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There were many people involved in the development of the Strategy Report and in the organisation of the Conference *Investing in Parenthood - to achieve best health for children*. It was a team effort in every sense, involving the Supporting Parents Sub-Committee and all the staff of Best Health for Children, in partnership with the Department of Social, Community and Family Affairs and the National Children’s Office. Particular thanks are extended to;

**Department of Social, Community and Family Affairs**  
- Ms Catherine Hazlett  
- Mr John McDermott  
- Mr Heber McMahon  
- Mr Brendan Walker  

**National Children’s Office**  
- Mr John Collins  
- Ms Theresa McGovern  

**Conference administration Best Health for Children**  
- Ms Deirdre Rooney  
- Ms Kerry McCaughey  
- Ms Michelle Wallace  

**External Conference Organiser**  
- Ms Anne Jones
On Wednesday 27th February a conference was held at Dublin Castle to launch a major new initiative entitled *Investing in Parenthood*, to achieve best health for children. It was organised by Best Health for Children in association with The Department of Social, Community and Family Affairs and The National Children’s Office.

**The Conference objectives were to:**

- Launch the *Investing in Parenthood* strategy
- To provide information on the strategy for senior policy makers and managers from statutory and non-statutory organisations, with responsibility for and interest in supporting parents
- To learn from international experience
- To explore some implementation issues

Mr Dermot Ahern T.D., Minister for Social, Community and Family Affairs gave the opening address and Ms Mary Hanafin T.D., Minister for Children, gave an address to the conference that afternoon.

The International speakers were Dr Sarah Stewart-Brown, Director, Health Services Research Unit, University of Oxford, who presented ‘the rationale for supporting parents’ and Ms Gillian Calvert, Commissioner for Children, New South Wales, Australia, who described the journey of parent support policy ‘Families First’ in her own state.

The strategy, which is the third in a series of policy documents from the Best Health for Children initiative, celebrates the role of parents as the most important people in their children’s lives and health. It recognises their need for support in fulfilling this task and describes a framework for the delivery of support to all parents.

This is the first time that parents have been considered comprehensively at a national strategic level.

This conference report follows the order of the conference timetable in bringing together the information that was presented on the day of the conference.

It is intended as a record for those who were able to attend, and a further source of information for those who are interested in supporting parents.
conference programme

09.15 ARRIVALS AND REGISTRATION

09.45 CONFERENCE OPENING
Chairperson - Mr. Michael Kelly, Secretary General, Department of Health & Children

OPENING ADDRESS
Mr. Dermot Ahern, T.D., Minister for Social, Community & Family Affairs

10.05 BACKGROUND
Dr. Sean Denyer, Director, Best Health for Children
Dr. Julie Heslin, Chair, National Supporting Parents Committee

10.15 REPORT OVERVIEW
Ms. Celia Keenaghan, Senior Research Officer, Best Health for Children

10.45 BREAK

11.15 KEYNOTE ADDRESSES
Chairperson - Ms. Catherine Hazlett, Principal Officer, Family Affairs Unit, Department of Social, Community & Family Affairs

SUPPORTING PARENTS - THE RATIONALE
Dr. Sarah Stewart Brown, Director, Health Services Research Unit, University of Oxford, London

12.00 SUPPORTING PARENTS - POLICY & IMPLEMENTATION
Ms. Gillian Calvert, Commissioner for Children, New South Wales, Australia

13.45 QUESTIONS
Panel: Dr. S. Stewart Brown, Ms. G. Calvert, Dr. S. Denyer, Ms. C. Keenaghan, Dr. Julie Heslin

13.00 LUNCH

14.15 MINISTERIAL ADDRESS
Chairperson Fionnuala Kilfeather, Chief Executive, National Parents Council
Address by Ms. Mary Hanafin, T.D., Minister for Children

14.30 PARALLEL SESSIONS
Focusing on Implementation issues

15.45 DRAMA PRESENTATION by members of Dublin Youth Theatre
Produced by Ms. Ciannait Clancy and Directed by Mr. John Delaney

16.15 PLENARY SESSION
Chairperson - Mr. John Collins, Director, National Children’s Office

FEEDBACK ON PARALLEL SESSIONS
Ms. Mary Roche, Supporting Parents Project Officer, Best Health for Children

16.40 CLOSING ADDRESS
Ms. Caroline Cullen, National Child Health Co-ordinator, Best Health for Children

16.45 CLOSE OF CONFERENCE

CONFERENCE OBJECTIVES
would like to extend a welcome to our overseas visitors and say how delighted I am to be here. Rearing children is one of the most vital jobs, for most of us, as primary educators and protectors of our children. This Government recognises that families can and should be very much supported. This document points to the connection between poverty, social inclusion and health. Just this morning, I, together with an Taoiseach launched our new anti-poverty strategy, called ‘Building an Inclusive Society’. This is a strategy, in which the Government sets out the objective of eliminating poverty, but particularly child poverty, in Ireland. Current figures indicate that this government has been successful in combating poverty in Ireland.

However we do realise that more needs to be done. Recognising the crosscutting nature of poverty and exclusion, Government has set targets in the area of child health and education. The objective is to reduce the inequalities that exist in the health of the population by focusing on these inequalities and making health central to public policy. By acting on the social factors influencing health, by improving access to health and personal services, particularly for people who are poor or socially excluded, and by improving the information and research base in relation to health status and service access for these groups. This is a National Strategy and we need the involvement of all key actors, Government, social partners, communities and more importantly families, if we are to achieve the objectives of the National Anti-Poverty Strategy.

This document Investing in Parenthood examines the current status of children in Ireland, looks at the key indicators of children’s health across a wide range of issues and places the Irish experience in an international context. That is why we are particularly delighted to have some foreign guest speakers.

Lifestyle and the wider society effects children’s health and well-being. They have also been examined in this document. The report makes a number of recommendations and suggests a way forward to implement these in relation to service and structural development for supporting parents.

The Government is committed to improving child and family supports and I will be discussing these issues with my colleague Mary Hanafin, the Minister for Children, who will, I understand be addressing the conference later on.

The report stresses the need for improved information and research on children and their lives. The national longitudinal study of children in Ireland, highlighted in the National Children’s Strategy, will significantly improve the knowledge base. This is a longitudinal study, which the Government will be bringing forward in the not too distant future. Such a study will be a major undertaking, but the information it will yield will be invaluable in terms of what it will tell us about how children from different backgrounds fare out in the longer term and how the state can better support families.
As I said earlier I will be bringing forward proposals along with my colleagues in Health, in relation to this longitudinal study, to Government in a matter of weeks.

One of the key issues identified in *Investing in Parenthood* is the need for a family friendly society. This is very timely, given the fact that next Friday is National Family Friendly Workplace Day. Research shows that employment demands are traditionally at their highest when childcare duties are also at their most demanding. Families today face huge pressures to combine work and family life and juggle competing work demands with their desire to be more available to their children in their formative years. Indeed it was for this very reason that I included a specific remit in the legislation to establish the Family Support Agency, to provide information to assist families in balancing their work and family life. Many of the issues raised in this report have been singled out for attention as part of the Government’s Families First approach, which is designed to make families central to policy-making and the development of services.

The Families First approach to policy encompasses a wide range of programmes introduced in line with Government commitments, to protect the family, support the stability of family life, prevent marital breakdown and address the effects of divorce in families. I will be shortly bringing forward the establishment of the Family Support Agency. We passed the Family Support Agency bill just before Christmas, so we will be establishing this new agency very shortly, which will bring together the main programmes and pro-family services introduced by the Government in recent years into one agency. It will provide a comprehensive and coherent response for families in need of support services and for families generally. There is a need to bring a much greater focus on the role of parents, the needs of children, children’s rights to stability and security, a loving relationship with their parents and wider family members. That is why support for parents is also very important, why it is crucial that they have access to support and help when they need it. *Investing in Parenthood* lays the basis for the work undertaken in this area.

I just want to finally thank and congratulate all of those people who were associated with the compilation of this excellent report. As I said my Department and the Department of Health and Children, look forward to working with people like yourselves and people in the voluntary and community sector, in fulfilling the aspirations and the targets that are set out in this particular document.

Could I wish the conference well? I know you have a very varied programme looking down the agenda for today; I won’t delay you any further just to wish the conference well and to apologise for my rushing off. The Dáil is about to start in 5 minutes time and I am due on my feet, probably in about 20 minutes time, in the chamber so I apologise for rushing off. I thank you for the invitation to participate at the start and I formally open the conference.

Thank you very much indeed.
Best Health for Children

The Best Health for Children initiative was established in 1999 following a review of child health screening and surveillance, commissioned by the CEOs of the Health Boards. Its aims were to:

1. develop and contribute to the development of policy and strategy on behalf of Health Boards in relation to child and adolescent health
2. disseminate research and good practice in relation to children and adolescents
3. develop partnerships with the DOHC and other government agencies and NGOs
4. facilitate joint working by Health Boards
5. monitor the implementation of agreed policies in relation to child health
6. carry out projects and reviews in relation to child and adolescent health as determined by the CEOs

The project is now part of the Health Board Executive (HeBE), an agency recently established to facilitate con-joint working between Boards.

Context

Best Health for Children is working within the framework provided by the National Children’s Strategy which has the following three major goals:

- Children will have a voice
- Children’s Lives will be better understood
- Children will receive quality supports and services

The project has also been endorsed by the new National Health Strategy published in 2001.

"Best Health for Children represents a co-ordinated approach to protect and promote children’s health in partnership with parents and health professionals and this approach is fully endorsed in the health strategy"
the work of the best health for children project

The Best Health for Children project has a small team, which consists of:

- Director
- Two Associate Directors (National Co-ordinators)
- Principle Research and Development Officer
- Assistant Research Officer
- Project Officers
- Admin. Support

The team is advised by a National Conjoint Child Health Committee and project staff are based in Dublin, Limerick and Sligo.

However most of the work relies on the activities and inputs of a much wider group of people from Health Boards and other statutory and voluntary agencies that contribute to a range of committees and task groups. Literally hundreds of people have become involved in the various aspects of the work.

Investing in Parenthood marks the third in a trilogy of reports produced from the project. The first was Best Health for Children: Developing a Partnership with Families, which looked at the 0-12 age group. The second was Get Connected: Developing an Adolescent Friendly Health Service, which looked at the 12-18 age group.

Recognising the central importance of parents in the lives of all children and young people led to the development of the report presented at this conference.
The Supporting Parents Sub-Committee of the National Conjoint Child Health Committee was set up in March 2000 to expand on the parents support issues identified in the Best Health for Children report and to make recommendations about service developments, based on best practice and the evidence of effectiveness.

The committee included representatives of, and/or consulted with, the health sector and other government departments, the voluntary and community sector and parents and their representative organisations. Two literature reviews were commissioned to identify the national and international evidence of best practice and evidence of effectiveness, and recent service developments in New South Wales in Australia were studied.

The evidence, based on listening to parents and on reading the latest research, showed that integrated services are more acceptable and are more effective. However, in order to impact on the health of the population, more services, with long term resourcing, need to be developed, particularly focusing on the early years of childhood.

Currently parents’ support needs are met by their families and friends, by their communities and their local voluntary groups and organisations, by services provided by different government agencies, including the Health Boards, and by society at large, including the media. Services provided by the Health Boards are only part of the whole range of services used and needed by parents.

This third report from Best Health for Children argues that investing in parenthood is worthwhile from the point of view of sound economics and of social justice. It calls for increased funding and increased integration of services which support parents in their parenting responsibilities.

The report makes recommendations, which can be actioned by the health sector on its own. It also invites other agencies and groups, both voluntary and statutory, to work together to achieve a common aim -

THE BEST HEALTH OF ALL OUR CHILDREN
investing in parenthood - report overview

Ms Celia Keenaghan, Senior Research Officer, Best Health for Children

This presentation aims:

> To introduce the strategy
> To outline its vision and principles
> To summarise the issues
> To introduce the recommendations and proposals for action

This is the third strategy document produced by Best Health for Children at the behest of the CEOs of the Health Boards, the first focusing on children aged 0 - 12, and the second on adolescents aged 12 - 18. The purpose of this strategy is to identify a strategic approach to supporting parents in order to achieve best health for children. It also proposes to support, reinforce, and act as a vehicle for the implementation of relevant aspects of existing national strategies that pertain to supporting parents. The strategy is based on the deliberations of the Supporting Parents’ Sub-Committee of the National Conjoint Child Health Committee, two academic reviews commissioned for the project, consultations with agencies and individuals nationally and internationally and consultations with parents themselves.

The principles of investing in parenthood are:

- Make the rights and well being of children a priority
- View parents as key to the child’s health and well being
- View parents as experts
- Support parents as individuals
- Facilitate access to supports
- Build on what is there
- Develop a partnership approach
- Work on an interagency and interdepartmental basis
- Plan in a locally responsive way

The first chapter of Investing in Parenthood outlines the current status of children in the country examining issues of mortality, breastfeeding, immunisation, mental health, injuries, lifestyle and the more macro issues of poverty, educational disadvantage, housing and play and leisure. The policy context of children’s health is explored. The second chapter introduces the development of the strategy from its commissioning by the CEOs to consultations with parents.
Chapter three is an important chapter in the document in that it presents the evidence base for supporting parents, drawing on a literature review and the two academic reviews commissioned from Queens University Belfast and University College Dublin on this topic. Some key points include the evidence for early intervention, for supporting parents as individuals in their own right and as key to their children’s health, the importance of prevention and thereby the need for universal as well as targeted supports.

Key areas for intervention in children’s health identified are, smoking prevention or cessation, antenatal education, parenting programmes, immunisation, breastfeeding, health promoting schools, home visiting, and community capacity building.

The fourth chapter reviews key areas of current parent support activities in Ireland. This review highlights a wide range of activity and good practice that is not always comprehensive in coverage and that lacks monitoring and quality assurance.

Chapter Five outlines the recommendations of the strategy.

Overall the following is called for:

- Universal and targeted support for parents
- Multi-agency and cross-departmental working
- People centred and community development approaches
- Promotion of children’s rights

Specific service developments are detailed under the following headings:

1. There should be lifelong learning and preparation for parenthood
2. Parents should have access to appropriate and accessible information
3. Parents should have access to locally available and affordable childcare and pre-school education services
4. All parents and children should have access to quality care and support services
5. Parents and children should have representation and opportunities for involvement in service planning, development, delivery and evaluation
6. Parents and children should have access to a society and environment that is family friendly
In relation to structural developments, recommendations are made at both National and County/City level. It is suggested that the Minister for Children should refer the document to the Cabinet Sub-Committee on Children and a multi-agency Taskforce be set up which would report within a 12 month period.

Specific recommendations are made in relation to the development of structures and the timeframes for implementation of this strategy. It is suggested that the Taskforce should assign responsibility for tasks and functions identified and decide how best they fit in with other national and county level developments.

**Meanwhile priorities for health boards should be:**

- Integrated planning of child and family support services
- Development of regional capacity for parent training and education
- Extension of supporting parents home visiting services
- Identification of local parent information and support centres in conjunction with other agencies

Each Health Board has been furnished with 150 copies of *Investing in Parenthood* report. Single copies of the strategy may be ordered for a limited time only, from:

**Best Health for Children**
57 O’Connell Street
Limerick
Tel 061 310437
Fax 061 310612
Email besthealthlimerick@eircom.net

The strategy document *Investing in Parenthood* and other reports are also available on the web -

[www.besthealthforchildren.com](http://www.besthealthforchildren.com)
Thank you to the organisers of today for inviting me to come and speak. It is very nice to be able to come to Ireland from time to time to see what progress you are making with Best Health For Children and it has been a privilege to be involved with that process on and off, to a small extent right from the start.

What I will talk about in the next session is:

- The evidence that parenting has an impact on child health
- The relationship between parenting and socio-economic circumstances
- And how best to support parents and parenting

Some of you will be familiar with some of what I am going to say, it isn’t radically different from what I have said before, but I am also going to be touching on some of the new research that we are bringing out from the Health Services Research Unit. I just want to put a bit of a government health warning on that. Some of it is not yet in the public domain. You have results on slides in your pack there, and if you do want to quote or use any of this material, I would be extremely grateful, if you could get in touch with us first to establish the status of the work.

The Impact of Parenting on Child Health

You might be forgiven for thinking that the first was an extremely banal place to start - children who are not parented or do not have substitute parents do not survive, let alone grow up to be healthy, so parenting is self-evidently important for child health, and there are all sorts of aspects of parenting like breastfeeding, like having your child immunised, like injury prevention that I am not going to be dealing with today.

I am using the term to cover subtle aspects of the relationship between parent and child. I am also talking about health in its broadest sense to cover emotional and social well-being as well as physical health.

When we come to talk about the relationship between parenting and inequalities those of you who have been following the debates in the literature will know that this is a very hot topic and that there are those who feel passionately on both sides of the equation when it comes to considering issues related to causality. We will deal with that a bit and then we will look at how to support parents.
First just a thought or two about how you measure these rather subtle aspects of parenting that I am talking about today. What are these studies that give us this evidence base - what are they based on?

There are three types of measures. Some people have observed parents either in a laboratory or at home, and they’ll give them some type of interaction task to do with the child and there will be a psychologist sitting there, noticing each time there is a criticism or there’s an encouragement, or there is hostility, warmth or all these aspects. Then there are parent’s reports of parenting behaviours and their attitudes beliefs and of their relationship with their child.

Now observations of parenting behaviour have to be a tiny moment in the lives of that parent and child and whilst they are regarded as much more robust from a research point of view because they are objective, they can only capture a little bit of the evidence.

Parents’ reports measures are very valuable and useful. Many of us who have been part of these parenting programmes and have been involved in them ourselves, have discovered - it is possible to be blissfully unaware of unhelpful parenting behaviours in yourself and so those behaviours will not be accurately reported by the self report measures.

Finally then there is asking children themselves what it feels like to be on the receiving end of the parent-child relationship and how they perceive their parents. There again there is the possibility for bias if the child is feeling profoundly depressed, they may well have a more gloomy view of the relationship with their parents than they do when they are feeling chirpier.

None of these measures is perfect in their own right and what is good about this literature I think is that all three different approaches have been used.

Harsh and inconsistent discipline, poor monitoring and supervision, and lack of warmth and affection are important causes of anti-social behaviour, delinquency, criminality and violence.
The largest number of studies, are the sort of studies which are of very considerable interest to our home office and there is a very big body of literature showing that these aspects of parenting, -harsh and inconsistent discipline, poor monitoring and supervision, and lack of warmth and affection are important causes of anti-social behaviour, delinquency, criminality and violence. Now I say ‘cause’ advisedly, because in this particular aspect of parenting all the epidemiological criteria for being fairly sure that something is causal have been worked out. Gerry Patterson and colleagues at the Oregon Social Learning Centre, who have done a lot of the research, have done intervention studies with parents and show that they can have an impact on criminal outcomes. There is also work going on in the UK, particularly I am thinking of Farrington and colleagues, who published on this subject.

Another area are the studies which take their lead from the research of people like Diana Baumrind, who was primarily interested in the kind of outcomes educationalists would be interested in. She did her observations with pre-school children in community samples. Patterson’s work was all done with boys from high-risk backgrounds and that is where that kind of Home Office research is targeted, because they are regarded as the highest risk group. This is both sexes and all social groups.

You will be, I think many of you, well aware of this schema of parenting that has been developed from the work of Diana Baumrind, with:

- Authoritative parenting -nurturing, accepting, responsive, clear but also clear boundaries and good positive discipline as the optimum
- Authoritarian: Restrictive, demanding conformity required, harsh discipline
- Permissive: nurturing, non-restrictive, responsive accepting
- Neglectful: non-nurturing, non-demanding

These studies show a clear link to self-esteem, social competence, and educational achievement.
In the next group of research I have put Alan Sroufe’s work, because that has been important. He has a longitudinal cohort study of twenty mothers, who were from poor backgrounds (so again a focus on poverty, but both sexes), looking at the very early mother child relationship and aspects of attachment between parent and the child and they have been able to demonstrate that these show aspects of social well being, but at the positive end of the spectrum, - not to do with just criminality and delinquency. Social competencies, school achievement, the quality of relationships with peers, and child behaviour can be tracked back to these aspects of the parent child relationship very early on in life and they are also finding much more subtle outcomes as well. Babies or children who have been on the receiving end of persistently unresponsive care, are the sort of people who are likely as adults to shut down emotionally under stress, and in ways that keep other people at a distance. It is much more difficult for them to access social support, when they’re in trouble later on. Also erratic care results in people who are needy anxious and dependant. It is important to think on the way through this, that postnatal depression is an important interrupter of attachment.

Then there is the work of the developmental neuroscientists who are looking at brain development. To me this is really the most exciting discovery of the last decade and one I am only recently catching up with. What is now clear, is that there is a remarkable interplay between nature and nurture in terms of the brain development. Yes genes play a role but there is a hugely important role of nurture. During the course of the first couple of years of life there is a proliferation, an explosion of synapses, connections forming between neurones in the brain. 15,000 per neurone, - astonishing. Twice as many form as are eventually retained. What then happens is that pathways that are not used get eliminated. That is how we develop the final architecture of the brain. The development of the brain is use supporting parents - the rationale cont’d.
dependant, and early experiences have a decisive impact on later brain architecture. Brain activity peaks at three years of age and it is twice as active at that age as it is in adult life. The other thing that is important is that development is non-linear and I think we all know this, particularly people who have been working in child health, like speech therapists. Feral children, who do not have any experience of language early on at their prime time for language development, find it terribly hard to learn to speak later on and children who aren’t spoken to have the same problem. Equally children that are never soothed, who do not get that kind of responsive attention seem to prune the pathways to soothing, so later on in life, they cannot self soothe. These are people who are, what is being called emotionally incontinent, and who will explode and are not able to quiet and calm themselves when faced with some sort of threat.

Warm responsive care, supports brain development and that is not just these emotional and social aspects but also the whole side of learning. Stressful or traumatic experience, undermine development. Cortisol is neurotoxic, so if you have lots of stress and lots of cortisol wandering round your body all the time, then your brain development will be less than optimal.

A number of people have contributed to that kind of work. Megan Gunnar, works with babies and has looked at abused babies and their resolution of raised cortisol levels after a stress, and has shown that it is different in abused and non-abused children. Alan Sroufe, we talked about and Gary Kraemer have shown a lot of this work with monkeys, which (although one might have views about animal experimentation), has resulted them in being able to look at brain architecture and the impact of nurture on brain architecture.

Studies of Parenting and Physical Health

Some work that I have only recently come across, and is part of a systematic review that we are undertaking in the unit, (I am stretching the limit of systematic reviews here) using this methodology to look at longitudinal studies, and I’m looking at longitudinal studies of any aspect of the quality of parent child relationship, or parent parent relationship, and any aspect of mental or physical health in adult life.

Systematic review of studies of parenting and health

- Longitudinal studies
- Exposure: Any aspect of the quality of parent-child relationship, or parent parent relationship
- Outcome: Any aspect of mental or physical health
I’m just going to concentrate on the physical health studies here now. Some of you may be familiar with the literature on adult relationships and health, and that is coming to light in discussions about social capital for example and social support and social trust. It is clear from that body of literature that relationships between adults in adulthood matter for adult health. People who make supportive and enhancing relationships are protected against diseases, and those who have terrible trouble making those relationships have a general susceptibility to getting ill. If parenting is so very important for emotional and social development, we can understand immediately how it might have an impact on adult mental health. Through these mechanisms I have been talking about, it is possible that it has an impact on physical health.

So we have looked (it has been a very difficult search strategy because these studies are not classified in the same way), and we have found 23 studies to date. Those numbers are in your packs. We have got 6 studies of general health symptoms that we will look at in more detail in a second. 3 very long-term studies, 2 of which are in a well to do population, looking at the impact of parenting on diseases like cancer, heart disease muscular skeletal disease, and even duodenal ulcer. 3 of those were positive and none were negative. Haemodynamic stress studies looking at primarily conflict in the family, here in teenagers, and measuring blood pressure at the beginning of the study and at the end and showing that you can predict a rise in blood pressure over the course of 6 months to a year in teenagers from what is going on in the home. Obesity, weight gain and height, the studies are more equivocal, we have got some showing positive, some showing negative and I’m not quite sure what is going on there. 6 studies of parental conflict, conflict in the home, conflict with the child and age of menarche in girls, are fascinating. 5 of them show that menarche is earlier in girls where there is conflict in the home. In one, they have done something rather odd with the stats and I think there is good reason why it is not agreeing. We put those in the review because of the possible implications for teenage pregnancy. I don’t actually think there is much there because we are only actually talking about two or three months earlier menarche. So nothing dramatic from that point of view, but still it does seem to me to be fascinating that you can pick up that physiological impact from these studies. One on asthma, possibly more work to be done there, but an interesting study because it shows that perfect parents, ones that have no conflict at all, actually are more likely to have children with asthma. I thought it was important, just to throw that in. What we are talking about here is not homes with no conflict. Interpersonal relationships with no conflict are unhealthy. It is what you do about the conflict and how you handle it that matters.

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<td>Haemodynamic stress</td>
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<td>Obesity</td>
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<td>Postnatal nutrition</td>
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<td>Height</td>
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Just briefly looking at 6 studies which looked at collected data in childhood and then looked at self-reports of symptoms such as coughs, colds, headaches, tummy aches, feeling sick, sometime later and also, in general how would you describe your health excellent, good, fairly good, poor, and all 6 studies had some positive results. Not all of them positive on every measure. Two of them had observational studies of parenting; two collected measures from parenting and most of them collected measures from the teenagers. The smallest was 56, the biggest was over a 1,000, and they were collecting reports of health from the children and from the parents. All of them showing positive impact and those which were only partly positive it tended to be the girls who were affected and relationships with mothers which were most important.

The Relationship Between Parenting and Socio-Economic Circumstances

Just moving on to our next topic. It seems to me that the studies we have been looking at, make it clear that parenting matters across the social spectrum, and there is definitely something that one can do to influence it with regard to criminality, violence and social competency and self-esteem. The work on physical health is newer and there are no studies which show that you can change physical health by intervening on parenting. They take a much longer time. But the studies, it seems to me, make it clear that parenting matters across the social spectrum. It is very interesting to know and to think why most studies and often the initiatives concentrate on parenting amongst people who are living in social deprivation or who are also coping with poverty. It is just worth asking ourselves whether there is any basis for the prejudice that the work with parents ought to be with that social group. And it is true that there is some.

This is an American study, and they looked at the incidence of physical abuse and neglect in high-income families, low-income families and families on welfare and this was both self-reported abuse and also recorded abuse.
Physical abuse was almost four times more common among families on welfare but there was not excess among low-income families. Neglect was eleven times more common among welfare families and five times more common among low-income families. Importantly sexual abuse was not socially related and I think that is a finding from other studies also. There is some evidence here that you are more likely to find problems in poorer groups.

Then there is a range of studies about hitting children as a method of discipline, which also can be called physical punishment.

There are quite a lot of studies in the UK, Deborah Ghaté and colleague have shown that physical punishment is more common amongst socially deprived groups.

But if you look at the work of Marjorie Smith and Nobes, they are able to show that most of that difference can be accounted for by parental stress and difficulties in the marital relationship and parental mental health and that’s known to be more common if you are living and also trying to cope with social deprivation. There are also a lot of papers asking if it is maternal age, or ethnic group for example or race that is the key issue, or is it your social class. There is a lot of co-variation and the jury is really out on which is more important. I think overall people would agree that it tends to be stress rather than social class that is the key determinant.

Then there’s some other lovely studies by Harte and Risley and the data are published in a book called ‘Meaningful Differences’, that have looked at the positive end of parenting.

Much of our research is based on what goes wrong. Have you read ‘Life and how to survive it’ - John Cleese and Robin Skinner? Their starting point is that if you want to help parents do things well, why don’t we study people who can do it well, but still the focus of the research isn’t on that end.

This graph shows the cumulative incidences of encouragement to the child between birth and 48 months of age, in professional, working class and welfare families and there is a very remarkable difference in the cumulative incidences of encouragement.
and this was a wonderfully detailed study and they also looked at the number of times parents spoke to their children. Even in this, whilst there is a clear difference, between the social groups, there were more differences among individual groups than there was between them. We are then looking at a mean difference not an absolute difference.

If we think about those slides it is reasonable to conclude that social deprivation does increase the risk of some aspects of unhelpful parenting, and you are more likely to find these unhelpful styles from groups who are having a hard time from other points of view.

Some of the health impact of social deprivation I think is likely to be attributable to unhelpful parenting, because we have shown that unhelpful parenting is likely to be more common in those groups, and we have also shown that unhelpful parenting has a long term health impact, particularly on social and mental well-being. I think it is just possible that unhelpful parenting may also be a cause of social deprivation, in the next generation and here is this issue we are coming back to - 'What part does parenting play in social inequalities? There are people who argue and get very cross with me for putting forward this agenda about enabling parents to do things differently, because they say it is all to do with the social circumstances in which parents are required to parent and if you were to completely revamp the social circumstances, everything would change completely. I firmly believe that we should make the social circumstances easier for parents to parent in, but I don't think things would automatically change from an awful lot of the things I am talking about with the parent child relationship, because it happens in very well to do families as well as in poor ones. It is an independent risk factor. The fact that parenting may be the cause of social deprivation in the next generation, is something that isn’t so often talked about.

On this slide we have here social deprivation tending to increase unhelpful parenting and we have got these red arrows, these are things that we have covered - unhelpful parenting leading to things like conduct disorder, and criminality, poor mental health, poor physical health, poor social skills, and poor educational achievement. If we go around this side, poor social skills and poor educational achievement are all reducing employment prospects, and to a lesser extent causing poor mental health and poor physical health. Reducing employment is a potent cause of social deprivation in the next generation.
There is also this little loop round poor educational achievement, which tends to enhance the chances of you getting pregnant as a teenager, that reduces your employment prospects and it also makes it less easy for you to do helpful parenting. There is a loop going on around there. At the individual level one can see how if you intervened in unhelpful parenting, you would give the next generation a greater chance of themselves not landing up in social deprivation. There is another route and this is epitomised by this side of the diagram, conduct disorder and criminality, is a real problem in communities. It has a detrimental effect on social capital, social support, social trust, feeling fearless; going out and about in the community, being able to feel that you can trust other people. And it also has a negative effect on other people’s mental health. All these things, individual poor mental health and conduct disorder reduce social capital. People who have severe mental health problems themselves, people who have mild mental health problems themselves, have much more difficulty having the time and energy to offer other people social support. They can do it sometimes, and it is hugely beneficial to them. On the whole, they are so busy struggling with what is going on in their lives that they don’t have anything to spare, to offer social support to other people. So you are reducing the amount of social capital that is available in communities, having a detrimental effect on community health and leading back into the cycle. Both in terms of the impact on the individual and the impact those individuals can have on other people there are several reasons for believing that if we really want to tackle social inequalities we do need to be including initiatives to work with parents at the same time.

How Best to Support Parents and Parenting

The solutions to child health problems caused by social inequality clearly start with fiscal policies that reduce or abolish childhood poverty.

I am quite happy that that is part of what we need to be doing. We need support for parents both in terms of social policies which make the job of parenting easier (which we’ve heard quite a lot of today and which I think Gillian is going to address), But then particularly, and this is where I am going to come on to concentrate, in terms of interventions, which enable parents to parent in a more helpful way.

One of the things though is that armed with the information I have just shown you about the relationship between parenting and inequalities in health, a lot of people and a lot of colleagues of mine are perfectly clear that the thing to do is to rush out and help parents, who are trying to parent in poverty, and that that’s where we need to target it. The whole of our Surestart initiative in the UK is predicated around that principle, basically. While it is a thoroughly good programme, it is going to meet with those kinds of limitations.
I thought I would illustrate to you, an epidemiological phenomenon called the population paradox, which means that that sort of targeting, in this sort of area is bound to be very inefficient.

This slide shows the proportion of children with behaviour problems (I am illustrating it using behaviour problems) in each social group in the 1970 birth cohort, aged 10 yrs. nice social class gradient, obviously this is the place to work and these are fine.

If you replot that data, looking at the number of children in each social class, you see a rather different picture, and it is very simple. There are relatively far fewer children in social classes 4 and 5, so even though there is a higher proportion with behaviour problems, it is a relatively small proportion overall with behaviour problems and the bulk of behaviour problems is in the more well to do communities. So if you target on the basis of deprivation, you are bound to have a policy that is relatively inefficient.

I thought I would just briefly rehearse some of the arguments in favour of universal provision for parents. I am delighted to see in the Best Health For Children work in the supporting parents documents, that that is a clear central tenet. I am not suggesting universal programmes or interventions instead of special interventions to help those most in need, but in a complimentary way. I think these are both complimentary and indeed synergistic- in that they both support each other. So one of the reasons for just going for the poor is the inefficiency of targeting. Another one is the distribution of mental health and illness in the community, which I will show you briefly. There is also the ubiquity of unhelpful parenting styles, the development of herd immunity and the avoidance of stigma.
This is another of the UK cohort studies and it shows the child behaviour inventory scores in that population aged 16 now. I just wanted to show you that whilst it’s skewed there is just a single hump. This is the number of children with each of the behaviour problems and this is the level of behaviour problems and that is regarded as abnormal. There is just one hump here.

If you wanted to do a targeted approach, or you want to screen, you need a distribution which looks like this, where the abnormal population has scores in this range, in the green one (on the right). This is called a bi-modal distribution, and the normal population has scores in that range. If you have got that kind of distribution it is quite possible to separate normal from abnormal. With the sort of population distribution that we have for every mental health inventory that has ever been used in any community study, adults, children, any of the inventories it has only ever given a uni-modal distribution, one with one hump. The two humps is something that is not a feature of mental health. And when you don’t have this distribution you are unlikely to be able to solve the problem with a targeted approach.

The next thing is the ubiquity of unhelpful parenting styles. This is one where people get quite anxious I think. Diana Baumrind suggested that about 30% of parents were doing authoritative parenting. We know from Marjorie Smiths work in the UK that 60% of parents have hit their under ‘ones’, as a method of discipline. Whilst we may disagree about physical punishment as a method of discipline, and there is not universal agreement, Scotland have managed to ban it, but the UK have definitely not. Most of us would agree that it is not an appropriate way to handle problems in your relationship with your ‘under-one’. Certainly 90% of under-fours have been hit, so this is something that’s very common. If you talk to teenagers, 50% do not feel they can talk to their parents about problems and 40% do not feel loved and cared for. So this is something that is very common not something that is affecting a small proportion of the population.
One of the other public health approaches is herd immunity and we particularly know it in terms of immunisation programmes where the few children you do not reach can be protected by immunising everybody you can reach.

I think there is a measure of that in this parenting work as well. It is possible to help parents who are not able to learn new skills at the moment, because of other things going on in their lives by helping those who can. Parents who learn new ways of parenting help those who have not, by modelling helpful parent styles by talking to other parents about what they have learnt and by being supportive to those who are being unhelpful to their children. Therefore we can shift the population mean. We can shift the way we tend to parent, and everybody will be helped in that process.

There is a question about whether we are looking for perfect parents or perfect parenting - is that what we should all be striving for, it is certainly something I haven’t achieved, and I do not know many people who can claim to have done. I don’t think going all out to get everybody to do it perfectly is really a sensible or realistic goal. What we are looking for is enabling parents to do a slightly better job, than they might have done without support and to shift things in the right direction so that parents develop an insight into some of their unhelpful behaviours, and are able to move on and find new ways of looking at them.

In this context I find the brain development research extremely helpful, because what it shows is that prime times for learning how to speak, relate to others emotionally, if you miss those, you can learn those things in later life. It is just very hard work and you need an awful lot of support, and probably a lot of therapy to go with it. It is not that if you miss that time, it is hopeless. The earlier in childhood you try and address it, the easier it is because the more flexible brain growth is, but even as adults people can change. One of the things I find helpful is, in thinking about those aspects of unhelpful parenting, that I have become aware of in myself, that I was previously blissfully unaware of, that they are not that easy just to do differently. It is helpful to me to think, that in trying to change my behaviour, respond to something my children do in a different way, in trying to have a different reaction, I’m actually trying to grow new neural pathways. And it is therefore not at all surprising that I have to practice rather a lot, that I never get it right the first time and that I screw up very often and that I need to ask my children (they are teenagers now and it’s a bit of a lark and we can do it together) but they need to have patience with me in trying to change. Now with a younger child you need to have patience with yourself and do not expect it to happen overnight. That was very helpful to me, you know it is like learning to play tennis as an adult, you have got to keep doing it an awful lot before you have got those kind of pathways, the ones that are predominant and the ones that take over when you are in trouble.
The other thing of course which I am not really going to talk about is, if you just offer parenting to parents you think are failing, you have this terrible problem of stigma to deal with.

I think the solutions are universal support for the development of helpful parenting. The underpinning and dissemination of the evidence to parents, just talking about it on reports, the TV, the radio, books, you know the sort of thing that is happening here is going to filter out to parents, it is making us all think about our own parenting, it is part of the dissemination package, and the universal home-visiting that you have planned in your programme would come in under that heading. Then coupled with targeted programme for parents with multiple problems, who have extremely deprived childhoods themselves, and that is intensive home visiting. We are doing a trial with parents where they are getting visited weekly from 6 months of pregnancy to the end of the first year of life and a lot of psychotherapeutic work going on with the parents, infant mental health work at that stage, not the sort of thing we could ever hope to offer to everybody.

I am just going to briefly refer, before we get to the end of the talk, to a study we have done, we have recently completed in Oxford, where we've tried to do a trial of a programme offered in a universal way.

We started off with a survey of all parents in three general practices in a socially mixed area of Oxford, of 2 to 8 yr olds. We had a 70% response rate, which is pretty good, and the parents filled in a child behaviour inventory, and answered some questions about whether they would like to go to a parenting programme or not. We said ‘would you be interested in attending a parenting group or class’, only 14% said unequivocally ‘yes’, but we got 45% who said ‘maybe’ and less than half said ‘no’. The other very important thing in Oxford is, we asked parents whether they'd previously been to a parenting group, and nearly one in five had. Oxford is a place where there has been a lot of community, voluntary sector action in the area of parenting and these groups have been around and lots of people will not believe this data, but I think it is real. Parents have had the opportunity to go and a lot of them have taken it up. It has been said that if you offer programmes universally you will only get the ‘worried well’ who will take them up, I hate that phrase. Parents do not go to these things for no good reason, they go because they would like information, as you have said and they have insights to be shared and they would like to know what other people know.
This slide is simply showing that if you divide the survey population into those who had children who scored at the clinical level of behaviour problems on the inventory, the parents were more likely to say ‘yes’, and more likely to say ‘maybe’ and much less likely to say ‘no’. So that gives me confidence that if you offer programmes universally, the people who are more likely to go are those in need rather than the reverse which is what is often said.

The other one in passing is that the child’s age at which parents were most likely to say they wanted to go to a parenting programme was when the first child was two to three years of age. So that just gives us a window of opportunity.

We went on to do a trial. We identified parents whose children scored in the lower half of the behaviour inventory, so children whose behaviour was worst, and we offered the trial to them. Now we did not do that because we didn’t think it would work or help the parents in the upper half of the distribution, but just that the behavioural outcome measures, which we were required to use because they are validated and well respected, we didn’t think had a hope in hell of picking up improvements in children who were already in the top half of the distribution. So we picked the bottom half. We invited all 400 parents to come. One in three of those eligible accepted and just about 60% of the parents who accepted and were randomised as the intervention group stayed the course. And here we measured a whole lot of parent and mental health outcomes and child mental health outcomes.

Here I am going to show you one of the ones that proved positive at 6 months, which was the Goodman Strength and Weaknesses conduct score. The colours are not terribly good, but the green one (on the right) is the intervention group and the yellow one is the control.
The intervention group started off slightly worse but have done much better over time. One of the key things I did not say, is that this was Webster Stratton’s ‘incredible years parent and children series’ programme, which is described as behavioural and humanistic, but actually for my money it is a behavioural programme. It is one of the ones I do not like as much. I much prefer the emotional literacy based programmes. Anyway we trialed it and it is perfectly clear it helps parents and it helps children. We have got some very nice qualitative data from the parents describing the ways it helped them. It enabled them to feel more in control, enabled them to take stock in stressful situations so that they shouted less and thought a bit first, all the sort of classic things. We have not got positive outcomes on everything. We have got some reasonable evidence that it improves parental mental health. But for example, emotional scores on this inventory were not changed. In some ways that is reassuring.

This is a behavioural programme and the areas it has proved most effective is in conduct and on the Eyberg Intensity as well. So that seemed to me to provide a reasonable level of evidence that these programmes, can be helpful in the UK, delivered by specially trained health visitors in a general practice setting, and can be reasonably helpful on a universal basis.

I just wanted before we moved on to put up one slide that I did show you when I came and spoke to you in 1999, and that is the principle that you cannot give what you have not got. The reason for putting that up is to remind us all that these programmes do not just run on their own, and they do not help at all if the facilitator is not very good with the parents and with enabling non-judgement and support.

In order to have those qualities and to be able to offer them to the group, you need to have a good level of mental health yourself. You need to have emotional literacy and awareness and insight. It behoves us all, to think about the need for us to develop those attributes in ourselves, at the same time that we are helping parents develop them in the community. We are part of the problem and part of the solution and we are part of the population. We need to be thinking about what we need to do as well.
Conclusions

- The way parents relate to their children shapes the development of their brains and has a profound impact on their future health and well-being
- Unhelpful parenting is part of the cause of health inequalities
- Social and fiscal policies which are supportive of parenting are an important part of any solution
- Effective interventions have been developed which enable parents to parent more helpfully
- Some of these have been tested and shown to work in the UK
- Their effectiveness depends on the way they are delivered
- A high proportion of parents want these interventions
- For maximum impact these interventions need to be provided on both an open access and a targeted basis

Just to conclude, the way parents relate to their children, shapes the development of their brains and has a profound impact on their future health and well-being. Unhelpful parenting is part of the problem and part of the cause of health inequalities. Social and fiscal policies, which are supportive of parents and parenting, are an important part of any solution.

I think it is also true to say that effective interventions have been developed which can enable parents to parent in a different way, which is more helpful to their children. They may need to develop new neural pathways and it is not going to happen like a magic wand overnight, but it can be done. Some of these interventions have been tested, here in Dublin, some in the UK, and they have been shown to work. A very high proportion of all parents seem to be interested in these programmes, and would be likely to take up universal provision. For maximum impact, we need to offer these services universally, and with special provision for those at high risk.

Thank you very much.
supporting parents -
policy and implementation

Presentation by Ms Gillian Calvert
Commissioner for Children, New South Wales, Australia

I’m here today to talk with you about the single most important thing for children - their family - and how we, as policy makers and leaders, can get the best results for children by supporting their families’ lives in a way that is meaningful and measurable.

A family that is supported and connected to a community has been shown to provide the best outcomes for children. This is especially true for babies and young children.

During these early years the quality of the relationship between a child and their parents is fundamental to the child’s survival, development and chances in life. Supporting this relationship is the best way to secure and maintain the well-being of young children.

This in turn, pays social dividends in the present and in the future.

We get better education results, health outcomes and crime prevention.

Families don’t exist in a vacuum.

They are influenced by economic, political and social factors - on a local, national and global scale.

Over the past 20 years, public policy’s relationship with families has often been limited to creating a safety net, for example through protective intervention, income support and crisis housing.

Government services have been arranged around helping families ‘survive’ and in the process families and all their needs have been divided up and neatly compartmentalised into boxes.

But families are complex social relationships living in a complex and sometimes unforgiving world.

If children and families are to thrive then public policy has to consider their needs in more than just basic survival terms.
As you can see I have put up some vital statistics that give you some idea of where I come from, New South Wales, the most populous state in Australia. I want to focus on how a strategic approach to public policy has revolutionised the services system for families with infants and young children in NSW.

It is called **Families First**.

And it has involved reshaping much of the policy, research and practice activities of governments, organisations, communities and individuals.

I want to share some of my thoughts on this experience as you launch your strategy for supporting parenthood. I’ll do this by first talking about how we conceived and nurtured **Families First**, in particular managing change, then I’ll talk about moving from idea to implementation and finish by highlighting some remaining challenges.

In preparing for this conference I spent a lot of time reflecting on the history of **Families First** to work out what I wanted to share with you today.

No matter how I looked at it, there was no way of simplifying **Families First** into a formula or recipe that could be universally applied.

I cannot give you a fail-safe recipe.

Putting **Families First** in policy was and remains, in many ways, a random confluence of personalities, timing, opportunities and vision.

Throughout the process, people, relationships and ideas interacted with and fed back to each other, creating momentum and constantly evolving ideas.

And this leads me to the first point I’d like to emphasise.

*It is that successful policy development seems to involve as much art, as it does science.*
It involves an ‘x’ factor or two, not a plan to follow. Plans are always subject to variables beyond one’s control. In many ways it was our ability to respond to those changes that helped our success.

_Families First_ certainly did not proceed according to plan or to logic, and was unpredictable even to those of us most closely involved.

Today, however, I will impose some structure on the creative process to try and tease out from our experiences what helped and hindered us putting _Families First_ in policy.

Much of what I am highlighting has only become apparent in hindsight. At the time, there was neither the clarity nor the awareness of all the events and conversations taking place that would eventually have an impact on the successful introduction of _Families First_.

So what I will do is tell you the story of _Families First_ and as I go, try and highlight some ideas you may find useful.

Establishing _Families First_ was, in many ways, a surprising event in New South Wales.

It is not the sort of thing that happens often. Back home, it has been suggested that one of the reasons it happened was that the right people were in the right place at the right time.

There is truth in this, but as I apply it to myself, I also know it’s not that simple.

The path that took me to the position where I could help make _Families First_ happen was the end-result of a chain of unforeseen events.

It was not planned and certainly was not aimed at getting to _Families First_.

That path led me to the Office of Children and Young People in The Cabinet Office of the New South Wales Government.

The Government had acted on a recommendation to set up the Office made by a Parliamentary Report into Children’s Advocacy.
It was the first time a Government had created an office with a focus solely on children, let alone in The Cabinet Office which was a powerful, policy co-ordination office, with direct access to the Premier who is the head of the Government.

At the same time the office was established, a high profile Royal Commission into Paedophilia and its links with organised crime and police corruption in New South Wales got underway.

One of the responsibilities of the new Office for Children and Young People was to plan and coordinate the Government’s response to the Royal Commission’s report. The report was expected to be quite damning of the government's approach to protecting vulnerable children from sexual abuse and organised paedophile activity.

I was recruited to head up the Office for Children and Young People because of my work in dealing with sensitive and complex issues as adviser to the then Minister for Community Services - who oversaw the department with statutory child protection responsibilities.

In my role as a Ministerial Advisor I had also developed strong links with some of the Premier’s key advisors. I also had developed strong ideas about prevention of abuse and neglect.

These ideas had crystallised in the early-nineties when I prepared a National Strategy for the Prevention of Child Abuse. So my commitment and previous experience meant I was one of the right people and I happened to be in the right place.

I recruited another person, Steve Robertson who still works with me at the Commission, to work on high-level cross-domain policy issues - who, as it turned out, was another ‘right’ person.

- Our backgrounds meant we had extensive and complementary relationships with people in politics, the bureaucracy, academia and service provision.
- Our skill mix meant we had experience with influencing, communicating, analysing and thinking strategically and creatively.
Our personalities meant we had the wherewithal to challenge how things were traditionally done, yet still survive in the quite highly controlled environment of the Cabinet Office.

We were generally regarded as knowledgeable and experienced, and could speak with some authority on these issues.

I’m giving you this personality inventory to help crystallise what I think are the critical skill sets the ‘right people’ often possess.

As I mentioned earlier I had previously written a National Strategy for Preventing Child Abuse that was endorsed. Unfortunately, it was not to be due to a change of Government. Ironically the wrong time for that policy at the Federal level became the right time for this new policy, Families First at the State level.

The Labor government had only recently been elected following a period of intense economic rationalism. This had effectively made NSW a social policy free zone. In contrast Labor was keen to demonstrate social policy innovations as a way to distance them from the former government.

There was pressure on The Cabinet Office to come up with something new and the Office of Children and Young People had the necessary social policy focus and skill base to oblige.

It was also the right time because NSW had developed a real commitment to interagency approaches in child protection.

We’d had a whole-of-government approach to protecting vulnerable children for over 10 years in New South Wales so we had the building blocks and relationships in place to transfer to a new policy arena.

While we had developed a well-coordinated approach to intervention, over time it become apparent that the number of reports of child abuse and neglect were continuing to rise. The upward trend was occurring despite the large numbers of additional staff being injected into child protection services.

At this point, there was a synchronisation of two important ideas.

The first was the awareness of the significance of supporting families and dealing with issues early before they turned into major problems that put children at risk.

This coincided with the powerful new evidence that what happens in the first three years of a child’s development lasts a lifetime.
This synchronicity was great timing.

The time was right for *Families First*, and the right people were in the right place to make it happen.

Let me jump ahead a moment and say that we have found that this is a continuing key aspect of our approach.

The right people in the right place at the right time is still really important - it doesn’t stop once Government signs off on the policy. For example as the right people in the right job leave we go back and turn their replacements into champions - we sell *Families First* over and over again. One of the most difficult challenges we found in the early days - and to an extent are still faced with - was dealing with people who were used to thinking about children and parents in certain ways.

They had their disciplines and specialisations. They clung to familiar paradigms about service provision.

Those in decision-making, funding and policy roles thought the problem was lack of co-ordination, poor targeting, inadequate training or some other inefficiency by service providers.

Service providers thought the problem was that they didn’t have enough resources to do their job.

Many in both groups thought that if only the problems - as they saw them - could be solved, things would be fine. They didn’t see the need for change, just some tweaking at the edges. Many people could not conceive of, nor did they want, systemic change. We had to convince all these people that change was needed.

There was another group of people who we called ‘the old hands’.

They had lived and worked through decades of change in service provision. They were used to the myriad pendulum swings between community control versus government control; government versus private sector provision; universal versus targeted services; prevention versus treatment; multiculturalism versus mainstreaming. They were suffering from change fatigue. We had to convince these people that change was possible and that this change was different.
We learned that *Families First* was as much about change management as it was about articulating an idea in a policy framework.

- It’s about managing change in family’s lives as they welcome their new baby into the world and adjust to being first time parents, as they find their feet in this new and exciting role.

- This in turn meant nurses, doctors, social workers, family support workers, and childcare workers had to change their practice.

As one nurse said to me recently... "When I found myself sitting on a log instead of in a clinic, having a cup of tea with a bikie who previously would never have agreed to see me, and talking with him about ways he could support his partner and their new born baby...well I knew then what *Families First* was about."

- It has also meant changing the way we plan our services and fund them. Introducing change on such a large scale required ongoing support from a range of different sectors.

- Understanding people’s attitudes, and then influencing them, continues.

We learned that agreement wasn’t always necessary. Some people simply had to acquiesce or agree not to block change. That would be enough.

In some cases, we found that the key people were often not the ultimate decision makers but those the decision makers trusted. For example, in politics they were often ministerial advisers. In government departments, they were often the deputy rather than the boss.

We had to think about what other change was happening in public policy or to the service system surrounding families and children. We had to avoid colliding with what they were doing. We started ‘drip feeding’ to reinforce our message that there were new ways to achieve good outcomes for children and families. We dropped it into every conversation, sent them copies of interesting articles, and suggested they meet with particular advocates or innovative service providers.

People who were themselves parents of young children were natural allies.

We listened to stories about their children and then used these stories to illustrate the research. We organised lunches where Ministers could meet and be briefed about the research of international experts at the cutting edge of developmental
science that supported our idea. On the seemingly infertile ground of the Treasury Department, we did our detective work and located a person who was open to different ways of working.

We also appealed to our potential critics. In our case, this meant non-government service providers. They form a significant proportion of the service system for children and families in New South Wales, and they would be an integral part of our plan for a new way of working.

They are vocal and therefore capable of influencing public opinion and political outcomes. We listened, we learnt from them and we valued what they had to say. This long process of creating, educating and influencing key people began, and indeed was well progressed, long before we had worked out our idea in anything but the sketchiest outline.

In fleshing out the idea of **Families First**, we started with two major principles.

- The first was that we needed to make children and families and their needs our focus, not programs, structures or organisations.
- The second was that we needed solid evidence on which to make our decisions.

For a couple of months, we sifted through mountains of research - both local and international - attended conferences and talked with researchers and practitioners.

Sometimes we stumbled across opportunities. One morning, we heard an interview on Sydney radio with Marilyn Trail, an academic visiting from the United States. She was talking about a very successful community development program she had just evaluated in a deprived urban area in Seattle.

We tracked her down through the radio station, and that afternoon, we spent two hours with her finding out more about the approach and her results. Very rapidly, two things became clear.

- First, good supports for families have outcomes in child health, child education, crime prevention, and enhanced safety for children, social functioning and even community amenity.
- Secondly, there were four obvious areas of support that consistently, around the world, delivered good outcomes for children and families and these became the four fields of activities that form the framework of Families First:
These are:

Universal health-based support for parents who are expecting and having a new baby;

Universal information and advice support for parents with children from birth to three years;

Targeted support for families who need additional help;

Targeted support for communities that need additional help. In New South Wales, we were already doing some of this.

And this was good news. It meant that we didn’t need to develop major new organisations or programs, but there were inadequacies.

Some of these essential support services were part of different systems that didn’t necessarily ‘talk’ to each another.

They lived in silos, each looking after their own slice of family life and failing to see the whole picture.

Some support services didn’t have sufficient coverage.

They had been shown to make a difference but there just weren’t enough of them. Some services didn’t see themselves as part of an integrated system of family support; some weren’t available to particular cultural communities and so on.

Few of them reached the hard to reach families whose children were most at risk of poor outcomes.

In the New South Wales context, this meant Aboriginal parents, many of whom were also very young. It meant social excluded parents usually living in isolated, unfriendly, at times frightening public housing estates. It meant newly arrived and isolated parents from other countries. In short, it meant the families whose children have the poorest outcomes on any measure throughout their entire life.

Old-fashioned practice was another inadequacy.

This practice meant that as a new mum you had to pack up your baby, walk a mile to the nearest bus stop then catch two buses to visit an early childhood clinic, often in weather that was hot and all so you could have your baby weighed and measured.

Then you did it all again to get home. Old-fashioned practice meant professionals and planners moaned about the drop in breast-feeding rates and complained about parents in these areas dropping off visiting the clinic after their first time.
Frankly, a tape measure and kitchen scales would have looked an attractive alternative to me too. The basics were there, but they needed to be reshaped, added to, and changed so the staff could focus on the needs of families and children.

Babies and their parents really needed people who were there to care for them to think about doing things differently, to approach them differently and work together as a team, regardless of whether they were employed by the Health Department or the Community Services Department.

When we tried to convince people about the need for change, we avoided the mistake of saying that everything we needed was there, it just had to be organised better.

People dislike being told to work smarter not harder, even if it’s appropriate. And in our case, we did actually need more resources for some things. We needed significant funds for:

1. New services
2. Training people in the new system
3. Monitoring and evaluation

In hindsight, the most important decision we made was not to focus on which service models to use but to create a new way of thinking and working - to think about *Families First* as a change management process.

In our experience, existing organisations and their structures had often proved so immovable that new approaches, plans and funds were invariably subsumed by the weight of prevailing organisational priorities. We wanted to break down the silos of the bureaucracy that had led to a hit and miss approach towards family support. We had to invent a management solution to suit our objectives.

*So as frequently as we outlined the four fields of activities, we more frequently outlined that Families First would:*

- Reshape the existing system, into the four key activities of family support and deliver better outcomes for children that would continue for the whole of their lives.
- Deliver funds for new services, to support the change process and for training, monitoring and evaluation. We would use the new money to change older investments.
supporting parents - policy and implementation cont’d.

- Be a state wide policy, but with decision-making about services and how they were to be delivered, made locally.
- Reform public administration and,
- Use an interagency approach to achieve common goals.
  We now had something concrete to sell.
- We also built into our proposal things that would appeal to the many people who were interested in the early years.

When we sold *Families First* we tailored our explanation to fit the audience. In hindsight this was an important aspect of our success. The economic rationalists liked the focus on reshaping the existing system, and the potential for reining in expenditure in later years, as problems were prevented. Academics liked the commitment to monitoring and evaluation. Lots of people found it very attractive that volunteers would be one potential source of support for parents. Unions and professional associations liked the funds for new staff, and the recognition of the skills of some professions.

- We also made *Families First* important.

A special Cabinet meeting was held with Dr Bruce Perry who we had brought out to Australia. This was a first for social policy ideas and word spread - it became hot.

No one could afford not to be on board about *Families First*. We used our position and our relationship with The Cabinet Office to get support from the highest level and in short, NSW finally put *Families First* in policy.

And we did it because of these factors:

*Having the right people in the right place at the right time*

*Recognising and seizing opportunities*

*Investing time in building relationships*

*Understanding and using the motivators that will drive people to change*

*Being creative*

*Having an occasional dose of good luck*
It is because I know how tough it can be getting to the point of putting your ideas into policy that I warmly congratulate you all on your achievement that we are celebrating here today with the launch of your Supporting Parents Strategy.

I am sure you have gone through a similar process as I have outlined, probably relying on similar factors as these. It is exciting but it is a process that requires courage too. And I do salute you Ireland, for your courage in getting here today as we launch your strategy to give kids a good start in life.

I also want to set out for you some challenges you now face as you move from idea to implementation.

*Families First* has now been implemented in about three quarters of New South Wales.

Much of the expansion has been linked to the electoral cycle. This has put us in a fortunate position as it provides regular opportunities to expand *Families First*. In their first term, the government agreed to pilot the idea in three areas. As part of their policy platform when they contested the next election, the government agreed to roll *Families First* out across the State accompanied by a funding commitment of $54 million which covered a further eight areas. Approval for an additional amount to roll out *Families First* across the remaining quarter of New South Wales is still needed, and I anticipate that will be achieved within the coming year - by the way there is another election early next year. It is these kinds of opportunities that a good policy developer needs to recognise, seek out and act on. Governments too need to recognise, seek out and act on these kinds of opportunities.

Once we had the green light for *Families First* we then faced a whole new set of issues in particular how do we hold this complex, multifaceted, multi layered, multi pronged strategy together.

We have kept the financial and reporting accountabilities located within the existing line agencies of Health, Community Services, Housing, Disability and Education but developed joint approaches to planning and implementation.
We knew a key risk factor to the survival of *Families First* was being absorbed into the general background noise by the inertia of the bureaucracy; by the turf wars between government departments, and by the sheer number of vested interests in such a multi-tiered service system.

We overcame this risk by applying a management solution. We argued that the *Families First* staff, working both centrally and in the regions, should be employed by the Cabinet Office. In doing so, we were leveraging off the interest in a ‘whole-of-government’ social policy agenda we knew the Government wanted.

In effect, *Families First* staff were not located in a service provider organisation, and so were immune to the inter-agency rivalries that could arise. They were free to focus on connecting communities and supporting parents to get the best outcomes for children.

- We also connected *Families First* to the Human Services CEO’s Group. This helped them manage the program reform as we reshaped older investments.
- To avoid the risk of inertia that may be encountered in the head office of each agency, we gave the priority-setting and planning responsibilities to regional committees, most of which already existed and could take on an additional function.
- An inter-agency and inter-sectoral group was created to provide advice. It is made up of all the players from all directions: it has central and regional bureaucrats as well as representatives of population groups such as Aboriginal people and representatives from each of the four fields of activities such as volunteer home visiting and early childhood nurses. It provides advice to the Human Services CEO Group and is serviced by The Cabinet Office.

I am now the chair of this group in my role as Commissioner for Children and Young People. This is a happy or an unhappy coincidence depending on how well the meeting has gone. The point to be made here is that it is important to have an independent, yet sympathetic, arbiter to help deal with conflict when it occurs. It is also important to have a champion that is both connected to Government but independent of Government.

A feature appreciated by almost everyone as we moved from ideas to implementation was that there was time to get things right by rolling it out over time.

We start four new areas each year that means the business systems supporting the rollout are not overwhelmed and the areas get the attention they need. It also means we get better at starting *Families First* as we learn from previous experience.
What was a major drama in the first area is now a routine operation. Once an area has started it has time to reflect on their system and plan for changes and new services. Their total new dollars are distributed over three years - this has created a continuous improvement culture and been the carrot to reshape existing investments. It also means *Families First* is not a flash in the pan to be forgotten once the first allocation of money is made. The management structure of *Families First* has also been important to maintaining momentum in the implementation phase. A considerable management challenge has been our need to change systems while managing the complexities and maintaining services at the same time.

To help its longevity, *Families First* developed a profile. It became identifiable, recognised and part of the vernacular.

A *Families First* communication strategy is getting our messages across to internal and external audiences.

Internally, the communication strategy is to help manage change among the practitioners and managers within the service system who need information to help them work differently. Externally, the communication strategy is helping us build community awareness about the importance of supporting families while their children are very young.

Money is always the key to the hearts of bureaucrats and managers so we have used that too, to help us manage change.

Budgets are still held by a line agency but they are now held “in trust” for the interagency regional groups. All the *Families First* agencies plan how that money should be spent then the budget holding agency implements that plan and manages the expenditure.

Thinking differently about the money has also helped people think differently about our services.

Our service systems had largely been developed in separate ‘silos’, interested in only one facet of families’ lives. This meant families were confronted with disconnected activities and services that they had to work out how to navigate in order to have their needs met.

As a professional I often found it hard to navigate the system. As a mother with young children it would have defeated me, and many families were defeated.
To think differently about our services, we had to think about them from the point of view of families’ needs rather than an organisation’s needs. We had to put Families First in our policy, services and practice. Schools as Community Centres illustrate the success of this new way of thinking about services and budgets.

The idea behind Schools as Community Centres is that schools are a natural hub of the community. We have used them as a focal point to connect with the community to make contact with hard to reach families and marginalised communities.

Four government agencies come together to plan and coordinate the services run from the Schools as Community Centres.

- The budget is held by the Education Department “in trust” for Housing, Health and Community Services Departments. All agencies have input into deciding where the centre will be located, what activities they will offer and sit on the local and statewide management committees.

- The ‘community centre’ is usually a room within a school located in a public housing estate. A community development facilitator and often a family support worker, staff the centre. Playgroups, health clinics, mothers’ groups and so on are run from the one location.

- Schools were chosen as the sites because they are non-stigmatising, all kids go to school, and all parents want their kids to do well at school. These centres help prepare kids, parents and teachers for the child’s transition to school, so they are ready to learn from day one. A child who knows how to sit, who can be part of a group, who knows where things are, in the school, will be more settled.

If we can identify any special needs a child has before they start school, such as speech therapy for example, then the teacher can prepare for the child’s learning needs and the child can be supported with the appropriate assistance. Unlike disadvantaged kids in other schools, kids don’t spend the first year of school learning basic social skills and teachers don’t have to gradually work out why a child can’t read.
Because of the connections made by the *Schools as Community Centres*, these important skills and knowledge have already been learned, so the child and teacher can use the first year of school learning to read and write.

Some *Schools as Community Centres* do **bus runs** to pick up kids who are always late for school because of the chaos in their family homes.

Having a bus collect your child helps parents in a practical way and also focuses their attention on getting their kid ready for the day.

Often the teachers on the bus run help find the kids’ shoes and help the kids finish **dressing**.

Importantly we get the kids to school on time for them to go into class and be there for their peak learning time before little lunch.

If the teachers see the results of the domestic violence when they go into the house to find the shoes, then the **family support** workers at the *School as Community Centre* can follow up. These schools often run **breakfast clubs**.

Kids who haven’t had dinner the previous night, or haven’t had breakfast in the morning are not going to learn. By giving them breakfast, we know their nutritional needs have been met and they are ready for school.

*Schools as Community Centres* build **community capacity and connection**. At playgroup, parents get to meet others in their area.

It’s a place for **information** and help with housing problems and health clinics are run from the school and so on.

Some *Schools as Community Centres* have set up food co-operatives; others have attracted childcare services to their neighbourhood.

You can see how the new way of thinking about planning, budgets and management has created the space for practitioners to do their job differently and in the process relate differently to children, families and communities.

In doing this though, we have made a complex management system even more complex for government. At the outset, few, if any, people really understood how everything fitted together in theory, let alone in practice.
We have had to develop a detailed level of understanding of the inter-connections of children, families and communities with organisations, and think carefully about the sequence and location of changes as we made them. This level of complexity was not apparent until we started.

We have also been lucky in that there has been no change of Government. Key people remain involved over five years as guardians of the idea. It has been remarkably stable. In *Families First*, we’re committed to learning and development.

- We have tried to remain open to new ideas, to keep learning from research as it is published and to make adjustments to our evolving systems.

- It can be hard to remain flexible about something you have been involved with for so long, but CEOs and the senior staff regularly make time to reflect on progress and discuss changes and adjustments that might lead to even better outcomes for families.

In hindsight, it is interesting that our original approaches to developing the idea have helped us commence and sustain implementation.

- In each region, and in many communities, we have had to get the right people into the right place at the right time, use or create opportunities, develop relationships, and understand what will motivate people to change.

The great news is *Families First* works and I think it has worked for these reasons:

- It is protected by the support it has from the highest levels of Government.

- Strategically placed ‘champions’ have been nurtured to advocate and protect *Families First*.

- Staff understand the rationale behind *Families First* and are committed to implementation.

It is an interagency project, so it’s hard for individual agencies to break rank.

- The planning processes place priority on local knowledge.

- Resistance to change has been minimised because new money is being used to update old investment and we’ve used new management solutions to overcome the inertia of old systems.
We have some remaining challenges.

Despite our emphatic statements that *Families First* is an overall approach based on reshaping existing services, with some funds for new and expanded services, it is often described as a $54 million funding program.

- At other times, *Families First* is sometimes spoken of as a set of services for families, rather than a way of working.
- We are still trying to find ways to keep people thinking holistically and with a family-focus, so that *Families First* doesn’t become just another bucket of money for a new service or an extra nurse. It is hard to break old habits and stop thinking about the service systems as based on funding programs locked away in silos.
- Some still see it as an add-on program - not about fundamentally reshaping existing services and activities. The good news is many more people pick up on it when someone slips back into old habits.
- I have already mentioned that one of our early tasks was to win over the ‘old hands’ who have lived through the fads and trends of service provision over the years and who thought *Families First* would be just another ‘nine day wonder’ that they could forget about. We want to ensure that the effort and interest are sustained, and particularly that the changes to practice and planning outlive the availability of new funding.

We have recently started putting in place our sustainability mechanisms.

- We are encouraging agencies to promote *Families First* as part of their core business, to ensure that all staff are clear about their roles and that *Families First* champions will be in place in agencies for the foreseeable future.
- We are concentrating on getting the planning, financial and evaluation systems bedded down so that they have become second nature within agencies.

Further investments are needed particularly for health to continue home visiting for families whose children’s outcomes are poor.

- By informing families and involving them in planning, we are hoping to develop sufficient community spirit to move even the most jaded old hand.
• And, most important, we are doing what we can to generate good outcomes for families and children, to demonstrate the outcomes and to let the community know that positives are being achieved. The interaction of people, ideas and relationships encourages a way forward.

Some of the things we learned may help you in achieving a similar change to your systems here. Because of differences in context, others probably won’t apply.

You will have to try to manoeuvre creative, intuitive, opportunistic people into the right places at the right time, and not to rely on logic, and avoid the delusion that having a good idea is enough. You have the advantage on us, as your strategy is wider than rearranging services.

We are yet to fully come to grips with the impact of transport or industrial relations on parent’s ability to raise their children and the community’s capacity to support them.

_Families First_ was designed to rearrange services yet these other issues may prove more enduring in their impact. Certainly the increasing gap between rich and poor in NSW must be tackled if our children are to have good outcomes in health, education and safety.

I am however proud of what we have achieved just as you should be proud of what you have achieved in launching your Supporting Parents Strategy.

I look forward to the day when we both have not only put Families First in policy but have got the good outcomes we need for our children.
Good afternoon Ladies and Gentlemen, in this election year a particular good afternoon to constituents! Thank you for inviting me to be part of it, I know you have already had superb speakers this morning. I had the pleasure of meeting Gillian yesterday, I would have loved to hear her presentation, but got a good flavour from her of her work in New South Wales. And you have had my colleague Dermot Ahern, who in many ways I suppose has responsibility for families. As Fionnuala says my title is Minister for Children. Some people would see that as just promoting children, children’s’ rights and welfare, I think if you read anything that we have produced, if you hear anything that we have said, if you have looked at anything that we have done in the last few years you will see that what we do in relation to children, is in the context of their families. And that is not just because we believe that families are important, but more particularly because children believe their families are important.

That is why the vision of our national Children’s strategy following on a consultation process, with many of you here in this room, with many of the voluntary organisations, with all of the groups who deal with children, and with thousands of children themselves, is set out as in Ireland, where children are respected as young citizens with a valued contribution to make a voice of their own - Where all children are cherished and supported by family and the wider society. Where they enjoy a fulfilling childhood and realise their potential. In that consultation the one message that we got across from children when we asked them - who are the most important people in their lives? It was ‘my family’, ‘my family’, and ‘my family’. Where there was one parent present, it was generally - ‘my mother’. In one case where I’ve often quoted and I’ll quote again, where one child wrote and she said ‘my father is the most important person in my life’. And I said ‘Isn’t that lovely, and why is your father the most important person in your life?’ She said - ‘I don’t know my Daddy, and that is why he is important to me’. But he was her family. Everything that we do, and the whole context for the National Children’s Strategy, is in the context of supporting families. That is why I am particularly pleased to be here today, to look and to share what is happening from my perspective for children in their families.

Throughout the 1990’s a lot of emphasis was put on child protection, and on child welfare. While there is still a lot of money obviously going into that we are indeed broadening the base. We are recognising that early intervention and family support is the key. That is why there are budget headings out there to every Health Board, saying ‘spend this money on the early intervention and you will protect families, you will protect children and you will avoid trouble down the road’.
Now it takes a sea of change in Health Boards, who have a crisis on their doorstep. It takes a sea change in people who have an over-run in residential and I am not one bit impressed when I meet people and I say ‘how exactly did you spend your money on family support’? and they say ‘Oh we had an over-run on residential care.’ You will always have an over-run on residential care, if you don’t put it in on the ground level. That is why that shift is taking place. That is why we are refocusing in aiming to support and expand the various projects that are there.

There are a myriad of very, very excellent projects and supports around the country. Whether it is groups like Homestart, Lifestart, Community Mothers or Family Support workers or the Springboard projects etc. they are all individually and collectively doing marvellous work.

But there are gaps in the service. There are areas, geographically that are not covered. There are age-groups that are not covered. There are areas where there is a very poor relationship between the statutory and voluntary organisations. That is why I am initiating a review, within the department of Health and Children, of all of the family support structures and processes that are out there at the moment, to be able to identify all of that and to see can we do a more complete mapping service, to ensure that in every area support is available to parents.

There is no doubt that every family has the capacity within them to be a good strong family. Some families need more support than others, in helping them along that way. Various research has shown this. What is very significant about today is the research, which will allow us to ensure that we have this evidence based approach which can ensure that we can move forward knowing what is best. Not what is best in terms of value for money, but what is best as regards getting results for the families and their children. I have had the pleasure of launching various pieces of research and reading a lot of research and seeing that despite what one might think in media reports etc, e.g. where you have big child welfare problems and issues that neglect is the biggest issue. Surely more support and training and help for parents can help overcome that significant problem. That was one of the key issues for example that came out of the Mid-West research and has been substantiated by research elsewhere as well. But it is only by putting in the services that will support all parents, at different levels, available to all parents, that we can hope to address some of these issues.

Equally, not only do we need to change the attitude of the service providers in relation to a balance of how we spend our money, we also need to do it in relation
to how we provide our services to all elements of the family. The research, which we had at Christmas from Kieran McKeown on ‘Fathers and Families’, showed that the services do not respond well to fathers. They need to change their attitude in the way they provide services to fathers recognising them and their role in the family as well.

We particularly need to change our attitude in relation to the involvement of children. I know you have heard it from Fionnuala in relation to the voice of children, that is the number one goal of the Children’s strategy. But there is not much point in us having a high profile super duper great fun day of Dáil na nóg, in the mansion house with the Taoiseach and the Ministers, where children can have their voice heard at a National level, unless it is heard more particularly where it counts, which is at the local level. Which is in the schools - with the development of the Schools Councils, which is in the Health Boards in particular for the children in their care, which is at the local level where children can be involved in their own communities in relation to play, recreation, safety and pride in their area. The word has to filter down as well as up from children, that they are involved at all those levels. That process has been started and I believe will continue. That new approach needs to take place as I say, in relation to parents, in relation to fathers as a distinct group and in relation to children.

As well as that, we also need to be looking more particularly and huge work is being done on this - on children as parents and teenage parents. There are some excellent teenage parenting projects around the country, who are supporting those girls, ensuring that they continue with their education, to give them the break that they need in order to succeed in life, for themselves and for their children. A lot of co-ordination and expansion of those types of programmes needs to be done as well. I think that will happen over the next couple of years.

We also need to see a sea of change in the attitude of some parents. I sometimes tell the story of two first cousins of mine, in Cork, both of whom had new babies, not their first and both decided they wanted to do a parenting course. One, went to the local one in her area, which was a middle to upper class area, where it was so oversubscribed that they had to run it on a couple of nights. The other one went to her local area, which would have been a lower economic group and they had to cancel due to lack of interest. These types of courses are for all parents. Everybody can benefit from them. We need to develop a situation where the atmosphere is such that people do not feel threatened by any of the services, supports or courses that are out there which are designed to help them.
In supporting families I am very conscious that for various reasons there are a lot of children that cannot remain within their own family. But being as firmly committed as I am and as the Government is, to try to enable as many children as possible to get the value of a family life, we are hugely supportive of foster families. At the end of last year, there were 4,020 children in care. 3,400 approx were in foster care. Now that shows the importance of the foster family in our whole child welfare system. It is not just a question of increasing the allowances, which is one important thing obviously, to recognise the value of the work, which they are providing (and this payment has trebled), but particularly to ensure that there are standards which are now being devised for them and that there are inspections and supports for them as well, to enable them to give the quality family life to children who otherwise would not have a home. In our whole child welfare system for those children who cannot get that family life, that the quality of our residential care, backed up by the social services inspectorate and the standards set down by them, backed up by a strong capital investment, strong supports for staff etc. can ensure that children can get a valued life. Not with a view to keeping them in residential care, but with a view, where possible, to re-integrating them back with their families as quickly as possible.

That too is the aim of the National Youth Homelessness Strategy, which I launched last October. Youth Homelessness is not about a child without a home, it is a child who has had to leave their home for various reasons, whether it is domestic violence or physical abuse or emotional trauma or behavioural difficulties. That child needs support, and that family needs support. The aim of that is to eliminate child homelessness, where they can be re-integrated back into their families and communities. That is the focus of every policy, which I have been pursuing in the last two years, which my predecessors and the Government have been pursuing. We firmly believe in the value of families and family support for our children.
In talking about the various supports that are there across different departments, (and I know Dermot Ahern has spoken about what is going on in his Department) but there are other groups as well. I know the Department of Education is crucial in this, particularly in early education and in supports there. The Department of Justice is crucial for young people who might otherwise end up in custody. That is why the Children Act that was passed last year, the main focus in that, is to ensure that children would not be detained or criminalized at an early age, but can be absorbed and supported within their families and communities as well. Keeping them out of the criminal justice system is the focus of that.

For once I think and many of you will be aware, we have finally come up with a structure, which will ensure that different Departments will pull together in the interests of children and in the interests of their families. That is with the establishment of the National Children’s Office under the National Children’s Strategy, which will co-ordinate the work of all those different Departments. You will have seen the logo on the back of the report here today, as being one of the sponsors of this, because it is now up and running just barely a couple of years, and will continue to play an even stronger role in being a support, for children in the context of their families and for society.

I know Gillian spoke dirty words this morning like election. She told me she spoke about things as challenges and opportunities. Some of us would call them difficulties and problems. But it does pose challenges and opportunities for all of us, to see what direction we are going to be taking, not in the election but in the formation of the next Government. What direction are we going to be taking for our children and for our families? All I can say to you is that my commitment and that of this Government, which we aim to continue, is to ensure that children are supported in the context of their families.

We believe in children. We believe that family support works and by doing that we believe that society will be better off for it.

Go raibh maith agaibh.
This conference provided an opportunity to present and launch a National Strategy for supporting parents.

There was a general and genuine welcome for the fact that parents were finally being recognised, valued, and having their needs considered. There was support for the idea of universal interventions, which was backed by the international presentations and the commissioned papers.

The evidence that the first three years of a child’s life is the critical time for growth and development was reiterated and endorsed.

It was recognised that there will be a need for a concerted collaboration between government departments to drive this strategy nationally. Participants were excited by the community development emphasis and the recognition of the need for a partnership approach. They were also realistic about the ease with which this is talked about and the difficulties of making it happen.

There was considered reflection on the balance involved in working with structures that are already there and those that will have to be built on.

There was also a belief that many of us have to accept responsibility for the re-orientation that will be required to plan and deliver services to families in a way that is consultative, flexible and responsive.
This is only the **beginning**. Parents now have to be put on the map in a real way.

It was felt that the **time is right**.

The first structural recommendation calls for the establishment of a **multi-agency interim body**. The setting up of this **Task Force** would be a timely response by the Cabinet Sub-Committee on Children.

In the meantime there is much we can all do to begin the process of implementing the service recommendations at local and regional level, in putting parents on the agenda.

Best Health for children will be supporting this work on an ongoing basis.
Mr Michael Kelly  
*Secretary General,  
Department of Health & Children*

Mr Michael Kelly was appointed Secretary General to the Department of Health and Children in January 2000. He has spent most of his career with the Department of Health and Children, with shorter assignments with the Department of Finance and the Department of Justice, Equality and Law Reform. Mr Kelly has specialised in Policy Analysis and has been engaged in a lot of strategy preparation over recent years. He led the development of the *National Children’s Strategy* and the development of the new Health Strategy - *Quality and Fairness - A Health System for you*.

Mr Dermot Ahern TD  
*Minister for Social Community and Family Affairs*

Mr Dermot Ahern was first elected to the Dáil Parliament in February 1987. He was Assistant Government Whip from 1988 - 1991. Minister of State at the Department of the Taoiseach with special responsibility as Government Chief Whip and Minister of State at the Department of Defence from November 1991 - February 1992. Mr Ahern was appointed Minister for Social, Community and Family Affairs in June 1997. He is a member of the special Oireachtas Committees on Judicial Separation and Child Care, Foreign Adoptions and the Solicitors’ Bill.

Dr Sean Denyer  
*Director, Best Health for Children*

Dr Sean Denyer has been the Director of Public Health in the North West of Ireland for the last six years. Prior to this he was the Director of Public Health in a health authority in England. He trained in medicine in Manchester, England. He worked in psychiatry and undertook higher specialist training in Public Health, obtaining a Masters in Public Health and Membership of the Faculty of Public Health of the Royal College of Physicians. In Ireland he has taken the lead in developing a *Regional Primary Care Strategy* and has led a National Review of Child Health. He is Director of Best Health for Children, a joint Health Board initiative aimed at improving the health of children and young people in Ireland.

Dr Julie Heslin  
*Chair, National Supporting Parents Committee*

Dr Julie Heslin is a specialist in Public Health Medicine, South Eastern Health Board (SEHB). Her areas of expertise include child health and well being, injury prevention, teen pregnancy and population health. She is the Chair of the Supporting Parents Sub-Committee of the National Conjoint Committee on Child Health and is the South Eastern Health Board representative on the National Conjoint Committee.
Ms Celia Keenaghan

Senior Research Officer, Best Health for Children

Ms Celia Keenaghan is a Senior Research Officer with Best Health for Children where she has worked for the last two years on secondment from the North Western Health Board. Prior to that she worked as a social research consultant to a number of voluntary and statutory agencies and groups. She is a Social Science graduate from University College Dublin and holds an MA in Communications Studies from Dublin City University. She is studying for a PhD in Sociology with Queens University Belfast. Her current research interests are child and adolescent health, parent support and public consultation methodologies.

Ms Catherine Hazlett

Principal Officer, Family Affairs Unit, Department Social, Community & Family Affairs

Ms Catherine Hazlett is a Principal Officer with responsibility for the Family Affairs Unit in the Department of Social, Community and Family Affairs. The functions of the Unit include co-ordinating family policy, undertaking research, and promoting awareness about family issues and parenting matters. The Unit has responsibility for providing support for marriage counselling organisations; the State funded Family Mediation Service and the development of a number of family services. From 1995 to 1998 she was Secretary to the Independent Government Appointed Commission on the Family. Currently she is working on the establishment of the new Family Support Agency which will have a range of responsibilities in relation to promoting family well-being.

Dr Sarah Stewart-Brown

Director Health Services Research Unit
University of Oxford, London

Dr Sarah Stewart-Brown is Director of the Health Services Research Unit at the University of Oxford and Reader in Health Services Research. She worked in the National Health Service in the UK first as a paediatrician and subsequently as a public health doctor in London, Bristol and Worcester. She has also held academic appointments at the Departments of Child Health and of Epidemiology and Community Health, at the University of Bristol. Her past research has been in two fields, community child health and health promotion. Her current research interests centre around the importance of parenting for health in adult life, including both mental and physical health. Current research projects include randomised controlled trials and systematic reviews of interventions with parents, both in general practice settings and through home visiting, together with school mental health promotion programmes, and epidemiological studies of parenting and health.

Ms Gillian Calvert

Commissioner for Children and Young People
New South Wales, Australia

Ms Gillian Calvert is Commissioner for Children and Young People in New South Wales (NSW), Australia. The Commission works with children and young people and their families, communities and government to help make NSW a better place for children and young people. She reports directly to the NSW Parliament and is an independent voice for children and young people. Gillian has over 25 years experience working with children, young people and their families. She was the principal architect of Families First, a major rearrangement of early childhood services for 0-8 year olds and their families.
Ms Fionnuala Kilfeather

Chief Executive
National Parent’s Council

Ms Fionnuala Kilfeather is chief executive of the National Parents Council-Primary. She serves on the National Council for Curriculum and Assessment and was a member of the working group that developed the RSE curriculum. She has recently been appointed to the Education Welfare Board. Fionnuala, an architect by training, is committed to children, to education and to partnership.

Ms Mary Hanafin TD

Minister for Children

Ms Mary Hanafin T.D. is a Fianna Fáil Deputy for Dún Laoghaire. She was first elected to Dáil Éireann in 1997. In January 2000, still a newly elected T.D., Mary was appointed Minister of State at the Departments of Health and Children, Justice, Equality and Law Reform, and Education and Science, with special responsibility for Children. In November 2000, the Government announced an expanded role for her and she has since overseen the co-ordination of all government policies for children and the implementation of the National Children’s Strategy.

Mr John Collins

Director, National Children’s Office

Born in Northern Ireland and educated at Trinity College Dublin from where he graduated in History and Politics. He joined the Civil Service where he has worked in the Department of Finance and then the Department of Health and Children. John has extensive experience in the Social Policy field. Most recently he has worked in the areas of disability and children’s services and also headed the team that produced the National Children’s Strategy last year. He has now established the new National Children’s Office.

Dublin Youth Theatre

Since its foundation in 1977, Dublin Youth Theatre has forged a unique contribution to the worlds of theatre and youth work. It continues to provide innovative and exciting opportunities for young people in the 14-22 age group to gain experience in drama, theatre and the related arts. DYT has a current membership of over 115 young people. The administrative and artistic work of DYT is co-ordinated by a board of directors, comprised of six adult directors, four member directors and a full-time general manager.
Ms Mary Roche

Supporting Parents Project Officer
Best Health For Children

Ms Mary Roche is the Supporting Parents Project Officer with Best Health for Children having joined the team in December ’01. The North Western Health Board has seconded her for two years. Mary’s background is in Social Work and she holds a CQSW and MA in Applied Social Science. More recently she has worked in Health Promotion as a co-ordinator of the Fás Le Chéile Parent Project.

Ms Caroline Cullen

National Child Health Co-Ordinator,
Best Health For Children

Ms Caroline Cullen was appointed as joint National Child Health Co-Ordinator during the summer of 1999. Previously she worked as the Education and Training Officer with the Health Promotion Unit of the Department of Health and Children. Her role involved co-ordination and development of national health promotion programmes and she acted as a facilitator for staff development and service planning throughout the Health Boards. She originally trained in teaching, guidance and counselling, group facilitation, health education and obtained a Masters in Educational Management. She has worked with the University of Limerick in developing and delivering on a number of postgraduate courses.
The Office provides a dedicated team to support the Minister in the expanded role of overseeing the implementation of the National Children’s Strategy and co-ordinating Government policy on children.

While government departments retain responsibility for implementing the Strategy, the Office co-ordinates and monitors progress in this regard. The Office is taking the lead role in a number of key policy areas. These include:

> Co-ordinating and monitoring the implementation of the Children Act, 2001

> Co-ordinating and monitoring the implementation of the National Youth Homelessness Strategy

> Developing National Play and Recreation Policies

The National Children’s Strategy - "Our Children - Their Lives" was launched by An Taoiseach in November 2000. It is a 10 year plan of action which calls on the statutory agencies, the Voluntary Sector and local communities to work better together to improve the quality of all childrens’ lives.

For more information on the National Children’s Strategy and progress on its implementation, contact:

National Children’s Office,
94 St. Stephen’s Green, Floor Three,
Dublin 2

E-mail: child_strategy@health.irlgov.ie
APPENDIX 3

family affairs unit

Department of Social, Community and Family Affairs

The Family Affairs Unit is part of the Planning Unit of the Department of Social, Community and Family Affairs.

The responsibilities of the Family Affairs Unit are:

> to co-ordinate family policy

> to pursue the findings in the Report of the Commission on the Family following their consideration by Government

> to undertake research and promote awareness about family issues

> the Family Mediation Service

> a pilot programme in relation to local offices of the Department of Social, Community and Family Affairs building on the one-stop-shop model with the aim of providing improved services at local level to families

> an information programme on parenting issues

As part of its function, the Family Affairs Unit is working on the legislative, administrative and practical issues involved in the establishment of the Family Support Agency.
APPENDIX 4
dublin youth theatre

PREPARING POSSIBLE PARENTS FOR POSITIVE PARENTHOOD

A Drama Presentation by members of Dublin Youth Theatre
Produced by Ciannait Clancy and Directed by John Delaney

Members of Dublin Youth Theatre have devised the presentation for this conference. We have been asked by the Conference organisers to provide a theatre performance celebrating parenthood in a positive way. Hmmm.... Some people may well ask, where is the drama in that? Well, we hope to provide some.

The theatre process is quite a simple one. You start off with a brief. You discuss what this brief means to each individual. You start tossing ideas in the air, the themes involved, their relevance to young people today, their relevance to the members of the group. You argue. You agree sometimes. You discuss the ideas some more. You take a break. Over a cup of tea and biscuits you argue some more and agree some more. You return to the rehearsal room and agree on a starting point. You move this theme forward and discuss some more. You decide to go back a little to a point you can all agree on and move forward from there and so on... A central theme emerges. A group dynamic emerges. It’s fun, it’s exciting and it’s empowering.

The central image, which emerged in rehearsals, was of a child pushing a shopping trolley. Inside the trolley is the child’s parent. This image means something different to all of us in the group and will to all of you also. All I will ask you is, - have you ever stood inside a shopping trolley and tried to get out without any help from anybody else? Can you imagine what it would be like to move that trolley forward under your own steam? If you do manage to get out and try to push, do you find all the wheels seem to be going in different directions?

We hope to provoke, entertain and provide a few laughs too.
John Delaney, Director

Performers from the Dublin Youth Theatre:

Stacey Cox (15) Mercy College, Coolock
Niamh Molloy (15) Dominican College, Griffith Ave.
Lynsey Jordan (16) Colaiste Bride, Clondalkin
Cheryl Rock (18) Loretto Convent, Letterkenny
David Moore (15) Pobalscoil Rosmini, Griffith Ave.
Louisa Loomes (16) Holy Faith, Clontarf

Barry O’Rourke (17) Moyle Park College, Clondalkin
Julianna Grogan (16) Santa Sabina, Sutton
Kim Buckley (15) Holy Faith, Clontarf
Neil Sharpson (17) Scoil Chiartiona, Griffith Ave.
Aoife Courtney (16) St. Joseph’s College, Lucan
Dublin Youth Theatre

Since its foundation in 1977, Dublin Youth Theatre has forged a unique contribution to the worlds of theatre and youth work. It continues to provide innovative and exciting opportunities for young people in the 14-22 age group to gain experience in drama, theatre and the related arts.

The objectives of DYT are:

• To provide for the personal and social development of its members through participation in drama workshops and productions
• To attain a high artistic standard in the public performance of plays which include work relevant to the lives of young people.

DYT has a current membership of over 115 young people. Auditions are held in September of each year and the selection criteria used ensures that membership includes representation from many areas in Dublin and a balanced ratio of male/female. Previous experience is not necessary - interest and enthusiasm, are what is important. DYT’s main activities consist of workshops & productions and its reputation for creating exciting, challenging, high-quality productions is renowned.

The administrative and artistic work of DYT is co-ordinated by a board of directors, comprised of 6 adult directors, 4 member directors and a full-time general manager. It gratefully acknowledges the support of the Arts Council, City of Dublin Youth Services Board and Dublin Corporation. It is a company limited by guarantee and has charitable status. It is also approved for tax-deductible sponsorship under Section 32 of the Finance Act. Company Reg. No: 153220/Charity No. CHY 10897

For more information, please contact;

Dublin Youth Theatre
23 Upper Gardiner St.
Dublin 1
Tel: 01-8743687
Fax: 01-8745189
E-mail: dyt@iol.ie
Please use scale of 1 - 5 to rate each aspect of the Conference:
1 - Poor     2 - Fair     3 - Good     4 - Very Good     5 - Excellent

1 Pre-Conference
- Booking
- Registration arrangements
- Pre-conference information

2 Conference Venue
- Delegates pack
- Audio-visual facilities
- The catering
- Assistance you received with any problems

3 Speakers
- Ms Celia Keenaghan, Principal Research Officer, Best Health For Children
  Title - Report Overview
- Dr Sarah Stewart-Brown, Director Health Services Research Unit, University of Oxford
  Title - Supporting Parents - The Rationale
- Ms Gillian Calvert, Commissioner for Children, and Young People, New South Wales
  Title - Putting Families First in Policy

4 Parallel Sessions  Please tick room number(as shown on badge)
- Room C 209
- Room D 203
- Room E 213
- Room D 105
- Room E 207
- Room E 214
- Room D 106
- Room E 208

5 Feedback from Parallel Sessions

6 Drama Presentation
- "Preparing Possible Parents for Positive Parenthood"

7 Comments


Thank you for taking the time to complete this form. Please leave on seat in Conference Hall or Box Provided at Registration desk
Best Health for Children, 1 Conyngham Road, Dublin 8
**APPENDIX 6**

evaluation outcome

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Drama Presentation

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Delegates were invited to meet in smaller facilitated groups following lunch, to discuss key aspects of the strategy - *Investing in Parenthood*. Three questions were posed:

1. **What is it that excites you or interests you most in the strategy?**

   A number of themes emerged which have been collated for this report under the following headings:

   **The valuing of parents**
   What was particularly welcomed here was the recognition of; the lifelong aspect of parenthood, the role of the parents in relation to their child’s health, seeing families as assets rather than problems, viewing parents as experts who deserve to be consulted have their needs met and be supported. (see 3.1 and 3.6 in part three)

   **Universal intervention**
   The broad socio-economic focus was seen as key to a lack of stigma. Home visiting and antenatal supports are examples of where universal provision could be led out. Targeted services will also be necessary (See 3.7 in part three)

   **The community development dimension**
   This is how barriers to access could be best tackled and how services are more likely to be flexible and responsive. The buy in of the Non Government Organisations sector to the strategy will be more likely in this context. (The concept of schools as a local focal point was picked up from Gillian Calvert’s input and stirred imaginations). (See 3.2 in part three).

   **The time is right**
   It was thought to be the right time for this strategy. The timescale was thought to be realistic.

   **The importance of early childhood years**
   Finally there was welcome recognition for the pre-school services and their input is acknowledged.
2 What is it that you find most challenging in the strategy?

There were five main themes that emerged:

**Funding and resources**
There is a staffing crisis in existence for front line services. This will pose a threat to delivery. The fiscal reality of funding universal services is daunting. Core services must be maintained (See 3.5 below).

**Structures**
Linkages will be essential at Departmental level as will proper coordination at regional level. The ‘fit’ with County Childcare Committees was a controversial issue. There will be resistance to another layer! But leadership for interagency endeavour is a scarce resource. There are issues to be ironed out with regard to the links with and representation on the proposed task force.

**Partnership**
There is cynicism about current collaboration. Yet partnership is seen as essential at every level (See 3.8 below).

**Consultation**
The consultation process and response to parents will be vital. Engaging and motivating parents is a tough task. Children will have to be included in the consultation process.

**Re-orientation**
A shift in emphasis from a service to a child approach is needed, current focus is on work not family. It will be about change management. (See section 3.4)

3 What is the key to dealing with the challenges?

Each group was then asked to prioritise two or three 'challenges' and agree what the key to dealing with these might be. In an effort to capture what emerged this has not been edited or interpreted, but recorded as it was and numbered only for cross-referencing with the themes above.
3.1 The concept of parent support

The following points were noted on the flip chart:

- It is important to promote respect of the individual within ‘parent support’.
- Respecting diversity will mean we won’t be trying to produce clones.
- A key question is who gets to decide what is acceptable within parenting?
- We need to ensure that parenting supports are offered by people with open minds who are open to diverse lifestyles.
- Parenting support is not necessarily just a Health Board led thing; it extends beyond to other social policies eg. Fiscal, taxation.
- Partnership is the key
- Promotion of teamwork model-positive, pro-active, communication. Parents and children as part of the team.
- Removing the ‘threat’ implied in needing to change behaviour - through promotion of positive image of parenting.
- Identifying the first step - what it might look like, leads to a vision of what is needed next
- Family support agencies
- Cultural shift in work; Can we change to a community development approach - ground up. Parents need to be involved. Resources will be necessary. Parent training. There is not enough communication and co-ordination.
- Attitude shift: Everyone is equal. Should have equal expectations. Make education accessible. Motivation - change your own views. Hope not expectation.
- Shift in power; Acknowledge and value workers on the ground.
- Have real participation with a gender balance.

3.2 Community development model

The following points were noted on the flip chart:

- Key Stakeholders
- Holistic view
- Involve educators and use schools
- PHN and Youth services need to become disability friendly for parents and children
3.3 How can a school become a hub?

The following points were noted on the flip chart:

- Create schools with nurseries, coffee shop, library etc. This will bring in other agencies. The process will take time and will need to be acknowledged.
  - Insurance issues will need to be addressed - a barrier that can be overcome

3.4 Re-orientation of staff- towards prevention/support

The following points were noted on the flip chart:

Actions needed;

- More information about services
- Performance indicators
- Cross training for staff joint approach
- Training is essential - not available
- Needs to be a change of culture/environment to allow service providers to work in a different way - restructuring
- Demands on service providers make it difficult to look at prevention.
  - Need to structure ourselves to enable families - not just children at risk
- Services used to thinking in boxes
- Huge demands/shortage of staff
- Under resourcing of education
- There is little evidence of involvement and attention to parents of children with disabilities/ethnic minorities - need to be represented on task force
- Competition for resources, universal approach is a challenge
- Risk of being diluted - so many strategies
- Funding will drive implementation
- ‘Value’ of parent has to be recognised. Childhood in and for itself has to be valued.

3.5 Time Framing and Resourcing the Strategy

The following points were noted on the flip chart:

- Strategies need to be linked to costing and time framing
- Gives meaning to strategies
- Increases accountability
- Accountability would become actioned
- Negotiations would take place prior to launch
• Incomplete strategies without costing and targets
• Funds need to be earmarked & not re-routed at point of delivery
• Being "heard" not simply being "right" with evidence is key to success
• Change takes time - need to keep pushing
• Value of community/voluntary sector influence shouldn't be underestimated
• How do political decisions that don't support families get challenged?
• Need to speak with one voice, have clear messages
• "We" needs to be cross-departmental and broader representation
• Leadership/PR implementation needs to come from government - otherwise it won't work
• Conjoint working did not result in adequate funding
• Changing the context for service provision
• Huge challenge
• We should dispel the notions that there is adequacy to cope at the moment
• Connect parents to what is available to them
• Difficulty in reducing resources to child protection/crisis
• Need to increase overall resources but focus more on children/communities and decrease hospital.

### 3.6 Valuing Parenting

The following points were noted on the flip chart:

• Parenting is often portrayed in a negative way (to teens in school -'Don't become a young parent). Has this attitude rubbed off on society as a whole? Valuing parenting involves valuing children and vice versa.

• At a practical level parents have a role to play; professionals need training, to accept and work with this

• Government needs to put in place real supports (e.g. Paid extended parental leave, supportive tax regimes) to value parenting. Investing in parenting and children will lead to beneficial outcomes.

• Experts say 'authoritative' is best parenting practice but climate (media etc.) would appear to suggest that 'permissive' parenting is the way to go or the way parents choose especially in families where there is greater time pressure.

• How to manage conflict between parents and child carers (e.g. minders, childcare workers) need to establish boundaries and further understanding of who's role is what.
3.7 Targeting
The following points were noted on the flip chart:

- Have a defined age group -0 to 5, key time
- Interagency working - fine-tuning, not creating another layer of committees. Senior management responding to needs as identified by staff. Awareness raising re. learning to be a parent.
- Putting resources into under 3’s will by default further empower parents.

How do you define the targeted need in terms of the criteria?

- Diversity in families
- Staffing and skills retraining
- Service meeting individual needs
- Not creating another level of bureaucracy
- Cultural change in peoples’ attitude is needed-multi-cultural society today.
- Multi-disciplinary team is needed in place

3.8 Communication and co-ordination
The following points were noted on the flip chart:

- Public Health Nurses can provide a link, an access point, a service link, are key people in the community. There are gaps there until a certain age.
- A multi-agency and departmental approach is necessary. Building on what’s there and making services more accessible to rural and disabled people.
- Information from community and the community development sector needs to be made accessible.
- Need support from above (interdepartmental) for real collaboration on the ground
- Need to integrate strategies for delivery - joint Education and Health
- Think about what it means for teachers to be central, to implement action DES involvement
- All plants need water - resource implications
- To change ‘culture of blame’ and promote collaboration
- If working well now, why fix it (acknowledgement needed)
- No need for new structures - do real consultation, build alliances before proceeding (champions)

3.9 Questions raised by delegates  
  in the course of these sessions:

The following points were noted on the flip chart:

- Who will lead this?
- Who or what is community?
- Should parent support be health driven?
APPENDIX 8

delegates who attended the national conference

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