for Tusla. Additionally, 3 stakeholders noted that a funding priority for them was funding for services for teenagers.

Many questioned the absence of HSE funding to CMP sites, as Tusla perceived the Programme to be strongly aligned to health and wellbeing as well as family support.

CYPSC stakeholders did note the strong health promotional role of the Programme and raised the possibility of securing long term core funding through this avenue.

5. Challenges, opportunities and a shared national model

While the review has highlighted a number of differences across the 9 CMPs, it has also highlighted considerable similarities, most especially those that form the essence of the CMP and differentiate it from other home visiting models.

5.1. Similarities and differences across Community Mother Programme sites

Although all CMP sites had variations in their origins, 7 out of all 9 sites had an influence from the original Barker Childhood Development Programme (Barker, 1984) and all of these 7 sites received their initial funding from the Bernard Van Leer Foundation.

The 9 CMP sites hold similar ethos and values despite their variations in origins and divergence from the original model. This could suggest that this ideology, through on-the-ground practice, has the most success in engaging with families and that while the CMPs have evolved, they have retained those elements that work.

Tables 17 and 18 summarise the feedback from focus groups, coordinators, parents and stakeholders outlining the key similarities and differences across CMP sites.

All CMPs, however, face a range of different challenges in terms of their future sustainability. The next section outlines many of these.

Similarities across CMP sites	
Description	Community based early child and family home visiting programme
Levels of need	Universal with built in targeted supports depending on need All groups consistently support children and families at levels 1 to 2 All groups noted working within direct provision services and/or with families in homeless accommodation[32]
Core inputs/activities	Home visiting
Additional inputs/activities	All CMP sites have adopted an evidence-based parenting programme and deliver it through 1:1 or group supports
Core values	• Relationship of trust, respect, honesty and patience • Non-judgmental and informal approach • Strengths based • Time: giving sufficient and necessary time to each family depending on need • Not a medical/ health model, but a community health and wellbeing model • Engaging with the family as a whole • Person centred • Being 'on the parent's side'
Core practices	• Flexible • Responsive • On the ground interagency working • Developing greater levels of 'professionalism' • Valuing training and learning opportunities
Common aims	Better child outcomes through parental support: • Social connectedness • Building confidence • Providing information and linking into services • Maternal health • Empowerment • Advocacy • Supporting attachment
Induction training	All CMP sites have a varying level of induction training with a mix of group or 1:1 inputs
Support and supervision	All CMP sites have established regular monthly support and supervision with responsive support in between should the need arise

Table 17 : Summary of similarities across all CMP sites

[32] CMP sites had a profile of families attending which presented as being vulnerable when compared to the national average, especially given that the Programme is universal in its approach.

Differences across all CMP sites	
Different governance structures	3 are directly governed by the HSE 2 are directly governed by their own community structure 3 are governed by a community structure offering a range of other community supports 1 is governed by an educational facility with an ethos of community lifelong learning
Para-professional or volunteer home visiting	4 CMP sites operate a **volunteer** home visiting programme 5 CMP sites operate a **para-professional** home visiting programme[33]
Funding arrangements	1 receives its core funding from the HSE 2 are co-funded by the HSE and Tusla 1 receives its core funding through the ABC Programme 1 is co-funded by Tusla and the ABC Programme 4 have their core funding from Tusla
Additional inputs/activities	There are variations in the range of additional supports but 8 of the 9 provide some form of baby/toddler parent group While all are supportive of breastfeeding, only 5 of the 9 CMP sites provide a formal input from a trained CM
Levels of need	7 out of the 9 provide supports as an integrated package of care at level 3
Manual based	The use of a fixed manual varies across all CMP sites 3 of the 9 sites use or refer to a manual. Other CMP sites refer to a 'toolkit' of materials
Intensity of input	3 CMP sites have monthly visits 2 CMP sites have weekly visits but then move to monthly 4 CMP sites have weekly visits All groups reported being flexible and responsive to need and would see the home visit frequency increase in line with need
Duration of input	2 and 5 years with variations
External training opportunities for CMs	This has varied across all CMP sites primarily due to funding limitations in terms of the cost of the training and the cost of reimbursing/paying the CM for attending. The ability to access 'free' training does appear to be influenced by interagency working at the level of the CYPSC and ABCs where greater opportunities for no cost training were available The impact of a volunteer team was noted as a limiting factor as attendance often relied on the good will of the volunteer despite the reimbursement of expenses

Table 18 : Summary of differences across all CMP sites

[33] 2 of these have just recently moved from a volunteer to a paid home visiting programme.

5.2. Common challenges facing all Community Mothers Programmes

Meeting families' needs

Supporting high level need families: Supporting high need families was raised by many CMPs as an area requiring considerably more time and resources in terms of frequency of home visits, as well as additional interagency working.

This places additional pressure on the service as it moves towards an increased targeted provision within the universal model. While in some areas this flexibility has been referenced as a key strength of the Programme locally, it does require adequate funding to deliver this more targeted support.

Meeting the needs of non-English speaking families: Given the multicultural profile of many families availing of supports, a need was identified for appropriate visual materials which could underpin and clarify engagement when there are language-based issues.

Childcare: The need to access emergency or drop-in childcare, both to support the facilitation of parenting programmes and as a resource to employ in an emergency family support context, was raised during the review.

Funding

Commissioning: All CMPs currently in receipt of funding from Tusla will have to prepare for the commissioning process.

While some organisations have considerable experience in tendering, others will be challenged by the requirements of the proposed commissioning process. It will be important that they are supported to prepare for and participate in the commissioning process. They will need support to evidence the outcomes of their work and to gather relevant data to support this.

Meeting current Tusla service level agreements (SLAs): There is the ongoing challenge of how all CMPs can fully address the need to meet SLA agreements and targets without compromising the ethos and core value of the CMP. One of the greatest benefits of the Programme as reported by parents was the time afforded to each home visit.

There is a need for all CMPs to adopt more efficient data gathering mechanisms of outputs and outcomes. This will be more challenging for those CMPs with limited administration and IT supports.

Interagency

Unmet gaps in provision of local services: Many CMPs raised the issue of children with additional or emerging needs as an unmet need in the area. This has resulted in increased pressure on many CMPs given the absence of other support services or long waiting lists for statutory disability/therapy services.

This can lead to programme drift in some cases and add to a lack of clarity as to the core model for potential referrers.

Antenatal engagement: A minority of CMP sites have a consistent mechanism for engaging with families antenatally i.e. through antenatal classes organised by the maternity services. All CMP sites are keen to establish a mechanism to receive referrals for families antenatally and extend the Programme to initiate supports at this early stage.

Maintenance of existing and enhancing additional interagency links: While many CMP sites have good on-the-ground links with some of their co-located primary care teams, this is not consistent across all 9 CMPs or within each catchment area.

Some PHN teams are strong and regular referrers with many joint initiatives in place with the CMP, while other teams are less likely to engage and refer.

Additionally, there are established links with some maternity and antenatal services, but this is not consistent and is made more challenging for those CMP sites who have a number of maternity hospitals/ units serving the catchment area.

There is a need for 'greater endorsement' for the Programme within these structures at a national and service level rather than just at an interpersonal level.

The time involved in maintaining strong interagency links is substantial and many of the CMPs do not have a full-time coordinator. This could limit the potential of each site to participate in both CFSNs, Meitheal Processes and subgroups of local CYPSCs.

Finally, some CMPs do have additional challenges of working across a number of HSE Primary Care Teams or the challenge of working across 2 CYPSCs. These place considerable additional challenges on the coordinators of these CMPs.

Support when making a child protection referral: Many CMPs noted the need to make a referral to the Duty Social Worker in relation to child protection. Such a referral can have a negative impact on the established relationship of trust with the family and requires a coordinated and timely response from Tusla to prevent this from happening.

Visibility and promotion of the Programme: This was raised in all CMPs with many of the parents also raising it as they had previously never heard of the Programme. There is a challenge in promoting the Programme and then having the capacity to respond to the demand this raises.

Organisational

Quality service delivery: At a national level and in line with BOBF, all CMPs are facing increased pressure to review and continuously develop their service delivery model.

While these initiatives are to be greatly welcomed, they do put additional demands on the CMP, with the impact felt more by smaller structures with more limited resources.

Ongoing training and development of Programme team: While many CMs have received considerable training, this has been inconsistent across CMP sites and depends largely on the resources made available locally e.g. through the CYPSC or through the host organisation.

Many CMPs noted that in the past they could call on local HSE professionals to deliver training inputs for the CMs but noted that this has now reduced with increased pressure on all HSE services.

Many sites identified the need for a variety of essential training for the CM teams as well as having access to resources to provide ongoing professional development opportunities.

Evidence base, outcome focused and mechanisms for evaluation: Some of the CMPs have participated in external evaluations and have a growing level of evidence. Other CMPs have begun to focus on either tracking whether a family's needs or outcomes have been achieved.

There is now considerable pressure on all services to demonstrate a strong outcome-focused evidence base and CMPs will, like many other family support services nationally, be required to incorporate clear outcome measures as part of any service level agreement.

Data gathering: As noted above under commissioning, the ability to gather key data is a challenge for all CMPs. There is a need to have clarity as to what key data should be gathered in terms of evidencing outcomes. CMPs also need to establish mechanisms to evidence outcomes for each individual family, this is important but challenging as families engage at different levels.

Some CMP sites are exploring Customer Relationship Management (CRM). Having such mechanisms integrated into an easy to use IT system will make this process more manageable for all, but will require training and upskilling for all CMs, some of whom may not have IT confidence.

Support for coordinators: Some CMP site coordinators raised the challenge of accessing support and supervision for themselves; they often carry a considerable workload, supporting many families with complex needs. Access to external support and supervision would address this.

Board support and development: The challenges of operating a not for profit company given the extremely limited finance and staff resources was raised as a

challenge for some of the smaller companies. The small size of the company and turnovers in the region of €100,000 raise issues in relation to future sustainability.

All not for profit community and voluntary companies have considerable governance and regulatory requirements which can be challenging to meet with limited resources.

Sustainability and succession planning: This is a key challenge for all CMPs. While many CMP sites have short term security in terms of financial sustainability there is considerable uncertainty about longer term future sustainability. This makes the challenge of recruiting and developing a sustainable skill set within each team more difficult.

Challenges of managing a volunteer-based group: Most CMP sites have moved away from a volunteer model.

However, for those sites which retained this model there were a number of consistent issues which arose.

Meeting SLA targets: When working with volunteers there is a limit to the commitment which each volunteer can offer the Programme. This may not be sufficient to meet the demands of SLA targets established with the funder, thereby placing increased pressure on the coordinator to respond to these outstanding needs.

Supporting and supervising larger teams of volunteers: To meet SLA arrangements, it may be necessary to increase the number of volunteers as they may not wish to increase the hours they have committed to. This again places additional demands on the coordinator to provide the necessary 1:1 support and supervision required when working with a wide range of families and their needs. This is exacerbated in rural areas where a coordinator may have to travel considerably to provide this professional supervision.

Training and professional development: The balance of placing demands on a volunteer e.g. to attend full day training, while maintaining their engagement is a challenge for the volunteer-based CMP sites.

These concerns highlight the challenge of having a programme supported solely by volunteers and could limit the skill base of CMs if they don't avail of ongoing external training and professional development.

However, the Programme strongly articulated for the need to maintain some 'avenues' for interested individuals to volunteer and it was suggested that it might be possible to support this through the large numbers of community-based groups.

5.3. Towards a shared national model

On the 21st November 2017 2 to 3 representatives (23 in total) from each 9 CMP sites came together for a facilitated day of feedback and consultation. Each project was sent, in advance, a draft report and feedback on this draft report and possible recommendations were gathered throughout the course of the day.

Overall, there was very positive engagement by all 9 CMP sites during the day with many sites noting it was the first time they met and were brought together in such a forum. The CMP sites noted a strong commitment to collaborate and there was considerable openness and willingness to share information and work together. Finally, there was an articulated shared ownership of the Programme and a strong sense that the Programme needed to develop, grow and become more standardised in line with national policy objectives.

Additionally, the group was divided into 2 smaller focus groups and were asked to explore:

- possible areas for collaboration across the CMP sites
- what a national standard model might look like

5.3.1. Areas for collaboration across the Community Mother Programme sites

Figure 27 below outlines potential areas for future collaboration based on data gathered during site visits but also from the 1 day of consultation with all CMP sites. Creating a greater level of standardisation would support the CMP in terms of clarity of model and enhanced visibility. However, in working towards such collaboration there should remain a level of flexibility to respond to the specific needs of each locality.

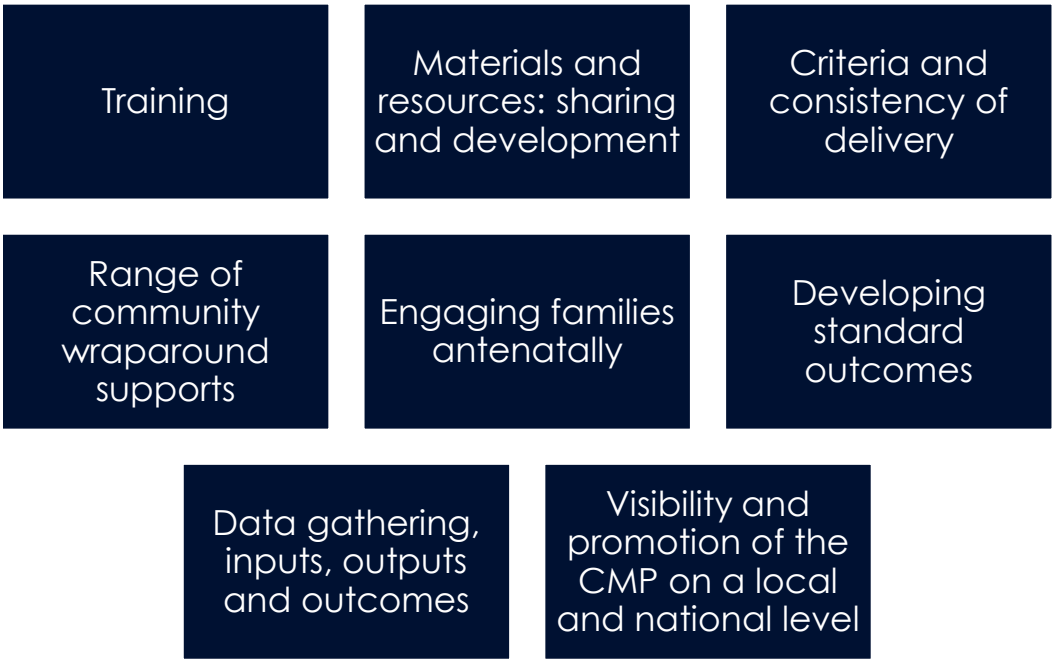


Figure 27: Areas for potential future collaboration

Feedback from the 1 day of consultation with all CMP sites indicated that all CMP sites would favour the establishment of a national standardised model. Such a national model could be developed through collaboration of existing services with supports

from key national stakeholders. It could have core and optional elements reflecting the need for local flexibility.

This model could provide supports for individual CMP sites to not only adopt a standard approach but to support the CMP sites as they navigate local commissioning processes. This national model could also support the development of new CMP sites in areas of identified need.

5.3.2. What would a national model look like?

Consultation within a focus group with representation of all CMPs regarding what a national model might look like took place on the 21st November 2017.

There were some areas which would require a greater level of engagement and consultation however; table 19 below represents 1 vision which was collated from the feedback during this consultation.

One option for a national model
Criteria
Universal model with integrated targeted provision: progressive universalism All parents who are pregnant or have a child aged 0–3 years within a defined geographic area Priority based on need with high need families defined by a range of factors including first time parents
Programme
1. Home visit as core element of the Programme. Weekly 1-hour home visit for pre-birth to 6 months as standard moving to monthly home visit from 6 months to 3 years but variable depending on need High need families or families experiencing crisis may have increased home visits up to 2 to 3 times a week if necessary **2. Range of wider family supports** Phone support Advocacy Interagency working – including CFSNs and Meitheals Supporting families to attend appointments etc. **3. Standard set of core community-based supports** While there may be local variation depending on the supports already in situ in local areas the following core elements will exist: • 1:1 breastfeeding support • Parent–baby group: including breastfeeding/feeding support • Infant massage • Weaning course: including nutrition and weaning – could be expanded to provision of basic cooking course (optional) • Parent–toddler group

Outcomes

This area requires additional engagement of national stakeholders but should include key outcome indicators from Healthy Ireland and BOBF. The indicators set out below are drawn from both Healthy Ireland and BOBF under the following headings:

Active and Healthy

- Increase pre-birth health of mother, including targets on smoking, drinking and substance misuse
- Increase provision of information and encourage access to supports to reduce number of low birth weight babies
- Reduce impact and incidence of parental mental health: lower levels of post-natal depression; earlier identification of post-natal depression; support to parents with pre-existing mental health conditions
- Increase information, knowledge and practice of infant mental health to support children's emotional development
- Physical health of parents including exercise both for themselves and to establish good role modelling
- Increase incidence and duration of breast feeding
- Increase and maintain high levels of uptake of immunisations
- Support establishment of healthy nutrition in young infant's life to promote a healthy weight and reduce obesity
- Increase uptake of 5 portions of fruit and veg in adult and child's diet
- Reduce intake of salt
- Increase the wellbeing of families availing of the service

Achieving full potential in learning and development

- Early detection of additional needs with earlier onward referral
- Increase the quality of home learning environment
- Increase uptake of universal free preschool years (2 full years)
- Increase parental knowledge of child development and early learning
- Increased language, social and emotional development and cognitive ability at 3 years of age before preschool

Safe and protected from harm

- Increase child safety and reduced accident and emergency attendances
- Early detection of safeguarding, welfare and child protection concerns
- Lower rates of children requiring support at level 4 (taken into care)
- Earlier access to services to support children and families at risk

Economic security and opportunity

- Increase access to information and supports in relation to welfare, housing and financial budgeting e.g. MABS
- Support parents to return to work or engage in training or learning opportunities towards employment
- Provide information and support to access services in relation to housing and homelessness
- Link with interagency partners in local government and community sector to support and increase access to safe play spaces for children aged 0–3 years

Materials underpinning the Programme

1. **A core standard manual drawn from evidence-based information** to support and underpin home visits and community-based supports. This should draw on:
   - Pre-existing manuals
   - Learning from ABC Programme
   - Learning and information arising from the Nurture Programme, the National Infant and Child Wellbeing Programme; Healthy Childhood Programme; Women and Infants' Health Programme and all HSE health promotional material
   - Infant mental health material
   - Parenting programme material – may vary depending on parenting programme adopted within each area
   - Local information regarding supports, services and adult education and employment opportunities – including MABS etc.
2. **Information handouts and tip sheets**
   Drawing on the above material, hard copy visual material should be provided to the family at various stages of engagement relative to the parent and child needs and stages of child development.
3. **An unobtrusive family friendly evaluation mechanism** should be developed. This should be in line with the core ethos of the Programme and should be transparent and in line with the **parent held child records.** Ideally this element of the national model could be developed in line with the progressive changes as a result of Nurture, such that the work of the CMP integrates seamlessly with the work of the local PHN services.

Home visitors

Recruitment and training

1. To develop a sustainable staffing model e.g. explore how remaining volunteer-led CMP sites could move to a para-professional model resulting in all CMs paid based on an agreed national pay scale
2. Recruitment should be based on skills and attributes with some experience of parenting or understanding of family life. QQI level 5 qualification in an aligned subject area is desirable e.g. Early Childhood Care and Education
3. All recruited CMs must commit to core additional training prior to commencing visiting with a commitment to ongoing professional development and training in key subject areas e.g.
   - Infant mental health
   - Lactation/breastfeeding
   - Parenting
   - Mental health first aid
   - Child development, especially programmes to support early learning through play and to promote language development
   - Domestic violence
   - Specific programmes on: equality and diversity; immigration; working with Traveller families.

Professional development

External professional supervision for all coordinators
Training for all supervisors in an agreed approach e.g. Morrison Approach
Monthly 1:1 supervision for all home visitors
Group and peer meetings/supervision based on local arrangements

Case load management
Consideration should be given to the range of needs of families on any given case load. Given the progressive universalism approach, some CMs will have a mix of high and low need families and so this must be reflected in the case load. Healthy Families America specifies that if a home visitor has high need families their case load should be capped at 15 families.

Operations

Electronic data gathering and CRM[34] system
Efficient and non-intrusive mechanisms for data gathering is required to evidence outcomes and outputs for funders. Adopting these developments within a CRM system would support communication with all families involved in the Programme and give a national overview of the reach of the Programme.

National Profile for Programme
Including web presence, integrated communications with statutory services and service level arrangements between key interagency statutory partners for joint working.

Governance

A national steering group
- A national oversight committee with representation from local CMP sites and high-level management from all the key national stakeholders e.g. HSE, Tusla, DCYA and key advisory organisations would oversee the development and implementation of a national model.

Local governance
- Primary governance would remain at the local level in pre-existing structures.

National coordination
- Provision of national coordination to interface between key stakeholders and all CMP projects and to support CMP projects to share their learning and vision for a national model

Table 19 : A vision for a national model

What was also clear from this consultation process was that arriving at a position where a national model could be developed and subsequently adopted by all existing sites would require considerable consultation and, most importantly, engagement and endorsement of many key national stakeholders.

5.4. Opportunities inherent in the Community Mothers Programme

The CMP model has considerable potential to address many national policy priorities. Its holistic multidimensional approach delivered within the community addresses

[34]CRM or Customer Relationship Management systems are widely adapted to support efficient data collection and communication between health or social support services and their service users/clients.

multiple and overlapping national priorities. It is a low-cost prevention programme and engages at such an early stage in the life of a child that it has considerable cost benefits in the longer term.

1. Health Promotion

- Healthy Ireland (Department of Health, 2013);
- A Healthy Weight for Ireland: Obesity Policy and Action Plan (Department of Health, 2016b);
- Breastfeeding in a Healthy Ireland: Health Services Breastfeeding Action Plan 2016–2021 (HSE, 2016a);
- Better Outcomes Brighter Futures (Department of Children and Youth Affairs, 2014);
- First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families (Department of Children and Youth Affairs, 2018)

a. Maternal mental health
b. Emotional wellbeing of children and young people e.g. infant mental health
c. Physical health of babies, young children and families
d. Immunisation
e. Nutrition and weaning
f. Breastfeeding
g. Child safety

2. Health – Child development

- National Healthy Childhood Programme (HSE, 2017b);
- Nurture Programme (HSE, 2017c);
- National Maternity Strategy (HSE, 2016b);
- Better Outcomes Brighter Futures (Department of Children and Youth Affairs, 2014);
- First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families (Department of Children and Youth Affairs, 2018)

a. General child development including language and sensory, regulatory and supporting emotional behavioural development
b. Gently support the Parent(s) to identify developmental delays and seek early intervention
c. Promotion of information and how to access state developed information and information 'routes'

3. Addressing Child Poverty

- Better Outcomes Brighter Futures (Department of Children and Youth Affairs, 2014);
- EU Commission Recommendations: Investing in Children – Breaking the cycle of disadvantage (EU Commission, 2013);
- EU Council Country Specific Recommendation on Child Poverty 2016 (EU Commission, 2016)
- First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families (Department of Children and Youth Affairs, 2018)

a. Provide integrated progressive supports to families depending on needs
b. Provide a single point 'gateway' access to a range of supports through its interagency links
c. Intervene at the earliest age
d. Bridge the gap in cognitive, socio-emotional development
e. Support maternal return to education and employment

4. Child welfare and family support

- Prevention, Partnership and Family Support (PPFS) Programme, Tusla including: Commissioning; Child and Family Support Networks; Meitheal; Parenting
- Children First Act 2015 (Department of Children and Youth Affairs, 2015); Better Outcomes Brighter Futures (Department of Children and Youth Affairs, 2014)
- First 5: A Whole of Government Strategy for Babies, Young Children and their Families (Department of Children and Youth Affairs, 2018)

a. Early parenting supports
b. Contribution to the exploration of an 'approach' to home visiting.
c. Early identification of family needs and ability to initiate preventative supports through interagency working
d. Strengths based non-threatening working can support package of supports at level 3 as demonstrated by the work of some CMP sites

5. Cost effective prevention and early intervention programme

- Better Outcomes Brighter Futures (Department of Children and Youth Affairs, 2014);
- A Programme for Partnership in Government (Department of Taoiseach, 2016)

a. Low cost pre-existing services with established infrastructure and interagency relationships
b. Capacity to engage antenatally with established models for how this could work in 4 CMP sites
c. High rate of social and financial return on investment

6. Summary and recommendations

6.1. Summary

The CMP was one of the first parent support programmes in Ireland to recognise the need for a strong evidence base using RCTs to demonstrate the effectiveness of a prevention and early intervention programme.

The work of philanthropic organisations such as the Bernard Van Leer Foundation was fundamental to the establishment of the CMP in Ireland. The Programme has also benefited from subsequent support from the Community Foundation for Ireland, the Tony Ryan Fund for Tipperary and the Katharine Howard Foundation.

From its origins in 1983, it was an innovative model of preventative early intervention with a focus on the holistic health and wellbeing of both mother and baby through a community approach. In Ireland it pioneered the importance of supporting parents, specifically mothers, in their children's development.

The original CMP model was designed to deliver a cost effective and thus financially sustainable programme. This review has highlighted that the Programme receives limited funding for considerable returns. This has been achieved on low pay rates and significant reliance on voluntary input. Addressing these funding issues would result in a sustainable and cost-effective service model with high value returns in terms of the impact on the lives of children and their families both in the immediate and in the long term.

Both the original and subsequent evaluations highlight that the CMP makes a significant and sustainable difference to the lives of children and their families.

This has been strongly emphasised by the 18 interviews with service users carried out during this review. There is convincing evidence, from this review and other reports, that the CMP is highly regarded by parents, many of whom powerfully describe the significant difference it has made to their own and their children's lives.

There has been considerable policy, practice and societal change since the CMP origins 34 years ago and many CMP sites have adapted their service to respond to these changes.

All the CMP sites are acutely aware of future sustainability issues. Most pressing are the range of issues relating to financial sustainability. It is very clear that the CMP sites view all their current funding as being 'at risk'. The low level of funding received coupled with the ongoing funding uncertainty from one year to the next was reported as a challenge by all CMP sites.

The CMP offers funders and policy makers many opportunities. The launch of First 5: a Whole-of-Government Strategy for Babies, Young Children and their Families (Department of Children and Youth Affairs, 2018) offers the CMP an opportunity to contribute to the development of a national approach to home visiting:

> *'..building on the current PHN home visitation programme, an approach to home visiting services, across a continuum of need, will be agreed, having regard to Irish evidence on the implementation of prevention and early intervention initiatives'* (Department of Children and Youth Affairs, 2018)

However, the challenges outlined in this review are becoming more evident as CMP sites prepare for the Tusla commissioning process. To address these challenges and secure an effective and sustainable nationally-recognised programme the recommendations in the following section are proposed.

6.2. Recommendations

***'It should be available everywhere in Ireland'* Parent**

The CMP is a programme which is worthy of enhanced and secure investment from a number of key funding stakeholders.

Short term recommendations

1. To bring together the current core funders of the Programme, the HSE and Tusla, through a national working group, to **agree a shared strategic engagement and approach** to sustain and develop the CMP nationally

2. To support the above recommendation, the national working group should include representatives from current core funders along with additional key national stakeholders and should explore:

2.1. a process for joint strategic development, oversight and funding at a national level

2.2. the primary aims of a national model in line with national priorities and its fit in the continuum of service provision

2.3. a framework and process for the development of a national model,

2.4. engagement of current funders to clarify a national funding structure and the identification of potential additional funding sources

3. To sustain the existing service provision, pending the processes outlined above, there is a need to address a number of **site-specific priority issues** in the immediate future including:

3.1. securing sufficient levels of funding for current service provision including the provision of sufficient staff/volunteer levels to ensure service delivery capacity

3.2. support for the development of sustainable governance structures

Medium term recommendations

4. Following the development of an agreed future strategy for the Programme arising from the short-term recommendations, the national working group should be expanded into a **national oversight committee** with engagement from all key stakeholders including representation from the 9 CMP sites to address the following:

4.1. The development of a **national standardised model**
This model should have standardised core elements drawn on best practice from the existing CMP sites, incorporating the learning from the ABC Programme and other relevant initiatives to address national outcomes. However, it should also allow for a sufficient level of flexibility to respond to local needs and contexts. A possible version of such a model is outlined in section 6.5 and expanded upon in the full report.

4.2. The establishment of a **national profile for the CMP**
This is to ensure greater levels of integration into the delivery of relevant front line statutory and community services and ensuing joint working, to include the following services:

- Maternity services
- Primary care services especially the Public Health Nursing and GP services
- Tusla including Child and Family Support Networks and Meitheal
- Family Resource Centres and the ABC Programme
- Children and Young Peoples Services Committees

4.3. The **promotion of the CMP** to potential funders and policy stakeholders highlighting the opportunities inherent in the Programme to address key national outcomes. The CMP could contribute to the delivery of many indicators within the following national strategies:

Department of Health and HSE

- National Maternity Strategy/ Women and Infants' Health Programme
- Sláintecare
- National Healthy Childhood Programme/ Nurture Programme
- Healthy Ireland
- Community Nursing and Midwifery Model
- Health Service Breastfeeding Plan
- HSE Healthy Weight for Children Framework

Tusla

- 50 Key Messages in Supporting Parents
- Parenting Support Strategy
- Prevention, Partnership and Family Support (PPFS)
- Meitheal: A National Practice Model
- Child and Family Support Networks
- Family Resource Centre Programme

DCYA

- High-Level Policy Statement on Supporting Parents and Families
- Better Outcomes Brighter Futures
- Quality and Capacity Building Initiative
- Area Based Childhood Programme
- First 5 – A Whole-of-Government Strategy for Babies, Young Children and their Families
- DCYA Parenting Support Policy Unit

Long term recommendation

5. Following the development and implementation of an agreed national standardised model and allowing for a period of establishment, the CMP should secure funding to **commission a national evaluation**, to contribute to the current body of evidence supporting the Programme's effectiveness.

6.3. Conclusion

'***We will tackle child poverty by increasing community based early intervention programmes'*** (Department of Taoiseach, 2016)

The CMP in Ireland represents a unique 'home-grown' community-based early intervention and prevention programme but in recent years it has been under significant pressure.

The Programme represents an extremely cost-effective intervention which is presently vulnerable due to uncertain and limited funding and lack of a national strategy in relation to the Programme. Addressing this would place the Programme on a secure and sustainable footing to deliver high quality services at a low cost in comparison to many existing health and family support services.

CMP sites have sought to be responsive to the local needs of their areas and the priorities of their funders. They have seen a change in the profile of families availing of the services with more families presenting with higher levels of need. Interagency working at a local level has increased substantially in line with national policy changes, reflecting best practice in family support.

There are many challenges facing the remaining 9 CMP sites including the Tusla commissioning process.

These challenges are too great for any one CMP site to face in isolation and this review highlights the essential need for CMP sites nationally to explore how a sustainable future can be secured through greater levels of collaboration both between the sites themselves and in partnership with the two key funders, the HSE and Tusla.

This review documents the core similarities of approach, ethos and aims of the Programme, while acknowledging logistical, organisational and governance differences. It also identifies many areas for the development and strengthening of the Programme nationally and locally. With the support of funders, and potentially philanthropic bodies, these developmental needs can be addressed effectively through national and local collaboration.

The CMP is a valued community-based prevention and early intervention programme with significant potential to address many policy recommendations and the development of a national standardised model could significantly inform 'a national approach to home visiting' as outlined in First 5 (Department of Children and Youth Affairs, 2018). This review recommends supporting CMP sites and encourages key national funding and policy stakeholders to work together towards a sustainable and secure future for the CMP in Ireland as part of a continuum of community services for parents and young children.

'It's amazing the impact one person can have on your life, at that very stressful and vulnerable time, the role of one person can make a considerable impact on you and then your family' **Parent**

Bibliography

Barker, W. (1984). *The Child Development Programme: a collaborative programme linking parents, community and health visitors.* . Bristol: University of Bristol.

Barnardos . (2014). *Limerick Quaility Assurance Framework.* 2014: Limerick City Children's Services Committee.

Bennet, J. (2012). *ECEC for children from disadvantaged backgrounds: Findings from a European literature review and two case studies.* Brussels: European Commission.

Blueprints for Healthy Youth Development. (2017, October 20). *Programs*. Retrieved from Blueprintsprograms: http://www.blueprintsprograms.com/programs

Brady. (1993). *Improving Health Status in Ireland: Some Lessons for Managers.* Dublin: Health Services Development Unit, Insititute of Public Administration.

California Evidence Based Clearing House for Child Welfare. (2017, November 1). *Ratings/ Scientific rating scale*. Retrieved from CEBC: http://www.cebc4cw.org/ratings/scientific-rating-scale/

California Evidence Based Clearing House for Child Welfare. (2018, January 20). *Home*. Retrieved from CEBC: http://www.cebc4cw.org/

Central Statistics Office. (2017, February 8). *Releases and publications*. Retrieved from CSO: http://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8itd/

Central Statistics Office. (2019, March 21). *Releases and Publications: Profile 8 Irish Travellers, Ethnicity and Religion.* Retrieved from CSO: https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8itd/

Central Statistics Office. (2019a, March 21). *Releases and Publications.* Retrieved from CSO: https://www.cso.ie/en/releasesandpublications/ep/p-cp7md/p7md/p7dgs/

Central Statistics Office. (2019b, March 21). *Releases and publications:Profile 4 Households and Families.* Retrieved from CSO: https://www.cso.ie/en/releasesandpublications/ep/p-cp4hf/cp4hf/fmls/

Centre for Effective Services. (2012). *An Introductory Guide to Implementation.* Dublin: CES.

Centre for Effective Services. (2012). *Prevention and Early Intervention in Young People's Services - Parenting.* Dublin: CES.

Centre for Effective Services. (2013). *Special Interest Group Position Paper : Supporting Parents in their Parenting Role.* Dublin: CES.

Centre for Effective Services. (2016). *On the Right Track: Learning from the Investment in Early Intervention and Prevention in Ireland. Parenting.* Dublin: CES.

Children's Workforce Development Council . (2009). *Early identification, assessment of needs and intervention: the common assessment framework for children and young people: a guide for practitioners.* Leeds: Children's Workforce Development Council.

Children's Workforce Development Council. (2010). *The common core of skills and knowledge - at the heart of what you do* . Leeds: Department for Children, Schools, Families and the Children's Workforce Development Council.

Clonmel Community Parent Support. (2017). *Community Mothers Parents Supporting Parents.* Clonmel: Clonmel Community Parent Suppport CLG.

Community Parent Support Programme. (2017). *Information leaflet.* Kerry: HSE.

Curran, M. (2017). *Preparing for the future: Clonmel Community Mothers Programme - A strategic review 2016/17.* Clonmel: Clonmel Community Mothers.

Deave, T. (2003). *Mothers' views on the First Parent Health Visitor.* London: King's College .

Department of Children and Youth Affairs. (2014). *Better Outcomes Brighter Futures: National policy framework for children and young people 2014-2020.* Dublin: DCYA.

Department of Children and Youth Affairs. (2015). *Children First Act 2015.* Dublin: Department of Children and Youth Affairs.

Department of Children and Youth Affairs. (2015). *High-Level Policy Statement on Supporting Parents and Families.* Dublin: Government Publications.

Department of Children and Youth Affairs. (2018). *First 5 - A Whole of Government Strategy for Babies, Young Children and their Families 2019-2028.* Dublin: Government of Ireland.

Department of Health. (2013). *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025.* Dublin: Department of Health.

Department of Health. (2016a). *Creating a Better Future Together: National Maternity Strategy 2016-2026.* Dublin: Department of Health.

Department of Health. (2016b). *A Healthy Weight for Ireland:Obesity Policy and Action Plan 2016-2025.* Dublin: Department of Health.

Department of Health. (2018). *Implentation Guide and Toolkit for National Clinical Guidelines.* Dublin: Department of Health.

Department of Health and Children. (2000). *National Children's Strategy : Our children their lives.* Dublin: Department of Health and Children.

Department of Taoiseach. (2016). *Programme for a Partnership Government.* Dublin: Department of Taoiseach.

Dowie, J., Clark, K., & Clementson, K. (2005). Volunteerism: Community Mothers in action. *Contemporary Nurse*, 188-198.

Doyle, O., & PFL Evaluation Team, UCD Geary Institue for Public Policy. (2016). *'Preparing for Life' Early Childhood Intervention Programme Final Report - Did 'Preparing for Life' improve Children's School Readiness?* Dublin: UCD.

Early Intervention Foundation. (2018, February 20). *Guidebook*. Retrieved from Early Intervention Foundation: http://guidebook.eif.org.uk/

Early Learning Initiative. (2016). *ELI Annual Report 2015-2016.* Dublin: National College of Ireland.

Early Learning Initiative. (2017, October 12). *0-2 Programme*. Retrieved from National College of Ireland: https://www.ncirl.ie/ELI/0-2-Programme

Emond, A., Pollock, J., Bonnell, S., Peters, T., & Harvey, I. (2002`). An evaluation of the First Parent Health Visitor Scheme. *Archives of disease in children - British Medical Journal*, 150-157.

EPIC. (2017, Novemeber 1). *European Platform for Investing in Children*. Retrieved from European Commission: http://ec.europa.eu/social/main.jsp?catId=1246&langId=en

EU Commission. (2013). *Commission recommendation. Investing in children: Breaking the cycle of disadvantage.* Brussels: EU.

EU Commission. (2016). *COUNCIL RECOMMENDATION on the 2016 national reform programme of Ireland and delivering a Council opinion on the 2016 stability programme of Ireland.* Brussels: EU Commission.

Felitti, V., Anda, R., Novdenburg, D., Williamson, D., Spitz, A., Edwards, V., . . . Marks, J. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *Journal of Preventative Medicine*, 245-256.

Fitzpatrick, P., Molloy, B., & Johnson, Z. (1997). Community mothers programme: extension to the Traveller community in Ireland. *Journal of Epidemiology and Community Health*, 229:303.

Fixsen, D., Blase, K., Naoom, S., & Duda, M. (2015). *Implementation Drivers: Assessing Best Practice.* Chapel Hill: National Implementation Research Network: University of Carolina.

Focus Ireland. (2019, March 21). *Latest figures on homelessness in Ireland.* Retrieved from Focus Ireland: https://www.focusireland.ie/resource-hub/latest-figures-homelessness-ireland/

French, G. (2006). *Learning from families: Policies and practices to combat social exclusion amongst families with young children in Europe.* Dublin: Home-Start National Office.

Haase, T., & Pratschke, J. (2012). *The 2011 Pobal HP Deprivation Indicators for Small Areas: Introduction and Reference Tables.* Dublin: Pobal and TH.

Hanran, N., & O Siochru, S. (2015). *The Tony Ryan Fund for Tipperary 2013-2015 Final Evaluation Report.* Dublin: Community Foundation for Ireland.

Hardiker, P., Exton, K., & Barker, M. (1991). *Policies and Practices in Preventative Childcare.* Ashgate: Avebury.

Hayes, J., Mc Guire, C., Carolan, M., Dorney, R., Fitzgerald, H., Scahill, B., & Kelly, S. (2015). *Infant Mental Health Network Groups: Evaluation of an interdisciplinary model for integrating infant mental health principles into everyday clinical practice and services in the community.* Cork: HSE.

Healthy Families America. (2017, November 1). *The Healthy Families America Strategy*. Retrieved from Healthy Families America: http://www.healthyfamiliesamerica.org/the-hfa-strategy-1/

Hermanns, J., Asscher, J., Zijlstra, B., Hoffenaar, P., & Dekovic, M. (2013). Long-term changes in parenting and child behaviour after the Home Start family support program. *Children and Youth Services Review*, 678-684.

Home Start Blanchardstown. (2017). *Information for Referrers.* Dublin: Home Start Blanchardstown.

Horgan, D., & Duggan, H. (2002). *An Evaluation of Clonmel Community Parent Support Programme.* Cork: South Eastern Health Board and University College Cork.

HSE & Healthy Ireland. (2015a). *Caring for your Baby 0-6mths.* Dublin: HSE.

HSE & Healthy Ireland. (2015b). *Caring for your Child 6mths- 2 years.* Dublin: HSE.

HSE. (2016a). *Breastfeeding in a Healthy Ireland: Health Service Breastfeeding Action Plan 2016-2021.* Dublin: HSE; Healthy Ireland; Breastfeeding.ie.

HSE. (2016b). *Creating a Better Future Together: National Maternity Strategy 2016-2026.* Dublin: HSE.

HSE. (2017a, December 12). *Baby and child health*. Retrieved from HSE: https://www.hse.ie/eng/health/child/nurture/

HSE. (2017a, November 3). *Child Health*. Retrieved from HSE: http://www.hse.ie/eng/services/list/2/PrimaryCare/pcteams/dublinsouthpcts/dunlaoghaireglasthulepct/childhealth.html

HSE. (2017b, November 3). *Health and Wellbeing*. Retrieved from HSE: http://www.hse.ie/eng/about/Who/healthwellbeing/Our-Priority-Programmes/Child-Health-and-Wellbeing/NationalHealthyChildhoodProgramme/

HSE. (2017c, November 3). *The Nurture Programme*. Retrieved from HSE: http://www.hse.ie/eng/about/Who/healthwellbeing/Our-Priority-Programmes/Child-Health-and-Wellbeing/NurtureProgramme/

INMO. (2015, October Vol 8). News: Community and public health nursing. *World of Irish Nursing and Midwifery*, pp. 14-15.

Institute of Public Health and the Centre for Effective Services. (2016). *Improving Health and Well Being Outcomes in the Early Years.* Dublin: Institute of Public Health and Centre for Effective Services .

Irish Times. (2014, November 1). A community mothers' scheme that helps struggling families is under threat. *Irish Times*. Dublin, Ireland: Irish Times.

Jennings, P. (2016). The National Healthy Childhood Programme. (pp. 1-19). Dublin: HSE.

Johnson, Howell, Molloy. (1993). Community Mothers Programme: randomised controlled trial of non professional intervention in parenting. *British Medical Journal*, 1449-1452.

Johnson, Molloy, Fitzpatrick, Scallan, Rooney, Keegan and Byrne. (2000). Community Mothers Programme: Seven year follow up of a randomised controlled trial of non professional intervention in parenting. *Journal of public health medicine*, 337-342.

Johnson, Z., & Molloy, B. (1995). The Community Mothers Programme: Empowerment of Parents by Parents. *Children and Society*, 73-85.

Katharine Howard Foundation/Community Foundation for Ireland. (2017). Community Mothers Programme - Draft discussion paper - March 2017. *Tender documents*. Dublin: Katharine Howard Foundation.

Kendrick, D., Elkan, R., Hewitt, M., Dewey, M., Blair, M., Robinson, J., . . . Brummell, K. (2000). Does home visiting improve parenting and the quality of the home environment? A systematic review and meta analysis. *Archives of Disease in Childhood*, 443-451.

Kortmacher, J., Kitzman, H., & Olds, D. (1998). Intervention processes as predictors of outcomes in a preventive home visiting program. *Journal of community psychology*, 49-64.

Lewin, S., Babigumira, S., Bosch-Capblanch, X., Aja, G., van Wyk, B., Glenton, C., . . . Daniels, K. (2006). *Lay health workers in primary and community health.* London: London School of Hygiene and Tropical Medicine.

Limerick Social Service Council . (2016). *50 Years : Supporting & Strengthening Reslience in Individuals, Families & Communities. Annual Report.* Limerick: Limerick Social Services Council Ltd.

Limerick Social Service Council Ltd. (2017). *The Community Mothers Programme.* Limerick: Limerick Social Services Ltd.

Longford / Westmeath Communitiy Mothers. (2017b). *Training Programme.* Mullingar: Westmeath Community Development Co.

Longford / Westmeath Community Mothers Programme. (2017a). *Community Mothers Volunteer Policy.* Mullingar: Westmeath Community Development Company.

Luker, K., Mc Hugh, G., & Bryar, R. (2016). *Health Visiting : Preparation for Practice.* New Jersey: Wiley-Blackwell.

Mc Auley, C., Knapp, M., Beecham, J., Mc Curry, N., & Sleed , M. (2004). *Young families under stress: Outcomes and costs of Home Start Support.* York: Joesph Rowntree Foundation.

Mc Donald, A., Duignan, C., Healy, M., Irving, A., Martiedisson, P., Molloy, B., . . . Frazer, K. (2013). *Public Health Nursing in Ireland: Demonstrating interventions from practice - Population Health Group.* Dublin: Institute of Community Health Nursing.

Mc Keown, K. (2000). *A guide to what works in family support services for vulnerable families.* Dublin: HSE.

Miller, S., Dunne, L., & McClenaghan, P. (2015). *Supporting Parents: Findings from the Lifestart Parenting Programme Evaluation - briefing paper.* Belfast: Queens University Belfast.

Molloy, B., & Harper, G. (2013). *Community Mothers Annual Report.* Dublin: HSE.

Molloy, B., Harper, G., & HSE. (2012). *Community Mothers Annual Report* . Dublin: HSE.

Moran, P., van der Merwe, A., & Ghate, D. (2004). *What works in parenting support? A review of the international evidence.* London: Department for Education and Skills.

Morton, S. (2015). *Community Mothers Programme: Evaluation of Tony Ryan funded services in Cahir, Cashel and Thurles.* Dublin: The Community Foundation for Ireland.

Mulvey, K. (2017). *Dublin North East Inner City: Creating a Brighter Future - An outline plan for the social and economic regeneration of Dublin's North East Inner City.* Dublin: Department of An Taoiseach.

Murphy, A., Murphy, T., & Smith, G. (2011). *Quality Services, Better Outcomes.* Dublin: The Childhood Development Initiative.

National Academy for Parenting Practitioners. (2008). *Parenting Programme Evaluation Tool (PPET).* lONDON: NAPP.

National Implementation Research Network. (2015). *Implementation Drivers : Assessing Best Practice.* Chapel Hill: University of North Carolina.

National Implementation Research Network. (2018). *The Hexagon : An Exploration Tool.* Chapel Hill: NIRN - University of North Carolina.

North Tipperary Community Services. (2017a). *Code of Conduct.* Nenagh: North Tipperary Community Services.

North Tipperary Community Services CLG. (2017b). *Community Mothers Programme - leaflet.* Nenagh: North Tipperary Community Service CLG.

North Tipperary Community Services CLG. (2017c). *Training Manual.* Nenagh: North Tipperary Community Services CLG.

Nurse-Family Partnership. (2014). *Overview of Nurse-Family Partnership Program.* Denver: Nurse-Family Partnership.

O Dwyer, M. (2010). *Evaluation of: The Community Mothers Programme.* Limerick: Limerick Social Services Council Ltd.

O Sullivan, M. (2008). *Evaluation of the Community Mothers Programme.* Limerick: Limerick Social Services Council Ltd.

O'Conner, P. (1999). *Parents Supporting Parents: An Evaluation Report on the National Parent Suport Programme Mid-West.* Limerick: Mid-Western Healthboard and University of Limerick.

Olds, D., Sadler, L., & Kitzman, H. (2007). Programs for parents of infants and toddlers rcent evidence from ranomized trials. *Journal of Child Psychology and Psychiatry*, 355-391.

Parents 1st UK. (2017, November 1). *What we do*. Retrieved from Parents 1st UK: http://www.parents1st.org.uk/what-we-do.html

Parents First Ltd Laois/ Offaly. (2015). *Annual Report.* Tullamore: Parents First Laois /Offaly.

Paulsell, D., & Pickens Jewell, C. (2012). *The Atlantic Philanthropies'Children and Youth Programme in Ireland and Northern Ireland : 2011 Programme Findings.* Dublin: Atlantic Philanthropies.

Peacock, S., Konrad, S., Watson, E., Nickel, D., & Muhajarine, N. (2013). Effectiveness of home visting programs on child outcomes: a systmatic review. *BMC Public Health*, 13-17.

PFL Evaluation team, UCD Geary Insititute for Public Policy. (2016). *Evaluation of the 'Preparing for Life' Early Childhood Intervention Programme.* Dublin: UCD Geary Institute for Public Policy and Preparing for Life.

Pobal. (2017, September 12). *Pobal*. Retrieved from Pobal: https://www.pobal.ie/AboutUs/Pages/Home.aspx

Pobal. (2017, October 12). *Pobal Maps*. Retrieved from Pobal: https://maps.pobal.ie/WebApps/DeprivationIndices/index.html

Pobal. (2018, January 29). *Funding Programmes - Area Based Childhood Programme*. Retrieved from Pobal: https://www.pobal.ie/FundingProgrammes/Area%20Based%20Childhood%20(ABC)%20Programme/Pages/default.aspx

Polek, E., & Wach, D. (2013). Child neglect neglected: should we make better use of teacher's reporting of neglect. *Growing up in Ireland Annual Conference* (p. 17). Dublin: Growing up in Ireland.

Preparing for Life. (2017, January 23). *About us*. Retrieved from Preparing for Life: http://www.preparingforlife.ie/about-us/#1513374959088-eec757b3-3685

Schrader-McMillan, A., Barnes, J., & Barlow, J. (2012). *Primary study evidence on effectiveness of interventions (home, early educaiton, child care) in promoting social and emotional wellbeing of vulnerable children under 6.* London: NICE.

Schweinhart, L., Montie, J., Xiang, Z., Barrnet, W., Belfield, C., & Nores, M. (2005). *The Highscope/PerryPreschool Study aged 40. Summary, conclusions and frequently asked questions.* Ypsilanti: Highscope Press.

Share, M., Mc Carthy, S., & Greene, S. (2011). *Baseline Evaluation of the Early Learning Initiative Final Report.* Dublin: Early Learning Initiative and Childrens Research Centre Trinity College Dublin.

Suppiah, C. (2008). *A collective evaluation of community parent programmes - what works well and in what circumstances?* Bassildon: Parents 1st.

Suppiah, C. (2008). *What Works Well and in What Circumstances?: A Collective Evaluation of Community Parents Programmes.* London: The Health Foundation; NHS South West Essex; Parents 1st .

The Corporate Governance Association of Ireland et al. (2012). *The Governance Code for Community and Voluntary Organisations of Ireland.* Dublin: The Governance Code.

Turnell, A. (2012). *Signs of Safety - Briefing Paper.* Pert: Perth Resolutions Consultancy.

Tusla. (2013a). *Child and Family Commissioning Guidance.* Dublin: Tusla.

Tusla. (2013b). *Guidance for the implementation of an area based approach to prevention, partnershp and family support.* Dublin: Tusla.

Tusla. (2013d). *Meitheal: A national practice model.* Dublin: Tusla.

Tusla. (2013e). *What works in family support?* Dublin: Tusla.

Tusla. (2017, November 1). *What are Child and Family Support Networks (CFSNs)?* Retrieved from Tusla: http://www.tusla.ie/services/family-community-support/prevention-partnership-and-family-support-programme/meitheal-national-practice-model/what-are-child-and-family-support-networks-cfsns

Van Dyke, M. (2013). The Science and Practice of Integrating Science into Practice : the Active Implementation Frameworks. *Global Implementation Conference* (p. 4). Washington: National Implementation Research Network.

Van Dyke, M., Fixsen, D. L., Blase, K. A., Duda, M. A., Metz, A. J., & Naoom, S. F. (2012). How Applied Implementation Science can inform area based strategies to tackle child poverty. *Area Based Strategy.* Dublin: Young Ballymun.

World Health Organisation. (1978). Declaration of Alma Ata. *International Conference on Primary Health Care* (pp. 1-3). Alma - Ata: World Health Organisation.

World Health Organisation. (1999). *Health 21: The Health for All Policy Framework for the WHO European Region.* Copenhagen: WHO.

Wrafter, D. (2013). *Masters Dissertation: An Evaluation of Parents First Family Support Services: Stakeholders' Perspectives of the Impact of Parents First Services for Parents with Young Children.* Galway: NUI Galway.

Young, E., & Kenkre, J. (2016). *New Volunteerism in Scotland with Home Start: Co producing positive impacts for families, volunteers and local communities.* Glasgow: Home Start.

Appendix 1

Initial pre-site survey

Phase1: Community Mothers Review

Background data on local Community Mothers/Home Visiting Programme

Thank you for agreeing to participate in this review.

As discussed over the phone we aim to gather a broad range of data from each site. To ensure we have some consistency in the data we would ask as a first step if you could complete the following questions.

If you have this data recorded in a different format then of course please forward this on, however please check that all of the following questions are answered.

The following questions can be answered online or by printing off the attached hard copy, completed by hand and returned in the stamped addressed envelop.

As per the phone call please forward on any additional data you may have about any of the following:

- history/origins of the programme in your area
- annual reports or evaluations that have been carried out
- presentations about the programme
- materials that form a core part of the work of the programme

I look forward to meeting with you as arranged and learning more about the work of the Community Mothers in your local area.

1. What year did the Community Mothers first start operating in your area?

Date DD / MM / YYYY

2. Under what name does the programme operate in your area:

3. At the end of 2016 how many Family Development Nurses or Coordinators supported the work of the Community Mothers?

0 3 6

4. Has the number of Coordinators/Family Development Nurses changed in the first 6 months of 2017 ?

- ◯ Yes - if yes please note how many worked in the programme as of the 30th June 2017
- ◯ No
- ◯ Number of Coordinators/Family Development Nurses in June 2017:

5. The number of Community Mothers delivering the programme in 2016?

Total number of Community Mothers in 2016	
Number of those who became a Community Mother in 2016	
Number of those who left the programme in 2016	

6. The number of Community Mothers delivering the programme in the first 6 months of 2017:

Total number of Community Mothers in first 6 months of 2017	
Number of these who became a Community Mother in first 6 months 2017	
Number of these who left the programme in the first 6 months of 2017	

7. Which of the following were the most common reasons for an individual to cease being a Community Mother?

	Least common	Somewhat common	Most common reason	N/A
Got a job	◯	◯	◯	◯
Personal - health or family reasons	◯	◯	◯	◯
Adult education / training	◯	◯	◯	◯
Retirement	◯	◯	◯	◯
Other reasons - please list below	◯	◯	◯	◯

Other (please specify)

8. How are Community Mothers recruited into the programme?

- ◯ By word of mouth
- ◯ The mother was previously in receipt of the community mothers programme herself
- ◯ Public Health Nursing colleagues identify local mums through their case load
- ◯ Through local advertising
- ◯ Other (please specify)

9. Is there an interview process to become a Community Mother?

- ◯ Yes
- ◯ No

10. Can you outline the duration of training a Community Mother receives prior to commencing in the role?

11. How is training delivered?

- ◯ 1:1
- ◯ Group
- ◯ Other (please specify)

12. How do Community Mothers receive support and supervision from the Family Development Nurse/Coordinator ? Please tick all relevant

- ◯ 1:1 basis
- ◯ Group basis supported by FDN/Coordinator
- ◯ Meeting with peers
- ◯ Other (please specify)

13. How frequent is support and supervision from the co-ordinator - include both 1:1 and group support?

- ◯ Once a month
- ◯ Twice a month
- ◯ Other

14. How many families were in receipt of home visits during 2016?

Total number of families	
Number of these who are new to the programme in 2016	
Number of these who left/finished the programme in 2016	

15. How many families were in receipt of home visits during the first months of 2017?

Total number of families for first 6 months of 2017	
Number of these who are new to the programme in 2017	
Number of these who left/finished the programme in 2017	

16. On average how many families does one Community Mother support through home visits i.e. how many families would be on a single case load at any point in time?

0 20 40

17. On average, how frequently are home visits to families?

- ◯ Twice a week
- ◯ Once a week
- ◯ Twice a month
- ◯ Other (please specify)
- ◯ Once a month
- ◯ Once every two months
- ◯ Once every three months

18. How long is each home visit - i.e. the standard length of time?

- ◯ 0 - 1/2 hr
- ◯ 1/2 -1 hr
- ◯ 1 - 1 1/2 hrs
- ◯ 1 1/2 hr - 2 hrs
- ◯ 2 hrs +
- ◯ Other (please specify)

19. On average how long are families engaged in the programme?

- ◯ 0 - 6 mths
- ◯ 6 mths - 1 yr
- ◯ 1 yr - 1 yr 6 mths
- ◯ 1 yr 6mths - 2 yrs
- ◯ 2 yrs - 2 yrs 6 mths
- ◯ 2 yrs 6 mths - 3 yrs
- ◯ 3 yrs +
- ◯ Other (please specify)

20. When can families first become involved in the Community Mothers programme - please tick all relevant ages of child?

- ◯ During pregnancy
- ◯ 0 - 1 week old
- ◯ 1 week - 3 mths old
- ◯ 3 mths - 6 mths old
- ◯ 6 mths - 1 yr old
- ◯ 1 yr - 2 yrs
- ◯ 2 yrs +
- ◯ Other (please specify)

21. On the 30th June 2017, how many families were in receipt of the Community Mothers programme for the following children?

First child	
Second child	
Third or subsequent child	

22. On the 30th June 2017, how many families were in receipt of the Community Mothers programme for the first time or were repeating the programme?

Number who were first time families in receipt of the programme	
Number who were second time families in receipt of the programme	
Number who were third time families (or more) in receipt of the programme	

23. How many referrals did the programme receive for families to participate in the programme ?

Total number of referrals received in 2016	
Total number of referrals received for first 6 months 2017	

24. How many referrals came from the following sources in 2016?

Public Health Nurses	
Maternity hospital	
Community Midwife	
GP	
Tusla Social Workers - Child Protection	
Other Tusla referrals	
Primary Care or Disability Social Workers	
Other health care professionals (Physiotherapist; Occupational Therapist; Speech and Language Therapists etc)	
Self referral	
Community group	
Other: Please list source of referral and number of referrals	

25. Of the referrals received in 2016..

How many were not allocated a place due to high demand for service?	
How many did not engage with the programme despite being allocated a place?	
How many did not complete the full programme/left early?	
How many were referred to access services/supports in addition to the Community Mothers programme?	

26. Can you outline the profile of families availing of the community mothers programme for the 12 months of 2016?

Number of lone parent families	
Number of Traveller families	
Number of families where English is second language	
Number of teen parent families	
Number of first time parents	
Number of families experiencing homelessness	
Number of families with maternal mental health issues	
Number of families with complex issues in their lives (note this can be explored more on site visit)	
Other family profiles not listed above:	

27. Of the families availing of the programme in 2016, how many had the following qualification background:

Number of parents with less than leaving certificate qualification

Number of parents with leaving certificate qualification

Number of parents with post leaving certificate qualification (excluding degree or higher)

Number of parents with degree level qualification

Number of parents with masters or higher qualification

28. Of the families availing of the programme in 2016, how many families have the following employment background (note if a parent is on maternity leave then they should be classed as in employment):

Number of families where no one in the household is in employment (include lone parents)

Number of families where one parent is in employment and one is not

Number of families where both parents work

Number of lone parent families where parent is in employment

* 29. In 2016, how many families presented with any of the following additional needs:

Families where infant has a diagnosed disability

Families where infant may have developmental/health related issues - preterm/low birth weight/other specific health issue

Families who were receiving supports from Tusla arising from a Child Protection concern

Families who were specifically referred (for reasons not listed above) as opposed to being offered the programme universally

* 30. Amongst all families on programme in 2016, how many had the following breast feeding experience ?

How many did not breast feed?

How many initiated breast feeding?

How many fed up to 1 month?

Breast fed up to 3 months?

Breast fed for 6 months?

Breast fed for 9 months?

Breast fed for up to 1 year?

Breast fed for longer than 1 year?

* 31. In addition to home visiting, which of the following activities does the Mothers programme support?

- ◯ Antenatal supports - preparation for labour / bringing baby home
- ◯ Antenatal supports - preparation for breastfeeding
- ◯ Breast feeding advice/support 1:1
- ◯ Breast feeding support group
- ◯ Parent and baby group
- ◯ Infant massage
- ◯ Parent and toddler group
- ◯ Parenting programme
- ◯ Other supports - please outline below

Other (please specify)

* 32. Can you tick who is the programme's **primary funder**? Please only tick one.

- ◯ HSE
- ◯ Tusla
- ◯ ABC programme - DCYA
- ◯ Other (please specify)

* 33. If you receive additional funding from other sources please **tick all** relevant sources below.

- [ ] No other funding sources
- [ ] HSE
- [ ] Tusla
- [ ] ABC programme locally
- [ ] Local charity - please name below
- [ ] Other sources - please list below

Please specific other sources of funding:

34. Can you please provide contact details for the following - apologies if you have forwarded these on already

Manager of the organisation responsible for the Community Mothers/Parents programme (name, address, email and telephone number):

Primary HSE contact for the programme (name, address, email and telephone number):

Parenting, Partnership and Family Support Tusla Coordinator (name, address, email and telephone number):

Primary link with the Child Protection Social Work Team (name, address, email and telephone number):

Coordinator of local Children and Young Person's Services Committee (name, address, email and telephone number):

Appendix 2

Framework document for coordinator interview and overarching headings: available on request due to length of document.

Appendix 3

Host organisation – points for discussion

Thank you for agreeing to participate in the review of the Community Mothers Programme.

In advance of our interview I have prepared a list of areas and points for discussion. It may be helpful to consider these in advance of our meeting.

If you have any queries, then please don't hesitate to contact me on: 0879979308

1. Background to the Programme within the organisation:
    - how the Programme fits with core ethos of organisation
    - levels of support for the Programme within the organisation
    - strengths/ developmental needs of the Programme
    - embeddedness in local infrastructures

2. Governance and funding:
    - governance/ reporting mechanism
    - funding for the host organisation
    - funder of the Programme/ level of funding/ security of funding

3. Sustainability and future developments of the Programme:
    - current or future challenges to or opportunities for the Programme
    - sustainability of the Programme – financial, governance

4. Other considerations or views on the Programme not already addressed

Appendix 4

Community Mothers focus group information and questions:

Thank you for agreeing to participate in the review of the Community Mothers/ Volunteer home visiting Programme[35].

A national review of the Community Mothers/ Parents home visiting Programme is being undertaken by the Katharine Howard Foundation, in partnership with the Community Foundation for Ireland and with the collaboration of Tusla and the Health Service Executive.

The purpose of the review is to establish the current status of the Community Mothers Programme and similar home visiting programmes in Ireland with a view to the development of a strategic plan for the future of the programme.

The review involves the gathering of feedback from each of the sites across Ireland in order to learn about the experiences of families within the Community Mothers/ Parents home visiting Programme.

- All information you provide will be anonymised so that it will not be possible to identify you or any other member of staff.
- All information you provide will be kept confidential. **However, should you mention something that leads me to believe that you and/or someone else may be at risk of serious physical and/or emotional harm, I will have to pass this information on to the local Community Mothers/ Parents Programme Coordinator and follow my Safeguarding Statement.**
- The focus group information will be included in a 'Review Report' which will be circulated within the HSE, Tusla, and other relevant agencies.

If you have any queries after meeting and sharing your feedback then you can contact any of the following:

Susan Brocklesby: Independent Consultant– 087 9979308

Francis Chance: Katharine Howard Foundation – 01 6618966

[35] Programmes do operate under different titles and at this early stage of the review process it was important to ensure that all projects could identify with the language in the information provided – hence the term 'Volunteer Home Visiting Programme' was used along with Community Mothers Programme.

Focus group questions:

1. What is the aim of the programme?
2. Describe the role of the Volunteer home visitor/ Community Mother?
3. Confidentially can you describe the types of families you visit and the areas of need which are important for them?
4. How do you link families in with other supports?
5. Range of activities you are involved in in supporting families:
    - 1:1 supports/activities with the family
    - group based activities/supports
    - 3 activities you feel are most successful in supporting families
6. When you finish working with a family, name 3 changes/outcomes you would like to see for a family, that Volunteer home visitors/ Community Mothers were responsible for?
7. What if any, changes would you make to the programme?

Focus group survey

Phase 3: Focus Group Community Mothers

1. For how long have you been a Community Mother / Parent?

2. What is your date of birth?

Date / Time DD / MM / YYYY

3. Can you describe what was happening for you prior to becoming a Community Mother / Parent e.g. were you at home with your own family, at work, in training etc?

4. Can you tell us about your past education and/or training? Please tick each qualification you have.

- ◯ Leaving Certificate
- ◯ Fetac level 5 - post leaving
- ◯ Fetac level 6 - diploma
- ◯ Fetac level 7-8 - degree
- ◯ Fetac level 9 - masters
- ◯ Professional qualification - described below

Other (please specify)

5. Why did you become a Community Mother / Parent?

1

6. List things you like/ dislike about being a Community Mother / Parent

I like..	
I like..	
I like..	
I dislike..	
I dislike..	
I dislike..	

7. List areas of your work you feel you would like to learn more about or develop your skills further.

I would like more training or information about..	
I would like more training or information about..	
I would like more training or information about..	

8. Is there any other feedback you would like to give me about your role as a Community Mother / Parent?

Appendix 5

Questions for parents, information and consent form

Dear Parent,

A national review of the Community Mothers/ Parents Programme is being undertaken by the Katharine Howard Foundation, in partnership with the Community Foundation for Ireland and with the collaboration of Tusla and the Health Service Executive.

The purpose of the review is to establish the current status of the Community Mothers Programme in Ireland with a view to the development of a strategic plan for the future of the programme.

The review involves the gathering of case studies from each of the sites across Ireland in order to learn about families' experiences of the Community Mothers/ Parents Programme.

- To document a case study, I would like to meet with you for 30-40 minutes and ask you questions about your experiences of the programme.
- With your permission, I may record the meeting or alternatively I can write down your feedback.
- All information you provide will be anonymised so that it will not be possible to identify you or any member of your family from the case study.
- All information you provide will be kept confidential. **However, should you mention something that leads me to believe that you and/or someone else may be at risk of serious physical and/or emotional harm, I will have to pass this information on to the local Community Mothers/ Parents Programme Coordinator and follow my Safeguarding Statement.**

Please turn over leaf for consent form:

The case studies will be included in a 'Review Report' which will be circulated within the HSE, Tusla, and other relevant agencies.

If having read the information on the previous page you are happy to meet with me to share your experiences, I would ask that you sign the consent form below.

If you have any queries after meeting and sharing your feedback, then you can contact any of the following:

Susan Brocklesby: Independent Consultant– 087 9979308

Francis Chance: Katharine Howard Foundation – 01 6618966

Please tear and leave a copy of the above information with the Parent/Guardian

Consent form: Regarding the Community Mothers/ Parents Programme Review,

I _____ give/ do not give my informed consent to be interviewed for the purposes explained to me.

I _____ give/ do not give my informed consent to having the interview be recorded for the purposes explained to me.

_____ _____

Signature Date

Appendix 6

Stakeholder interview HSE/Tusla/CYPSC/ABC – points for discussion

Thank you for agreeing to participate in the review of the Community Mothers Programme.

In advance of our interview I have prepared a list of areas and points for discussion. It may be helpful to consider these in advance of our meeting.

If you have any queries, then please don't hesitate to contact me on: 0879979308

1. Understanding of the Programme and its remit
    - primary focus and target population
    - level of support offered by the Programme (Hardiker)
    - individual service or part of integrated package of services
    - strengths/developmental needs of the Programme
    - embeddedness in local infrastructures

2. Interagency linkages and local infra-structures
    - Maternity
    - Primary care PHN/ other services
    - Prevention, Partnership and Family Support (PPFS) Tusla
    - Children's and Young People's Services Committee
    - ABC Programmes
    - mapping services and levels of need
    - duplication/complimenting services as packages of care

3. Governance and funding:
    - governance structure
    - funding of the Programme/ level of funding/ security of funding

4. Sustainability and future developments of the Programme:
    - current or future challenges to the Programme
    - sustainability of the Programme – financial, governance
    - commissioning

5. Regional or National considerations within HSE/Tusla/CYPSC
    - local, regional and national strategic planning
    - national policy perspective on the Programme

6. Other considerations or views on the Programme not already addressed

Appendix 7

Interviews with two parents

Interview 1:

Mum in her 30s parenting alone, with partner living in another city. 2 older children, 13 and 17 years. Mum presently on a methadone programme. Baby only 4 months at time of interview.

First contact or knowledge of the Programme: Mum was introduced to the CMP at the local maternity hospital antenatal classes.

'I was doing the antenatal classes, I'd never done them on my older 2 kids, and there is a huge gap of 13 years, so I wanted to do them this time. The CMs did a presentation and I really wanted to breastfeed, so I was delighted, and I asked them loads of questions and I decided there and then that it was something I wanted to avail of'.

First engagement with the Programme: Mum described calling into the office before she had her baby to sign up for the Programme and get information about mother and baby group and breastfeeding support group.

'I just popped in off the street, I mean at the time, I was completely deluded, I didn't realise my baby was going to be sick or anything. I really wanted to breastfeed, and I had no idea that wouldn't be possible. I was really trying to do the right thing'.

'You know there is such a difference between them and other health services. I mean at the time when I first popped in, I wasn't even going to tell the hospital I was on methadone or anything. But they supported me to do that'.

Mum outlined that her baby was born prematurely and that both herself and her baby were in hospital for a month, and her baby remained in hospital for a subsequent month and a half once Mum was discharged.

'That's when I really got the benefit from the Programme. My CM used to call to me in the hospital twice a week for a month. I wouldn't have great family support and I was really on my own and so without exaggerating, I know when my baby was born, I wouldn't have gotten through it without the support of the CMP'.

'I never felt judged, I mean it wasn't like counselling or anything – you know it was just knowing that someone cared. I could tell her stuff that I couldn't tell my family, I mean they didn't know I was on the methadone programme and I had social work involvement and I was so nervous about that'.

'It was just so invaluable in the hospital as I was up there every day myself and they'd pop up and have a coffee. It was so isolating being there and then I was embarrassed about my situation and the baby being sick so there wasn't very many people I felt I could talk to'.

'When the nurses would come in and see my CM with me they seemed to think a little bit more of me or something as they knew I was involved with services. I didn't feel as much like, I didn't have a voice, so it was great'.

How often did they visit? Twice a week both antenatally and postnatally. '*But you can contact them at any time, like this morning I was upset about something and I was able to call my CM about it. Cause family just can't, family are too close'*.

How long were visits? Home/hospital visits varied but they were no less than 1 hour.

What happens during a visit? *'We'd have a cup of tea, she'd teach me how to do baby massage, she'd check on how the baby was getting on, she'd let me chat about anything I'd like to chat about, it was all very informal. She might bring me some literature. It's like a friend dropping in so I don't feel like she is an authority figure.'*

What other activities are you involved in? *'I go to the mother-baby group, and baby massage group. And she's going to be doing baby yoga, but that hasn't started yet. I've done a parenting course also. While they don't run it, they've also given me the confidence to start a fitness class, which I did last night'*.

'I was thinking it was something I'd like to do, you know, go and train so I could become a CM. As my CM says with my life experience it would be invaluable to people especially people who had found themselves in similar situations to myself'.

What would you change about the Programme? '*No, like I know they have too many families sometimes they could probably have more visitors, I know if I had my way, I would see them every day. I couldn't fault them in any way'*.

What do you like about the Programme? '*The non-judgemental side, the way they helped me bond with the baby, the way I can turn to them for advice. Even when I had questions about my medication, they helped me find the answers. I would have always suffered from post-natal depression on each child, so it has been great. And it's just taken an awful lot of the isolation away even the mother and baby group. I've met people through the group.'*

'I can't see myself letting go of them any time soon, my baby is still very young only 4 months, if it were to come to an end now, I'd be devastated, it would be a major void in my life'.

Interview 2:

Single mum in her 30s from Eastern Europe having her first child. Mum had no family in Ireland and did not have the support of a partner.

First contact or knowledge of the Programme: Mum was introduced to the CMP from the Maternity Hospital.

'I didn't know [about the programme] before [I was] in hospital and they asked if I wanted the service. I said yes as I knew I was a single parent and I would need all the support I could get, and I am so glad and grateful that I said yes'.

First engagement with the Programme: '*She came to visit me 1 week after I got out of hospital. She was so down to earth, she really met me where I am, we found straight away very good communication and she was really so professional'.*

How often did they visit? Initially it was every week and then it moved to every 2 weeks right up until the first 3 months and then at least once a month for 1 year and then Mum availed of groups only.

How long were visits? Usually 1 hour depending on the situation.

What happens during a visit? *'She would always ask, how is the baby and then she'd be really helpful with information like nappy changing and giving the baby a bath. As a first-time parent it can be nerve-wracking, especially when you don't have any family and you are with your baby 24/7 and you can't switch off'.*

'She was so helpful, she helped me with forms and what I needed to do, introduce me to playgroups, baby massage. She gives me all the information – support with breastfeeding, I only just finished breastfeeding for nearly 3 years'.

'She would bring information, sit for a chat, ask me 'how are you?' and she knew what is really bothering me, if I was stuck she would provide me with information as to where I can go and get support. She gave really useful information about how to care for my baby especially food etc.'

'I was determined to breastfeed and of course at the start I had problems, he was 3 weeks premature and he couldn't latch so she got in contact with a specialist who came to see me in the house'.

What other activities are you involved in? After the visits ceased Mum reported still attending play group and the following other groups, as well as receiving support when needed:

'She still provided me with information and support, even though she isn't visiting anymore'

'I went to the weaning class even though he was already 1 year old, but it was still so beneficial. I am quite healthy, but it was really helpful to get other ideas. I also did the Incredible Years 6-week course'.

What would you change about the Programme? *'No, no change, but maybe even if [they had] more time with parents it would be great at the beginning and maybe once every two weeks for 6 months that would be great, as a parent, sometimes you*

just think [I'm not sure] what can I do? She is really helping me and breaking the everyday pattern and I was really looking forward to her coming to visit'.

'It should be everywhere in Ireland, when you don't have support it can be really hard, it's hard for the parents and then it goes to the child. How parents are feeling affects the child the calmer I am the calmer he is, the more stressed I am the more stressed he is'.

What do you like about the Programme? *'Biggest help was being more confident in myself and getting in contact with other parents and playgroups in the community, this has really helped. Not sitting at home [but] getting out and getting contact with other parents and to be more sociable. As I know if you stay at home it can get so 'drowning', as you can get depressed when you sit at home, all that kind of thing. It helped me as well. I haven't really said it to anyone, but I was actually a little depressed at the time, but my CM really helped me, I didn't develop into post-natal depression, but I was pretty close to it. I am just so grateful for the CM'.*

'I met so many people through the playgroup, like today I am minding my friend's son and I met her through the playgroup. I am still in contact with them and friends with them.'

'She helped me get more confident in myself and trusting more about myself, so she really helped me as a single parent, so much information and you start doubting yourself. But as you know mother's instinct is always right, but I just needed the reassurance. My CM was brilliant'.

Appendix 8

Questions asked in questionnaire	A lot	Some	None	I didn't need this	Not answered
Degree to which parenting support needs were met:					
An understanding of parent/child relationships	67%	24%	0%	9%	0%
Encouragement and reassurance in relation to parenting and parenting skills	74%	16%	0%	10%	0%
Support to develop my confidence in my parenting	67%	19%	2%	10%	2%
Support in developing my relationship with my child/children	66%	22%	0%	10%	2%
Service user perceived outcome: impact on parenting					
I feel more confident parenting my child/children	71%	22%	0%	7%	0%
My understanding of parent/child relationship has improved my family life	72%	21%	0%	7%	0%
Degree to which play and community support needs were met:					
Having a safe, friendly environment for my children to play and meet other children	93%	3%	0%	3%	0%
Receiving and giving support to other parents	72%	21%	0%	2%	5%
Supporting me to engage with other agencies within my community	47%	28%	5%	21%	0%

Table 20: Community Mothers Programme: Evaluation of Tony Ryan funded services in Cahir, Cashel and Thurles (Morton, 2015)

Questions asked in questionnaire	A lot	Some	None	I didn't need this	Not answered
Degree to which breastfeeding support needs were met:					
Encouragement and support feeding choices for my baby	57%	17%	0%	24%	2%
Understanding benefits and techniques of breastfeeding	33%	5%	0%	55%	7%
Service user perceived outcome: breastfeeding outcomes					
I am/was better able to make confident decisions about breastfeeding	29%	9%	2%	59%	2%
I am/was better able to sustain breastfeeding (if desired)	28%	7%	2%	59%	5%
Service user perceived outcome: advocacy and community impact					
I am better able to advocate for myself and my family/children	52%	26%	2%	21%	0%
I feel more connected to other families in my community	66%	28%	0%	5%	2%

Table 21 : Community Mothers Programme: Evaluation of Tony Ryan funded services in Cahir, Cashel and Thurles (Morton, 2015)

Appendix 9: Contact details for CMP sites

AREA	PROGRAMME NAME	ADDRESS	TEL / EMAIL
DUBLIN DOCKLANDS	0-2 Programme	Early Learning Initiative, National College of Ireland, Mayor Street, IFSC, Dublin 1	01 – 4498717 Marion.Byrne@ncirl.ie
DUBLIN FINGLAS	Community Mothers Programme	Wellmount Health Centre, Wellmount Park, Finglas South, Dublin 11	086 - 0261034 mary.callaghan1 @hse.ie
DUBLIN LOUGHLINSTOWN	Community Mothers Programme	Loughlinstown Dr., Ballybrack, Loughlinstown, Co Dublin	01 - 2822122 Triona.lucey@hse.ie
KERRY	Community Parent Support Programme	Cork-Kerry Community Services, Rathass, Tralee, Co. Kerry	066 - 719 9702 agnes.luceykeane@ hse.ie
LAOIS / OFFALY	Parents First	St Mary's Youth and Community Centre, Harbour St., Tullamore, Co Offaly	057 - 9322996 coordinator @parentsfirst.ie
LONGFORD / WESTMEATH	Longford / Westmeath Community Mothers	Westmeath Community Development Ltd., Enterprise Technology and Innovation Centre, Clonmore Business Park, Mullingar, Co. Westmeath	044 - 9348571 ccorcoran@westcd.ie
LIMERICK	Community Mothers Programme	Limerick Social Services Centre, Upper Henry Street, Limerick	061 – 314 111 liz.dunworth@lssc.ie
NORTH TIPPERARY	Community Mothers Programme	Silver Arch Family Resource Centre, 52 Silver St., Nenagh, Co. Tipperary.	067 - 31800 brigid.murphy@ silverarchfrc.ie
SOUTH TIPPERARY	Clonmel Community Mothers Programme	Room 3, Clonmel Community Resource Centre, Kickham St., Clonmel, Co. Tipperary.	052 - 6128199 ccpspl@gmail.com

Katharine Howard Foundation, 7 Red Cow Lane, Smithfield, Dublin D07 XN29
01 6618963 | info@khf.ie | www.khf.ie