



Review of Adequacy

Child Care and Family Support Services

1996

Eastern Health Board



Thanks are expressed to all those who contributed to this review of service adequacy and to those who assisted in the compilation of this report.

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EASTERN HEALTH BOARD

COMMUNITY CARE AREAS

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2. Dublin South East
3. Dublin South Central
4. Dublin South West
5. Dublin West
6. Dublin North West
7. Dublin North Central
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Introduction

This Report is prepared under Section 8 of the Child Care Act 1991 which requires Health Boards to annually review the adequacy of the Child Care and Family Support Services in its area and to prepare a report.

During 1996, our Board was allocated an additional £1.1m. which will equate to £2.2m. in a full year for the further development of Child Care and Family Support Services. A further sum of £1m. was provided in November in recognition of the provision of special care and accommodation arrangements which had to be made for individual children and legal fees incurred as a result of a number of High Court Judicial Reviews. The additional allocation approved for 1996 brings to £12.95m. the amount which our Board has received for the development of Child Care and Family Support Services since 1993.

New developments in 1996 included:

- establishment of additional preventative projects in six Community Care Areas including Neighbourhood Youth Projects, Family Resource Centres and an early intervention programme
- creation of new home based family support services in three Community Care Areas and the expansion of services in a further five Areas.
- creation of six additional social work team leader posts
- opening of two new high support units which together accommodate twelve children who require special care, treatment and education
- funding of additional residential child care staff in the voluntary sector to improve staff/child ratio at all times
- The establishment of a new residential facility on Dublin's north side for young people out of home
- refurbishment of several children's homes.

In this Review, it can be seen that Child Care and Family Support Services in the region had an extremely busy year in which every aspect of the service experienced increased numbers of referrals. Since 1992, our Board has experienced a 78% increase in the number of cases of suspected child abuse which were reported to us. Similarly, the Crisis Intervention Service reports that referrals to its service increased by 91% in just one year. Domestic violence continued to be experienced by women and children in the region to the extent that in the refuge and hostel described in this Review, there was an increase of 34% in the number of children admitted. This

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Chief Executive Officer

Chapter 1

Demographic and Socio-Economic Trends

The Eastern Health Board region comprises counties Dublin, Kildare and Wicklow. The region is divided into ten Community Care Areas: eight in Dublin (Area 1-8) and one each in Kildare (Area 9) and Wicklow (Area 10).

Population Trends

The population of the Eastern Health Board region is 1,293,964 (census 1996). This represents 36% of the national figure. The population of the region increased by 3.9% between 1991 and 1996. However this population increase was not evenly spread. Nine of the Community Care Areas had a net increase while one (Area 4) had a net reduction (Table 1). Area 9, Kildare, had the greatest percentage increase in population in the Health Board during this period at 10%. Kildare also had the highest percentage increase in population of all counties nationally.

Table 1: Total population in each Community Care Area of the EHB in 1991 and 1996 showing net change and percentage change				
<i>Community Care Area</i>	<i>Total population 1991</i>	<i>Total population 1996</i>	<i>Net change in population</i>	<i>% change in population</i>
1	125,573	127,014	1,441	1.1
2	118,975	128,681	9,706	8.2
3	89,129	92,577	3,448	3.9
4	145,339	143,035	-2,304	-1.6
5	105,755	112,608	6,853	6.5
6	136,378	141,461	5,083	3.7
7	115,549	118,312	2,763	2.4
8	188,606	192,978	4,372	2.3
9	122,656	134,881	12,225	10.0
10	97,265	102,417	5,152	5.3
Total	1,245,225	1,293,964	48,739	3.9

Community Care Area 8 remains the most populated area of the Eastern Health Board with a population of 192,978 while Area 3 has the smallest population of 92,577.

As the age breakdown of the population in the 1996 census is not yet available, the most recent available figures are from the 1991 census. The proportion of the Eastern Health Board population in the 0-18 year age group dropped steadily in the 20 years up to 1991. In 1991 there were 385,493 children under the age of 18 years i.e. 31% of the total population. In 1986 the corresponding child population was 415,012 i.e. 33.7% of the total population. Nationally, children under 18 years represented 32.5% of the population in 1991.

Births

The birth rate in Ireland had declined rapidly from the early 1980s but now seems to have reached a plateau. In 1980 there were 74,388 live births nationally, a birth rate of 21.9 per 1,000 population. In 1995 there were 48,530 births, a rate of 13.5. The birth rate varies considerably around the country, being highest in Kildare at 16.7 and lowest in Roscommon at 10.5. The birth rate in Ireland is much higher than the average for the 15 European Union countries where it was 10.9 in 1994 compared with an Irish rate of 13.4 for the same year.

Figure 1: Annual birth rate per 1,000 population, Ireland 1970-1995.

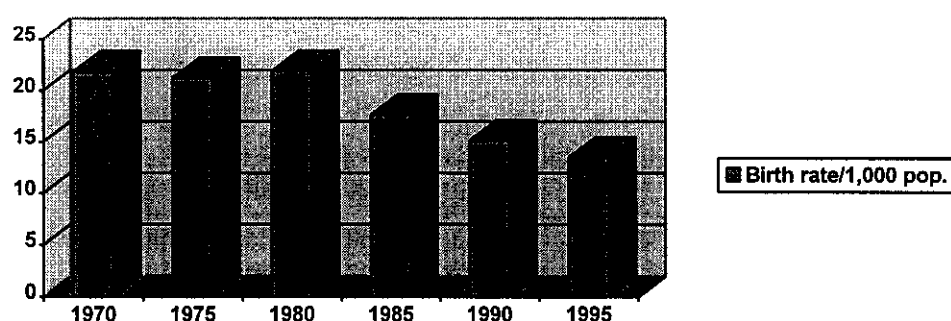


Table 4 demonstrates the number of births and birth rates in the Eastern Health Board region for 1991 to 1996. The downward trend in the number of births seen in the early 1990s has now been reversed. There has been no change in the birth rate since 1995. This may be explained by the fact that the birth rate is calculated per 1,000 population - the population of the EHB has increased between the 1991 and 1996 census.

County	1991	1992	1993	1994	1995	1996
Dublin	15,831	14,759	14,428	14,500	14,639	15,156
Kildare	2,188	2,353	2,141	2,130	2,251	2,374
Wicklow	1,653	1,712	1,600	1,551	1,542	1,575
Total EHB	19,672	18,824	18,169	18,181	18,432	19,105
Birthrate*	15.8	15.1	14.6	14.6	14.8	14.8

* calculation based on 1986 census for year 1990, 1991 census for years 1991-1995 and 1996 census for year 1996.
Source: RICHS (EHB computerised child health records), for children resident in EHB 27 March 1997

Non-marital and teenage births

The number of non-marital births has increased in all areas between 1992 and 1996. The most rapid increase has been Kildare where the rate has more than doubled in that period but still remains lower than in most other Community Care Areas. The highest proportion of non-marital births is in Area 7 at 44.8% (Table 5). In 1995, 22.2% of births in Ireland were non-marital. In 1993, 19.5% of births in Ireland were non-marital compared with 21.8% for the 15 European Union countries (1993 is the most recent year for which EU statistics are available).

continued to smoke and 24.2% continued to drink alcohol during pregnancy. 51.7% had used contraception in the past; only 27.5% had used it always. The age at first sexual intercourse, fertility awareness and the use of contraception were significantly influenced by social class and education.

Table 6: Births to teenage mothers (<20 Years) in the EHB region as a % of all births by Community Care Area in 1995 and 1996		
<i>Community Care Area</i>	<i>1995 *</i>	<i>1996</i>
	%	%
1	2.4	3.2
2	2.6	3.4
3	3.0	3.4
4	6.3	8.4
5	6.1	6.4
6	4.6	6.1
7	5.3	6.7
8	3.5	4.2
9	3.6	4.3
10	4.0	4.7
Total	4.2	5.1

Source: RICHs (EHB computerised child health records)

*calculated on basis of births for which maternal age recorded

Table 6 shows that 5.1% of all births in the Eastern Health Board region in 1996 were to teenagers. This figure had increased from 4.2% in 1995. The numbers of teenage births had increased in all areas between 1995 and 1996. There was considerable variation in the rate of teenage births between Community Care Areas. Area 4 had the highest rate at 8.4% compared with a rate of 3.2% in Area 1.

In 1995, 2,352 women aged under 20 years gave birth outside marriage in Ireland, representing 22% of all unmarried mothers delivering in that year.

Prematurity and Low Birth Weight

Prematurity and low birth weight are associated with increased morbidity and mortality in newborn infants. The predominant cause of low birth weight infants in developed countries is premature birth. It is difficult to completely separate factors associated with prematurity from those associated with low birth weight. A strong positive correlation exists between both premature birth and low birth weight and low socio-economic status. In families of low socio-economic status there are relatively high incidences of maternal undernutrition, anaemia, and illness; inadequate prenatal care; drug addiction; smoking in pregnancy; and obstetric complications. Other associated factors such as teenage pregnancies, close spacing of pregnancies and mothers who have borne more than 4 previous children are also encountered more frequently.

Figure 2: Percentage of mothers breastfeeding by selected father's occupation, EHB 1992

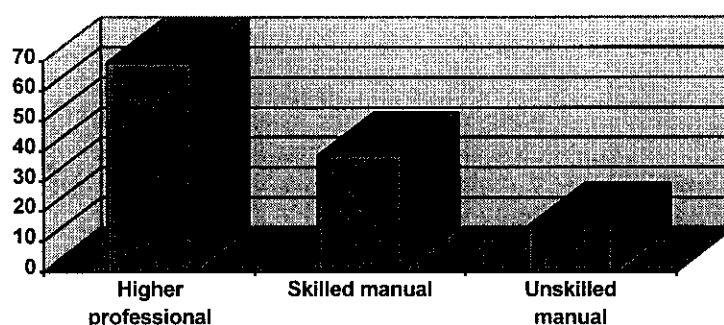
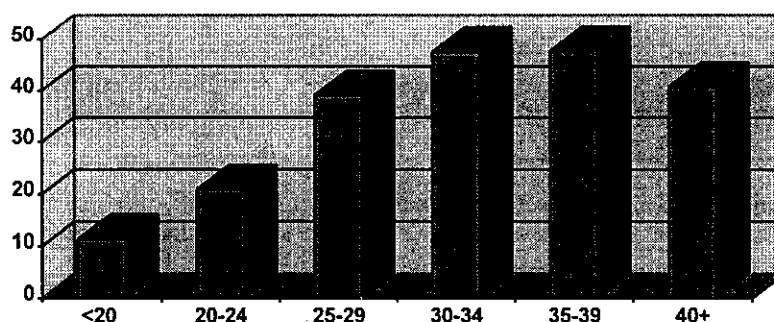


Figure 3: Percentage of mothers breastfeeding by age of mother, EHB 1992



The prevalence of breastfeeding in the Eastern Health Board by Community Care Area is largely unknown. The birth notification form records breastfeeding before discharge from the maternity unit. It is planned to record this data on the Eastern Health Board RICHs system (computerised child health system) in the near future. This will provide data on initiation of breastfeeding by Community Care Area. However, it is also important to determine the breastfeeding rates at later stages and a system to record this data needs to be developed.

Infant Mortality

The infant mortality rate is often taken as an indicator of the level of medical and social standards in a community. It is defined as the number of deaths of infants under 1 year of age per 1,000 live births. The infant mortality rate has declined steadily in Ireland since the 1970s. The rate was 19.2 in 1970 and 5.5 in 1995. Ireland's infant mortality rate of 5.9 in 1994 compares favourably with the European Union average rate of 6.1 in 1994.

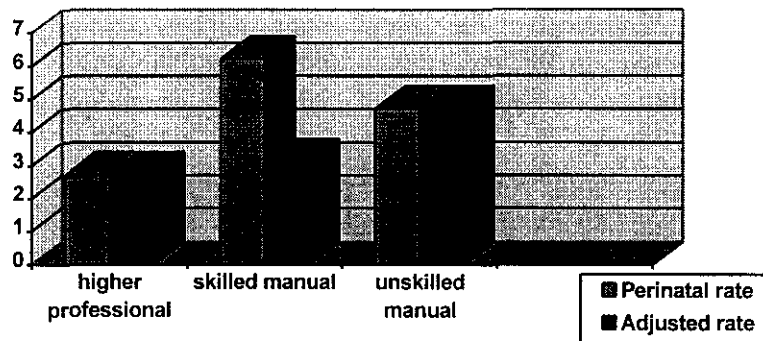
Table 9: Infant mortality rates for EHB region and Ireland 1988-1994									
	1988	1989	1990	1991	1992	1993	1994	1995	1996
EHB region	9.6	7.5	7.2	8.9	7.5	5.9	6.5	6.5	6.0
Ireland	9.2	7.5	8.2	8.2	6.6	5.9	5.9	6.3	5.5

Source: Central Statistics Office

Note: Since infant mortality rates are based on small numbers they are subject to random fluctuations. Thus, caution should be exercised in their interpretation.

Perinatal Mortality

Figure 4: Perinatal mortality rates by selected father's occupation in Eastern Health Board region 1992 (singleton births).



Note: The adjusted rate excludes all deaths due to congenital anomalies.

Figure 4 shows a gradient of increasing perinatal mortality rate with decreasing social class when adjusted rates are considered. The adjusted perinatal mortality rate excludes all stillbirths and early neonatal deaths due to congenital anomalies, and therefore to some extent removes those perinatal events where death was unavoidable.

	1988	1989	1990	1991	1992
PNMR	11.3	10.2	10.7	9.1	8.8
Adjusted PNMR	8.4	7.6	8.2	6.5	5.5
Stillbirth rate	7.3	6.1	6.7	5.4	4.5

Source: Perinatal Statistics, Department of Health

Perinatal mortality rate = Number of stillbirths and early neonatal (during first week of life) deaths per 1,000 live and stillbirths.

Stillbirth rate = Number of stillbirths per 1,000 live and stillbirths.

The perinatal mortality rate for Ireland in 1992 (singleton births) was slightly higher, at 9.2, than the Eastern Health Board rate of 8.8. The corresponding figure for the European Union average was 8.1 in 1991. Studies from many countries have found perinatal and infant mortality to be closely linked with socio-economic background.

There has been a dramatic decline in infant, neonatal and perinatal mortality in Ireland since 1970. The factors which determine the level of perinatal mortality are complex: birth weight, gestation, parity, mother's age, social status, type of antenatal care, and many others.

Sudden Infant Death Syndrome (SIDS)

SIDS is a leading cause of death in babies aged four weeks to one year. Over a third (37%) of all deaths in this age group in Ireland in 1994 were due to SIDS. The decline in infant mortality rate in Ireland in recent years is primarily attributed to a drop in the post-neonatal mortality rate (deaths in infants over 28 days and under one year of age).

Suicide

Suicide, particularly among young people, remains an issue of concern. Table 15 details the suicide figures for children in the Eastern Health Board region for 1994 and 1996, with age and sex breakdown.

Table 15: Suicide deaths by age (10-14 and 15-19 years) and sex in EHB region, 1994 and 1996					
Year	Male		Female		Total
	10-14 years	15-19 years	10-14 years	15-19 years	
1994	1	3	0	3	7
1996*	0	3	0	4	7

Source: CSO Vital Statistics

*1996 figures are provisional

Congenital abnormalities

Table 16: Commonly occurring congenital abnormalities: comparison between 1980 and 1995, EHB region				
	1980		1995	
	Number	Rate per 10,000	Number	Rate per 10,000
Neural tube defects	124	46.9	21	11.4
Congenital heart disease	113	42.7	98	53.3
Cleft lip/palate	45	17.0	32	17.4
Chromosomal disorders	68	25.7	45	24.5
Down Syndrome	57	21.5	34	18.5
Limb defects	165	62.4	122	66.4

Source: Eurocat.

Note: Care must be taken in the interpretation of these figures because of small numbers - minor random fluctuations in numbers may result in wide variations in rates.

Neural Tube Defects

The most striking change in these figures between 1980 and 1995 has been the reduction in neural tube defects (Figure 5). Extensive research has highlighted the importance of folic acid in the prevention of neural tube defects. Since 1993, the Department of Health has recommended peri-conceptual folic acid supplements.

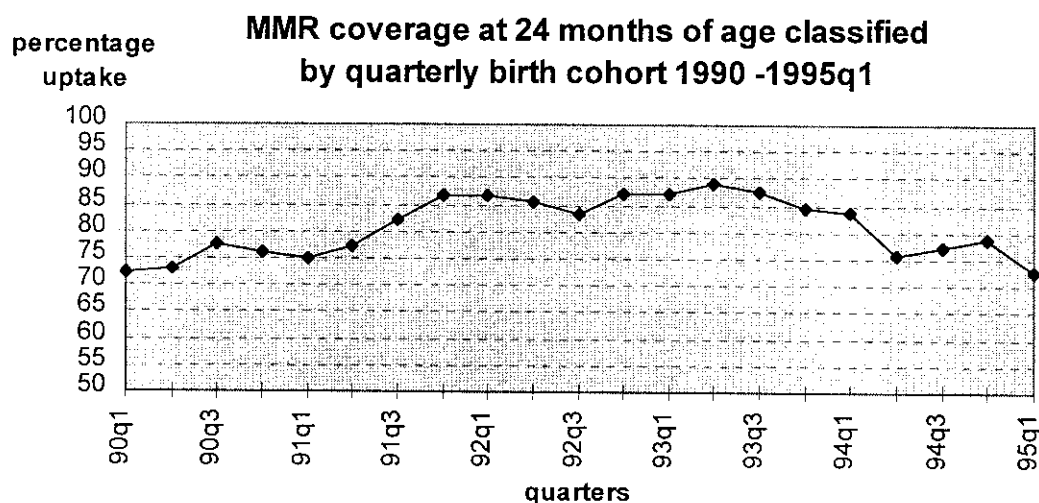
Under the Infectious Disease Regulations 1981 there is an obligation on the attending physician to notify to the health board cases of specified communicable diseases. It is well recognised in Ireland and in many other countries that there is considerable under-notification of these diseases. However the figures compiled are still important in indicating trends from year to year and in detecting excess cases and outbreaks. Table 17 lists the most frequently notified diseases for 1995 and 1996. It is important to note that measles, pertussis, rubella and mumps are all diseases which are preventable by vaccines which are delivered as part of the childhood immunisation programme in Ireland.

Congenital Rubella Infection

Rubella is important because of its ability to produce anomalies in the developing fetus. Congenital rubella syndrome (CRS) occurs in up to 90% of infants born to women who acquired confirmed rubella during the first trimester of pregnancy. Fetuses infected early are at greatest risk of intrauterine death, spontaneous abortion and congenital malformations of major organ systems.

The current recommended schedule of childhood immunisation includes measles/mumps/rubella (MMR) vaccine at 15 months with a second dose at 11-12 years. The second MMR dose was introduced for both sexes in 1993 - prior to this rubella vaccine was offered to teenage girls only. Rubella vaccine was included in this triple vaccine with the intention of interrupting the circulation of rubella amongst young children, thereby protecting susceptible adult women. The uptake rate of MMR vaccination falls short of the target of 95%.

Figure 6



It is important to ensure that all women considering pregnancy are aware of their rubella immune status. Data on rubella immune status of mothers, obtained from the national perinatal reporting system in 1992 (the most recent year for which statistics are available), showed that 1.6% of mothers are not immune to rubella, with a further 9% being of unknown immune status. The corresponding figures for the EHB are 1.1% and 6.5%.

The Eastern Health Board, in conjunction with the Rotunda Hospital, and with the support of Europe Against Cancer and the Health Promotion Unit of the Department of Health developed and implemented on a pilot basis a smoking cessation programme for pregnant women attending the public antenatal clinic at the Rotunda Hospital. The aim of the Rotunda Stop Smoking Programme was to encourage and support women to stop smoking in pregnancy and to maintain smoking abstinence after delivery. The study took the form of a randomised controlled trial. The study population was 418 women smokers attending the public ante-natal clinic for a first visit during a three month period in 1995. The intervention consisted of structured one-to-one counselling by the stop smoking facilitator, use of an information pack specifically designed for this programme, use of a carbon monoxide monitor, and stop smoking support groups.

The main findings of this project can be summarised as follows:

- There was a high participation rate in the programme at 88%
- There was a very high rate of smoking in the target population at 54%, and a low rate of quitting
- The study population was generally disadvantaged
- The programme showed some positive effects, although small, on smoking behaviour
- The long term effects are unknown
- The results indicated a high level of acceptability of the programme
- The materials were well received
- In general, the programme was successfully developed and implemented
- The experience of this programme will be of benefit in improving the programme for future use

Accidental Childhood Poisoning

Accidental poisoning of children by medications and household products remains a major cause of suffering. Surveys at one children's hospital in Dublin showed no change in the incidence of poisoning over the 15 year period from 1975-1989. Child Resistant Containers(CRCs) were found to be infrequently used or involved in children presenting to hospital with accidental poisoning (Gill, 1990).

A review of national Hospital Inpatient Enquiry Data (HIPE) for 1993 showed that there were 990 hospital admissions among children under the age of 5 due to poisoning. HIPE data of the Eastern Health Board (EHB) region for 1993-1995 showed that over 200 children under the age of 5 were admitted for each of these years due to poisoning (Table 18).

Table 18: Hospital Admissions as a Result of Poisoning in children under 5 years, EHB, 1993-1995			
	1993 No. (%)	1994 No. (%)	1995 No. (%)
Male	128 (55.9)	156 (60.2)	118 (52.0)
Female	101 (44.1)	103 (39.8)	109 (48.0)
Total	229 (100)	259 (100)	227 (100)



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3	89,129	92,577	3,448	3.9
4	145,339	143,035	-2,304	-1.6
5	105,755	112,608	6,853	6.5
6	136,378	141,461	5,083	3.7
7	115,549	118,312	2,763	2.4
8	188,606	192,978	4,372	2.3
9	122,656	134,881	12,225	10.0
10	97,265	102,417	5,152	5.3
Total	1,245,225	1,293,964	48,739	3.9

Community Care Area 8 remains the most populated area of the Eastern Health Board with a population of 192,978 while Area 3 has the smallest population of 92,577.

As the age breakdown of the population in the 1996 census is not yet available, the most recent available figures are from the 1991 census. The proportion of the Eastern Health Board population in the 0-18 year age group dropped steadily in the 20 years up to 1991. In 1991 there were 385,493 children under the age of 18 years i.e. 31% of the total population. In 1986 the corresponding child population was 415,012 i.e. 33.7% of the total population. Nationally, children under 18 years represented 32.5% of the population in 1991.

Births

The birth rate in Ireland had declined rapidly from the early 1980s but now seems to have reached a plateau. In 1980 there were 74,388 live births nationally, a birth rate of 21.9 per 1,000 population. In 1995 there were 48,530 births, a rate of 13.5. The birth rate varies considerably around the country, being highest in Kildare at 16.7 and lowest in Roscommon at 10.5. The birth rate in Ireland is much higher than the average for the 15 European Union countries where it was 10.9 in 1994 compared with an Irish rate of 13.4 for the same year.

Figure 1: Annual birth rate per 1,000 population, Ireland 1970-1995.

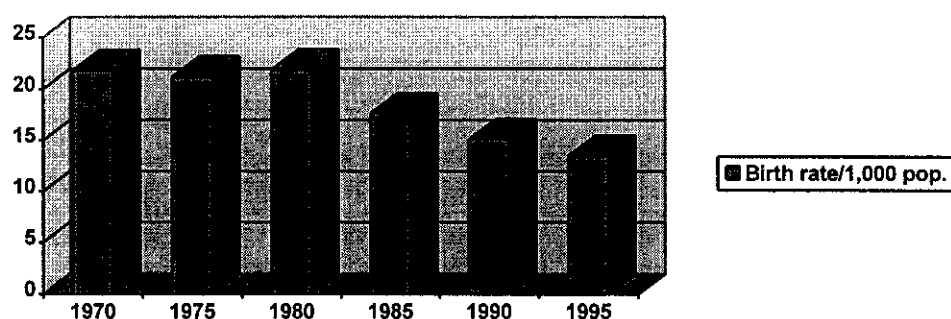


Table 4 demonstrates the number of births and birth rates in the Eastern Health Board region for 1991 to 1996. The downward trend in the number of births seen in the early 1990s has now been reversed. There has been no change in the birth rate since 1995. This may be explained by the fact that the birth rate is calculated per 1,000 population - the population of the EHB has increased between the 1991 and 1996 census.

<i>County</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>
Dublin	15,831	14,759	14,428	14,500	14,639	15,156
Kildare	2,188	2,353	2,141	2,130	2,251	2,374
Wicklow	1,653	1,712	1,600	1,551	1,542	1,575
Total EHB	19,672	18,824	18,169	18,181	18,432	19,105
<i>Birthrate*</i>	<i>15.8</i>	<i>15.1</i>	<i>14.6</i>	<i>14.6</i>	<i>14.8</i>	<i>14.8</i>

* calculation based on 1986 census for year 1990, 1991 census for years 1991-1995 and 1996 census for year 1996.
Source: RICHs (EHB computerised child health records), for children resident in EHB 27 March 1997

Non-marital and teenage births

The number of non-marital births has increased in all areas between 1992 and 1996. The most rapid increase has been Kildare where the rate has more than doubled in that period but still remains lower than in most other Community Care Areas. The highest proportion of non-marital births is in Area 7 at 44.8% (Table 5). In 1995, 22.2% of births in Ireland were non-marital. In 1993, 19.5% of births in Ireland were non-marital compared with 21.8% for the 15 European Union countries (1993 is the most recent year for which EU statistics are available).

continued to smoke and 24.2% continued to drink alcohol during pregnancy. 51.7% had used contraception in the past; only 27.5% had used it always. The age at first sexual intercourse, fertility awareness and the use of contraception were significantly influenced by social class and education.

Table 6: Births to teenage mothers (<20 Years) in the EHB region as a % of all births by Community Care Area in 1995 and 1996		
Community Care Area	1995 *	1996
	%	%
1	2.4	3.2
2	2.6	3.4
3	3.0	3.4
4	6.3	8.4
5	6.1	6.4
6	4.6	6.1
7	5.3	6.7
8	3.5	4.2
9	3.6	4.3
10	4.0	4.7
Total	4.2	5.1

Source: RICHs (EHB computerised child health records)

*calculated on basis of births for which maternal age recorded

Table 6 shows that 5.1% of all births in the Eastern Health Board region in 1996 were to teenagers. This figure had increased from 4.2% in 1995. The numbers of teenage births had increased in all areas between 1995 and 1996. There was considerable variation in the rate of teenage births between Community Care Areas. Area 4 had the highest rate at 8.4% compared with a rate of 3.2% in Area 1.

In 1995, 2,352 women aged under 20 years gave birth outside marriage in Ireland, representing 22% of all unmarried mothers delivering in that year.

Prematurity and Low Birth Weight

Prematurity and low birth weight are associated with increased morbidity and mortality in newborn infants. The predominant cause of low birth weight infants in developed countries is premature birth. It is difficult to completely separate factors associated with prematurity from those associated with low birth weight. A strong positive correlation exists between both premature birth and low birth weight and low socio-economic status. In families of low socio-economic status there are relatively high incidences of maternal undernutrition, anaemia, and illness; inadequate prenatal care; drug addiction; smoking in pregnancy; and obstetric complications. Other associated factors such as teenage pregnancies, close spacing of pregnancies and mothers who have borne more than 4 previous children are also encountered more frequently.

Figure 2: Percentage of mothers breastfeeding by selected father's occupation, EHB 1992

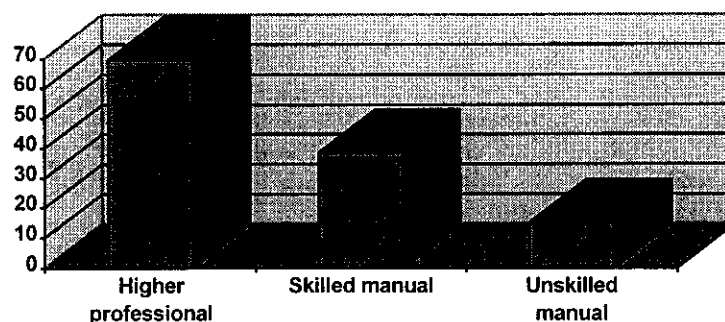
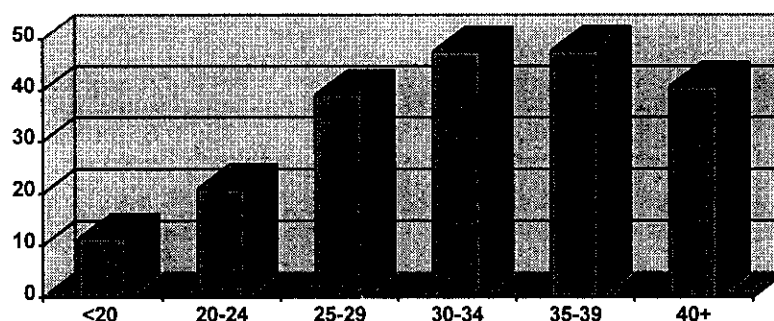


Figure 3: Percentage of mothers breastfeeding by age of mother, EHB 1992



The prevalence of breastfeeding in the Eastern Health Board by Community Care Area is largely unknown. The birth notification form records breastfeeding before discharge from the maternity unit. It is planned to record this data on the Eastern Health Board RICHs system (computerised child health system) in the near future. This will provide data on initiation of breastfeeding by Community Care Area. However, it is also important to determine the breastfeeding rates at later stages and a system to record this data needs to be developed.

Infant Mortality

The infant mortality rate is often taken as an indicator of the level of medical and social standards in a community. It is defined as the number of deaths of infants under 1 year of age per 1,000 live births. The infant mortality rate has declined steadily in Ireland since the 1970s. The rate was 19.2 in 1970 and 5.5 in 1995. Ireland's infant mortality rate of 5.9 in 1994 compares favourably with the European Union average rate of 6.1 in 1994.

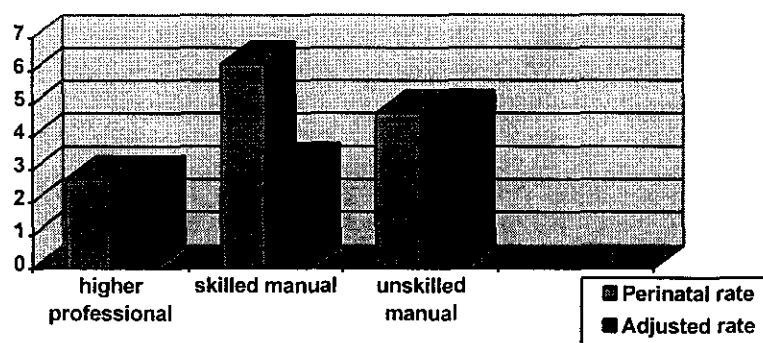
Table 9: Infant mortality rates for EHB region and Ireland 1988-1994									
	1988	1989	1990	1991	1992	1993	1994	1995	1996
EHB region	9.6	7.5	7.2	8.9	7.5	5.9	6.5	6.5	6.0
Ireland	9.2	7.5	8.2	8.2	6.6	5.9	5.9	6.3	5.5

Source: Central Statistics Office

Note: Since infant mortality rates are based on small numbers they are subject to random fluctuations. Thus, caution should be exercised in their interpretation.

Perinatal Mortality

Figure 4: Perinatal mortality rates by selected father's occupation in Eastern Health Board region 1992 (singleton births).



Note: The adjusted rate excludes all deaths due to congenital anomalies.

Figure 4 shows a gradient of increasing perinatal mortality rate with decreasing social class when adjusted rates are considered. The adjusted perinatal mortality rate excludes all stillbirths and early neonatal deaths due to congenital anomalies, and therefore to some extent removes those perinatal events where death was unavoidable.

Table 13: Perinatal mortality rates and stillbirth rates for EHB region 1988-1992.					
	1988	1989	1990	1991	1992
PNMR	11.3	10.2	10.7	9.1	8.8
Adjusted PNMR	8.4	7.6	8.2	6.5	5.5
Stillbirth rate	7.3	6.1	6.7	5.4	4.5

Source: Perinatal Statistics, Department of Health

Perinatal mortality rate = Number of stillbirths and early neonatal (during first week of life) deaths per 1,000 live and stillbirths.

Stillbirth rate = Number of stillbirths per 1,000 live and stillbirths.

The perinatal mortality rate for Ireland in 1992 (singleton births) was slightly higher, at 9.2, than the Eastern Health Board rate of 8.8. The corresponding figure for the European Union average was 8.1 in 1991. Studies from many countries have found perinatal and infant mortality to be closely linked with socio-economic background.

There has been a dramatic decline in infant, neonatal and perinatal mortality in Ireland since 1970. The factors which determine the level of perinatal mortality are complex: birth weight, gestation, parity, mother's age, social status, type of antenatal care, and many others.

Sudden Infant Death Syndrome (SIDS)

SIDS is a leading cause of death in babies aged four weeks to one year. Over a third (37%) of all deaths in this age group in Ireland in 1994 were due to SIDS. The decline in infant mortality rate in Ireland in recent years is primarily attributed to a drop in the post-neonatal mortality rate (deaths in infants over 28 days and under one year of age).

Suicide

Suicide, particularly among young people, remains an issue of concern. Table 15 details the suicide figures for children in the Eastern Health Board region for 1994 and 1996, with age and sex breakdown.

Table 15: Suicide deaths by age (10-14 and 15-19 years) and sex in EHB region, 1994 and 1996					
Year	Male		Female		Total
	10-14 years	15-19 years	10-14 years	15-19 years	
1994	1	3	0	3	7
1996*	0	3	0	4	7

Source: CSO Vital Statistics

*1996 figures are provisional

Congenital abnormalities

Table 16: Commonly occurring congenital abnormalities: comparison between 1980 and 1995, EHB region				
	1980		1995	
	Number	Rate per 10,000	Number	Rate per 10,000
Neural tube defects	124	46.9	21	11.4
Congenital heart disease	113	42.7	98	53.3
Cleft lip/palate	45	17.0	32	17.4
Chromosomal disorders	68	25.7	45	24.5
Down Syndrome	57	21.5	34	18.5
Limb defects	165	62.4	122	66.4

Source: Eurocat.

Note: Care must be taken in the interpretation of these figures because of small numbers - minor random fluctuations in numbers may result in wide variations in rates.

Neural Tube Defects

The most striking change in these figures between 1980 and 1995 has been the reduction in neural tube defects (Figure 5). Extensive research has highlighted the importance of folic acid in the prevention of neural tube defects. Since 1993, the Department of Health has recommended peri-conceptional folic acid supplements.

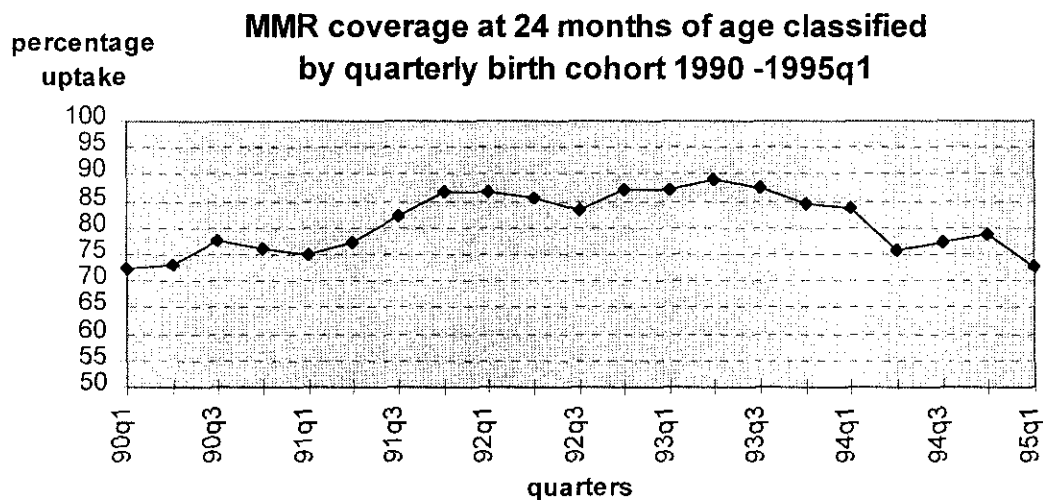
Under the Infectious Disease Regulations 1981 there is an obligation on the attending physician to notify to the health board cases of specified communicable diseases. It is well recognised in Ireland and in many other countries that there is considerable under-notification of these diseases. However the figures compiled are still important in indicating trends from year to year and in detecting excess cases and outbreaks. Table 17 lists the most frequently notified diseases for 1995 and 1996. It is important to note that measles, pertussis, rubella and mumps are all diseases which are preventable by vaccines which are delivered as part of the childhood immunisation programme in Ireland.

Congenital Rubella Infection

Rubella is important because of its ability to produce anomalies in the developing fetus. Congenital rubella syndrome (CRS) occurs in up to 90% of infants born to women who acquired confirmed rubella during the first trimester of pregnancy. Fetuses infected early are at greatest risk of intrauterine death, spontaneous abortion and congenital malformations of major organ systems.

The current recommended schedule of childhood immunisation includes measles/mumps/rubella (MMR) vaccine at 15 months with a second dose at 11-12 years. The second MMR dose was introduced for both sexes in 1993 - prior to this rubella vaccine was offered to teenage girls only. Rubella vaccine was included in this triple vaccine with the intention of interrupting the circulation of rubella amongst young children, thereby protecting susceptible adult women. The uptake rate of MMR vaccination falls short of the target of 95%.

Figure 6



It is important to ensure that all women considering pregnancy are aware of their rubella immune status. Data on rubella immune status of mothers, obtained from the national perinatal reporting system in 1992 (the most recent year for which statistics are available), showed that 1.6% of mothers are not immune to rubella, with a further 9% being of unknown immune status. The corresponding figures for the EHB are 1.1% and 6.5%.

The Eastern Health Board, in conjunction with the Rotunda Hospital, and with the support of Europe Against Cancer and the Health Promotion Unit of the Department of Health developed and implemented on a pilot basis a smoking cessation programme for pregnant women attending the public antenatal clinic at the Rotunda Hospital. The aim of the Rotunda Stop Smoking Programme was to encourage and support women to stop smoking in pregnancy and to maintain smoking abstinence after delivery. The study took the form of a randomised controlled trial. The study population was 418 women smokers attending the public ante-natal clinic for a first visit during a three month period in 1995. The intervention consisted of structured one-to-one counselling by the stop smoking facilitator, use of an information pack specifically designed for this programme, use of a carbon monoxide monitor, and stop smoking support groups.

The main findings of this project can be summarised as follows:

- There was a high participation rate in the programme at 88%
- There was a very high rate of smoking in the target population at 54%, and a low rate of quitting
- The study population was generally disadvantaged
- The programme showed some positive effects, although small, on smoking behaviour
- The long term effects are unknown
- The results indicated a high level of acceptability of the programme
- The materials were well received
- In general, the programme was successfully developed and implemented
- The experience of this programme will be of benefit in improving the programme for future use

Accidental Childhood Poisoning

Accidental poisoning of children by medications and household products remains a major cause of suffering. Surveys at one children's hospital in Dublin showed no change in the incidence of poisoning over the 15 year period from 1975-1989. Child Resistant Containers(CRCs) were found to be infrequently used or involved in children presenting to hospital with accidental poisoning (Gill, 1990).

A review of national Hospital Inpatient Enquiry Data (HIPE) for 1993 showed that there were 990 hospital admissions among children under the age of 5 due to poisoning. HIPE data of the Eastern Health Board (EHB) region for 1993-1995 showed that over 200 children under the age of 5 were admitted for each of these years due to poisoning (Table 18).

Table 18: Hospital Admissions as a Result of Poisoning in children under 5 years, EHB, 1993-1995			
	1993 No. (%)	1994 No. (%)	1995 No. (%)
Male	128 (55.9)	156 (60.2)	118 (52.0)
Female	101 (44.1)	103 (39.8)	109 (48.0)
Total	229 (100)	259 (100)	227 (100)

There is substantial evidence that the introduction of CRCs in other countries was accompanied by a reduction of childhood poisoning but it is evident that a professional requirement for their use rather than a voluntary code is needed to achieve results. One study showed that CRCs can reduce the incidence of accidental poisoning to less than 15% of former levels (Scherz, 1970).

The cost of CRCs

CRCs are not expensive. The price list from one major Irish supplier of medicine containers indicate that the CLICK-LOCK child resistant caps cost between £5.50 and £7.15 per 100 depending on size.

Conclusion

The use of CRCs on all oral medicines not already in protective packaging represents best practice, will lead to a substantial reduction in the incidence of accidental poisoning and consequently to real health and social gain for children. CRCs provide the most consistent and cost-effective method of prevention.

Recommendations

This Review strongly recommends that:

1. All oral medicines not already supplied in a blister pack or CRCs should be dispensed by pharmacists in a CRC. This should become a professional requirement.
2. All other agencies which dispense medication e.g. Health Board clinics and dispensing doctors should also be required to supply medicines in a CRC.
3. Methadone should always be supplied in a CRC.
4. Health promotion efforts should continue to ensure parents are aware of the dangers of medicines and to ensure that medicines are stored safely.

Poverty, deprivation and social exclusion

Towards the end of the 1980s the concept of poverty was gradually supplemented with the concept of social exclusion as it became obvious that the emerging problems were not only related to a lack of material wealth, but to various phenomena characterised by a weakening of attachment to the labour market, a weakening of family ties and informal networks, and a weakening of the access to human rights and participation in society (Fridberg, 1995).

The following concept of poverty was outlined in the decision of the Council of the European Communities in 1984: "The poor shall be taken to mean persons, families and groups of persons whose resources (material, cultural and social) are so limited as to exclude them from the minimum acceptable way of life in the Member States in

	D.E.D.	%with GMS card
Community Care Area 2	Royal Exchange A	75.2%
	Royal Exchange B	55.8%
	Wood Quay A	59.9%
Community Care Area 3	Merchant's Quay A	68.6%
	Ushers B	53.3%
	Ushers C	53.8%
	Ushers E	51.6%
Community Care Area 4	Tallaght Fettercairn	51.9%
	Tallaght Jobstown	73.9%
	Tallaght Killinardan	58.2%
Community Care Area 5	Cherry Orchard C	59.5%
	Clondalkin Rowlagh	53.1%
	Kilmainham A	51.6%
	Kylemore	52.1%
Community Care Area 6	Arran Quay C	69.7%
	Arran Quay D	51.1%
	Blanch.-Mulhuddart	53.1%
	Blanch.-Tyrrelstown	74.6%
	Inns Quay C	55.4%
	Rotunda B	51.6%
Community Care Area 7	Ballybough A	61.5%
	Ballymun B	55.2%
	Ballymun C	53.3%
	Ballymun D	69.5%
	Mountjoy A	66.5%
	Mountjoy B	65.2%
	Rotunda A	59.6%
Community Care Area 8	Priorswood B	60.7%
	Priorswood C	75.7%
Community Care Area 9	Rathangan	59.5%
Community Care Area 10	Ballyarthur	57.2%
	Bray No. 1	58.0%
	Humewood	50.6%
	Rathmichael (Bray)	62.6%

No D.E.D. in Community Care Area 1 had 50% or more of its population with medical cards. (Note: this analysis is based on coding of approximately 90% of GMS addresses for Dublin D.E.D.s and less for Kildare and Wicklow).

Table 20: Number of persons on the live register in EHB region by county, December 1996.							
	Male			Female			Total
	<25 years	>25 years	Total male	<25 years	>25 years	Total female	
Dublin	12,000	40,828	52,828	8,356	22,365	30,721	83,549
Kildare	1,052	3,553	4,605	910	2,349	3,259	7,864
Wicklow	930	3,805	4,735	628	2,210	2,838	7,573
Total EHB	13,982	48,186	62,168	9,894	26,924	36,818	98,986

Source: Department of Social Welfare

Table 21: Number of persons in EHB region in receipt of selected social welfare payments by county, December 1995 and December 1996.				
County	Family income supplement		Illness benefit*	
	1995	1996	1995	1996
Dublin	2,041	2,254	28,999	29,377
Kildare	418	432	2,690	2,869
Wicklow	379	403	2,161	2,223

*This category covers Disability Benefit, Invalidity Pension, Injury Benefit and Interim Disability Benefit.

Source: Department of Social Welfare

Table 22: Children assisted in each Community Care Area in 1996 by the Back to School Clothing and Footwear Scheme		
Community Care Area	Number of children assisted*	% children <18 years
1	4,480	13.0
2	3,700	15.0
3	4,187	17.9
4	13,809	27.2
5	12,082	31.6
6	11,601	26.9
7	10,069	34.2
8	11,513	18.1
9	7,862	17.6
10	7,990	24.1
Total	89,625	23.2

*The figures for "children" include some individuals up to 22 years of age. However, approximately 98% are under 18 years of age. The denominator used was age breakdown from census 91.

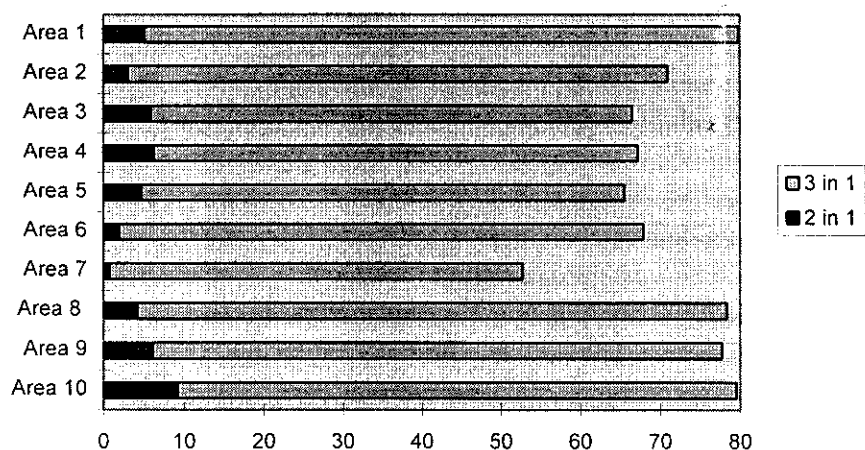
Chapter 2

Child Health Services

Primary immunisation programme

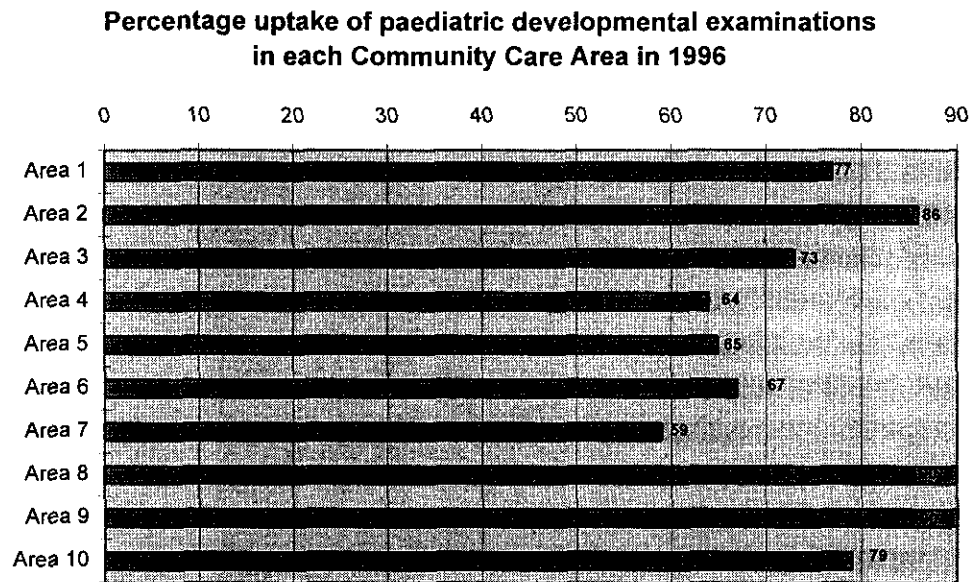
The recommended schedule for the primary immunisation programme is that babies receive their 3 in 1 (diphtheria, pertussis and tetanus), polio and Hib immunisations at two, four and six months of age. Uptake of this programme by babies born in the first quarter of 1996 is shown in the following figure:

Percentage uptake of 2 in 1 and 3 in 1 immunisation at 12 months of age by babies born in the first quarter of 1996 in each Community Care Area



Overall the combined uptake of 2 in 1 and 3 in 1 for the region for this birth cohort was 71%.

In addition, measles, mumps and rubella (MMR) vaccinations are given to babies at fifteen months; the uptake rate of these vaccinations is calculated at three years of age and this is shown in the following figure:



Uptake in Areas 8 and 9 is strikingly high at 90% and in Area 2 at 86%. However, in Areas 4, 5, 6 and 7 the uptake rate drops to 59%-67%. These uptake figures - and those for immunisation - represent the challenge which social exclusion presents to health services. Strategies to increase health gain must be targeted specifically towards the socially excluded from a very young age.

There was a wide variation between Areas in the percentage of babies being found at these examinations to require further attention. This ranged from 14% in one Area to 67% in another; the average for the region being 30%. This variation requires attention.

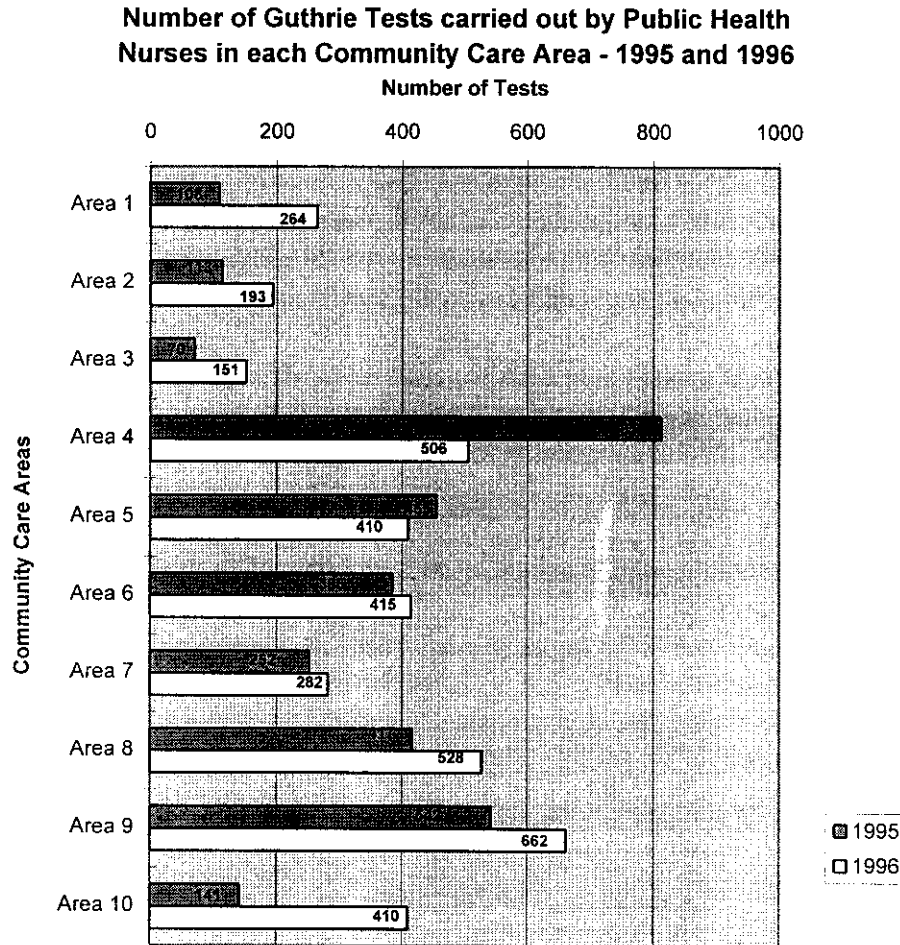
School medical examinations

During 1996, 513 schools were visited as part of the school medical examination programme. During these visits, 24,417 children were examined. Nowadays, these examinations tend to be more strategically targeted; children whose health is causing concern to the parent or teacher are examined rather than the previous universal screening.

Vision and hearing screening

Screening for vision and hearing difficulties is carried out in schools by Public Health Nurses. During 1996, the number of such tests carried out in the region increased as can be seen in the following figure:

placed on a special diet in order to prevent mental handicap; if the baby is found to have the condition (PKU) it is essential that the diet is begun as soon as possible. Now that babies are being discharged much earlier from maternity hospitals than was previously the case, many are discharged before the test is carried out. The responsibility for administering the test then falls to Public Health Nurses. The number of tests carried out by Public Health Nurses in 1996 increased by almost 16% on 1995 as is shown in the following figure:



It can be seen that although Areas 4 and 5 experienced a decrease in the number of tests carried out, there was an increase in every other Area, most notably in Area 10 where a 190% increase was experienced. These tests represent considerable workload and responsibility for Public Health Nurses. This Review recommends that ways of ensuring that more babies are tested while still in hospital are explored.

Child Care Act

A number of Areas report that the Child Care Act has increased requirements for court reports and court appearances. There have been increased numbers of referrals to the Public Health Nursing service of child protection and child welfare concerns. The number of case conferences to be attended has increased as has the rate of visiting to vulnerable families who require support and monitoring. Senior Public Health Nurses

Chapter 3

Speech And Language Therapy Services

Overview of services

Speech and language therapy involves the assessment, diagnosis, management and treatment of a wide range of disorders of communication. These include problems in language comprehension and expression, speech, voice and fluency. Therapists may also be involved in the evaluation and treatment of disorders of swallowing and feeding.

Up to 14% of children have delays in speech and language development. These range from mild developmental problems to severe impairments, which make it difficult or impossible for the child to cope with the communication demands of the normal school environment.

In addition, many children with special needs have communication problems associated with their primary handicap. For example Irish studies indicate that 71% of children and adults with learning difficulties (mental handicap) have communication disorders. 40% of children with a physical disability and a high percentage of children with sensory impairments, cleft lip and palate and autistic spectrum disorders also have significant communication problems.

Speech and language therapists play an important role in the prevention and early detection of communication problems. This may involve education of the general public and specific groups such as parents, teachers and other health professionals, through talks and seminars, provision of appropriate literature and input to in-service training. Therapists may also be involved in the clinical training of undergraduate therapists by providing clinical placement and clinical supervision.

In 1996, in addition to ongoing educational input, a specific campaign of public awareness was organised by Speech and Language Therapists' professional bodies throughout Europe. Therapists in this region provided a range of activities for Speak Week, including information days for parents, workshops for teachers and other professionals and provision of information leaflets.

In the region, each Community Care Area has a minimum of 4 speech and language therapists, including a Principal who has responsibility for the development, co-ordination and delivery of the service within the Area. In Areas where there are 6 or more therapists, Senior posts have recently been approved, in most cases in an acting capacity. These posts allow the Principal to delegate some administrative duties and to share responsibility for staff support. In addition there are Specialist Senior posts

Table 24: Age of children referred for speech and language therapy in 1996		
Area	No. of children aged 0-4	No. of children aged 5-18
1	142	162
2	229	95
3	166	90
4	157	215
5	223	142
6	293	184
7	148	156
8	439	180
9	266	254
10	215	144

Of the total referrals, just over 57% were aged 4 and under. There is a significant difference in referral patterns between Areas. For example, referrals of children aged four and under amount to 70% of referrals in Area 2, over 61% in Areas 5 and 6 and almost 63% in Area 8. In Area 1, 53% of children referred were aged over 4, while in Area 4 almost 58% of referrals were in this age group.

There is a continued increase in referrals of children in the school system from Department of Education Psychologists. Facilitation of referrals from teachers and parents might result in earlier referral of some of these children. The increase in referrals from other agencies has also continued. For example children with cleft lip and palate, who were previously seen in Temple Street Hospital, are now being referred out to the community following assessment.

In some Areas there is a continued increase referrals of adolescents with significant language difficulties, often associated with reading and written language problems and school failure.

Assessment and Intervention

The waiting time for assessment is still over a year in many Areas, and up to 22 months in some clinics. Following initial assessment many children are then placed on a waiting list for intervention.

Most Areas operate a system of screening the waiting list at set intervals – twice or three times a year. Children are seen for assessment to diagnose their communication problem and to determine its severity. Problems are rated mild, moderate or severe on a range of standardised assessments or rating scales. Children are then placed on a waiting list for therapy, those with severe problems are placed on a priority list for intervention.

severe difficulties. In many cases the length of time between treatment blocks can be several months.

Language Unit and Classes

This service provides assessment and intensive input to children with severe receptive and expressive language problems and severe speech problems. The Language Unit in Ballinteer provides a specialist service to 30 children up to the age of 6 years. Staff include speech and language therapists, teacher and child care worker. Seven Language Classes in Tallaght, Churchtown and Drumcondra provide a specialist service for 56 children of primary school age. These classes are located in normal primary schools and are staffed by teachers and speech and language therapists. A post primary service for children with severe language problems in Ballinteer Community School is now in its second year.

In Tallaght an intensive service is provided for children from the community, who are awaiting placement in the Language Classes, or whose application for Language Class placement was unsuccessful, due to the demand on places.

Plans for the development of a Pre-school Language Unit and an additional Language Class on the north side are currently in progress.

Service developments

During the year a number of Areas have run Hanen Programmes for parents of children with severe language and /or learning difficulties. These groups are generally run in the evenings to facilitate attendance by both parents.

The WILSTAAR (Ward Infant Language Screening Test Assessment, Acceleration, Remediation) will be introduced on a pilot basis in Area 8 in 1997. The aim of WILSTAAR is to provide a beneficial cost effective means of early identification, classification and treatment of children with language difficulty, whether associated with listening difficulties or not. Early identification is facilitated by screening infants under one year. In Area 8 the pilot project will involve two speech and language therapists providing one session per week to the Edenmore area. Area Medical Officers will administer a screening questionnaire to all infants attending for their nine month developmental examination. Speech and language therapists will score the questionnaires and issue appointment letters to carers of all infants who do not pass the screening. These babies will be assessed by speech and language therapists during a home visit and those presenting with receptive and or / expressive language delay, with or without associated listening difficulties, will be invited to take part in a remediation programme in order to accelerate the baby's language development. All remediation will be carried out in the child's home, with an average of four post-assessment visits over a four month period.

The potential benefits of WILSTAAR include prevention of educational, social and emotional difficulties associated with delayed language development, a reduction in the need for long term speech and language therapy intervention and therefore a

Computerisation

The pilot phase of the system is now completed and most Areas are now on the system. The remaining Areas will be linked in shortly. Statistical data will be available for all Areas for 1997. Forms have been devised to facilitate input of data. Provision of clerical support to input waiting lists etc. is strongly recommended.

Psychological Services

A significant percentage of children with speech and language problems require psychological assessment to ascertain their overall level of cognitive functioning and to determine placement needs. The provision of psychological services varies across Community Care Areas. For example Area 1 has 6 sessions per week, while Area 2 and 3 each have 2 sessions per week.

Most Areas report an increased waiting time for psychological assessment, with waiting lists of over a year. In some cases children miss out on the opportunity to avail of specialised placements – for example in the Language Unit or Classes - because they do not have a psychological assessment.

Within Kildare access to the service is inequitable. Clients with learning difficulties have access to services in South Kildare, while those who are not in the learning disabled range do not have access to an educational psychologist. Children who require psychological evaluation for placement, for example in a Language Class, have to have private assessments arranged.

Audiology / E.N.T service

Provision of an adequate audiology service for children with speech and language problems is very important. In all cases it is important to rule out hearing impairment before intervention begins, as the nature of intervention will be very different if a child is diagnosed as hearing impaired.

In most Areas access to audiological services has improved, however access to E.N.T. clinics remains a problem. There are long waiting lists for out-patient appointments and when children have been assessed as needing grommets, they often have to wait a year for the procedure.

Needs of Specific Client Groups

Some client groups have difficulty in accessing services as they are currently provided. Travellers needs are not adequately served in many Areas and this group often have difficulty in availing of appointments in conventional clinical settings. Area 4 therapists are currently looking at providing services to travellers within schools.

Chapter 4

Dental Services

There was no waiting list for children requiring dental treatment in the region during 1996. The following groups of children are eligible for treatment:

- pre school children
- children attending national schools
- children under fourteen years who have attended national school
- dependants of medical card holders up to sixteen years

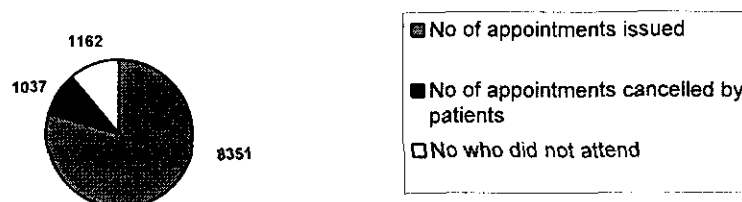
Dental services for children are delivered in a structured manner by targeting children in second, fourth and sixth classes in national schools. Routine dental treatment is provided for national school children following a school-based screening which is carried out in second, fourth and sixth classes. Routine treatment may contain a preventative element as well as any restorative care which is necessary. This structured, targeted approach to treatment allows services to be delivered on the basis of need.

Emergency services are available for eligible children without appointment, at any clinic during opening hours. An emergency can include any concern or need for advice a parent has regarding any aspect of the child's dental health.

In the past, dental staff were allocated to areas on the basis of demand from those areas. However, a report on children's dental health in the region (Eastern Health Board 1994) showed that children living in disadvantaged areas had higher levels of disease than those in the general population. Because of this, staff have now been redistributed between areas on a more equitable basis, allowing resources to be allocated within areas to take account of the needs of deprived groups. It is hoped to conduct a survey of children's dental health during 1997 to evaluate the re-orientation which has taken place. Where resources permit, children in senior infant classes of schools with particularly high caries rates are screened with a view to the provision of preventative services. Children identified in second or fourth classes as having a special dental need are also seen more frequently.

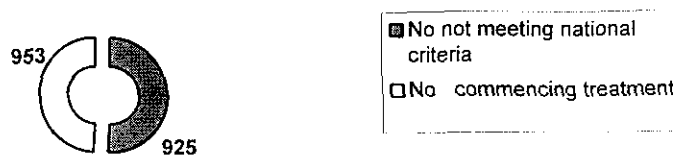
The identification of special needs groups within the population has been completed by the dental service and the enhancement of treatment services to these groups has commenced. A pilot project is in operation in one Area in conjunction with Pavee Point and the local Public Health Nurses to improve dental services for Travellers. This multi-disciplinary approach has been greatly facilitated by the services of a dental health educator. The appointment of such educators to the other dental areas would help to promote a similar multi-disciplinary approach across the Board's region. The role of the dental hygienist who work under the supervision of the

**Appointments offered for orthodontic treatment in EHB region
Sept-Dec 1996**



The figure below reflects the disparity between demand and need in the orthodontic service where 953 individuals were found not to meet the national need criteria:

**Outcome of orthodontic assessments in EHB region
Sept-Dec 1996**



(It should be noted that in addition to the above, 51 others are about to complete treatment while the remainder are under review.)

Chapter 5

Drug Misuse

"One fact which is not in dispute is that incidence of drug misuse is occurring more and more frequently among younger people".

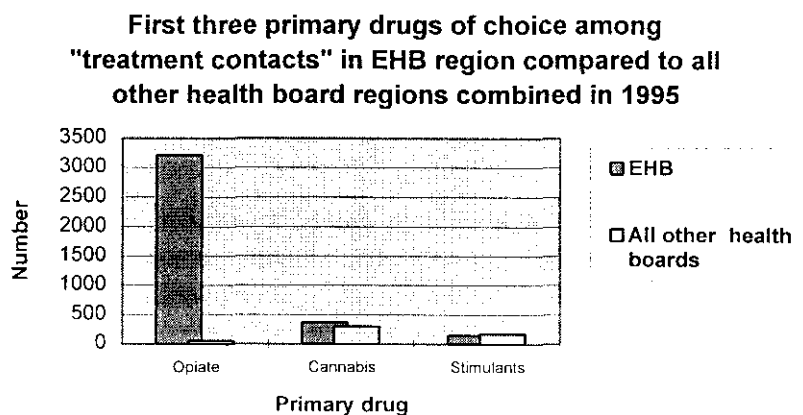
Ministerial Task Force (1996)

Incidence

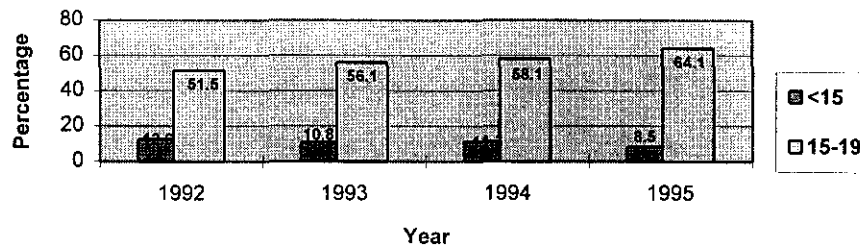
The most comprehensive data relating to drug misuse comes from the Health Research Board (1997) and it is their figures which are used in this chapter. It should be noted that these figures relate only to cases presenting for treatment (or "treatment contacts") - not to persons. The incidence of drug misuse in the region is not known. The report of the Ministerial Task Force (1996) pointed out that the numbers receiving treatment in 1995 amounted to 3,593 but, as the report points out: *"There is little doubt that the numbers actually misusing drugs is likely to be greatly in excess of this figure"*. (p25).

Heroin

It has been said that Dublin is experiencing a "heroin epidemic" and this is borne out when figures from the Eastern Health Board region are compared to those from all other health boards combined. (Health Research Board 1997). The following figure demonstrates the difference clearly, showing as it does the first three primary drugs of choice among those presenting for treatment nationally in 1995 (the most recent figures available):

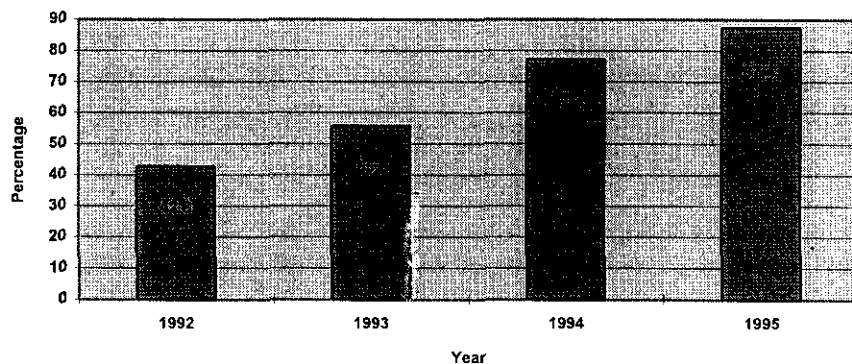


Age at which primary drug was first used in Dublin 1992-1995



When these young people begin to misuse drugs, it is to heroin which they turn:

Percentage of teenage "treatment contacts" for whom opiates were the primary drug in Dublin 1992-1995



Impact upon communities, families and individuals

While quantitative information is provided by the Health Research Board, qualitative information on the personal impact of drug misuse comes from *Dealing with the Nightmare* (1997). Here, the authors interviewed a small sample of drug misusers in a south inner city area, the families of drug misusers and service providers who speak of the high price which families and communities pay for drug misuse:

"Families are rotting away." (p54)

As the authors remark:

"The drug problem contributes to continuing marginalisation of the community, continuing the very cycle that has fostered the situation. It is extremely difficult for a community with such high levels of social exclusion and deprivation to fight back." (P53)

As one person in the area succinctly describe it:

"In (area), the bank moved out and the undertakers moved in". (p54)

Legal framework: Unlike health service provision for those aged over eighteen, parental consent is required when a young person is still a teenager. In many cases, young people do not agree to their parents being made aware of their drug misuse, particularly when they are misusing opiates. In the region, it is the policy of the Eastern Health Board that parents are involved in the treatment process as experience in other services has shown that parental involvement improves outcomes.

Project for adolescents at risk of heroin dependency: During 1996, one programme began in the north inner city for young people who are dependent or at high risk of dependency on opiates. The programme engages each young person for six months with a commitment to follow-up involvement in the project, further education or training. Occupational, recreational, educational, therapeutic and medical intervention is provided. The programme will be evaluated to determine its effectiveness.

Outreach programmes are experiencing difficulties in engaging adolescent heroin misusers. All programmes have a greater acceptance of intervention from misusers in their twenties and thirties; adolescents are reluctant to participate and when they do engage, their drop out is higher than from other age groups.

Detoxification: Through the development of community-based responses to drug and further steps towards integration between Trinity Court and the Eastern Health Board, the number of places available for outpatient detoxification increased in 1996. In that year, 94 young people aged under eighteen had outpatient detoxification. The Eastern Health Board is ensuring that outpatient follow-up and rehabilitation is available for those people who undergo outpatient detoxification. Seven young people under the age of eighteen were admitted to Cuan Dara for inpatient detoxification during 1996.

Chapter 6

Child and Adolescent Psychiatric Services

Child and adolescent psychiatry services provide an extensive range of services to clients experiencing psychiatric illness, psychological difficulties and inappropriate behaviour. These services are provided in partnership with the Mater Hospital Child and Family Services and the Hospitaller Order of St. John of God and are co-ordinated through the Child Psychiatry Co-ordinating Committee.

In order to provide cohesion to these arrangements, the senior managers from the three services have joined in a Central Co-ordination Committee which meets on a monthly basis to review and co-ordinate the services. These meetings are chaired by the Programme Manager of the Special Hospital Care Programme of the Eastern Health Board. A Director of Child Care and Family Support Services is responsible for liaison and co-operation between the Community Care Programme and child psychiatry services.

Service providers and their catchment areas are shown in the following Table:

Table 25: Provision of Child & Adolescent Psychiatry Services in EHB region showing service providers and their catchment areas		
<i>Service Provider</i>	<i>Catchment Area</i>	<i>Funding Body</i>
Eastern Health Board	Part of CC Areas 3 & 4 (inner city)	Eastern Health Board
	CC Areas 5,6 & 9	
Mater Child and Family Services	CC Areas 7 & 8	Eastern Health Board
Hospitaller Order of St John of God	CC Areas 2, 3 & 4 (excluding part inner city)	Department of Health
	CC Areas 1 & 10	Eastern Health Board

Consultant child and adolescent psychiatrists from the Eastern Health Board provide liaison services to the National Children's Hospital, Harcourt Street, Children's Hospital, Temple Street and Our Lady's Hospital for Sick Children, Crumlin.

Stillorgan, Co Dublin. The development of an intensive "assessment and statementing" service in this complex is gradually evolving. Interviews for some of the key personnel necessary for this planned "centre of excellence", which will include staff training and research, are in progress.

In-patient Care: In-patient care is arranged as follows: St Paul's in Beaumont (Mater) provides specialist residential accommodation on a national basis for autistic children and mentally handicapped children with major behavioural problems. A group home has been purchased at Farmleigh Park, Stillorgan which is adjacent to the Beechpark site, replacing James Connolly residential service and providing supported residential accommodation and respite care. On the northside of Dublin, an acute need exists for inpatient care, particularly for self-destructive and seriously disturbed and mentally ill adolescents.

Table 28: In-patient child and adolescent psychiatric provision in EHB region	
<i>Eastern Health Board</i>	<i>Mater Child & Family Services</i>
Warrenstown House Courthall Farmleigh Park Dromheath Avenue, Mulhuddart	St Paul's, Beaumont

Warrenstown House is an acute unit which also provides assessment facilities. The remainder of the units provide residential care for chronic psychotic and autistic children.

Parenting Skills Programme

Among the many psychology services provided to children and adolescents, the Eastern Health Board provides a parenting skills training course which focuses on the promotion of effective parenting and the prevention of child and family difficulties.

In 1996 a total of 302 parents participated in the course with an attendance of 94%.

Service developments

In 1996 new programmes and a home support and counselling service were provided at Beechpark, Stillorgan. The centre, with the support of the Department of Health, is now evolving as a major centre of excellence for persons with autism.

The residential centre at Warrenstown House was refurbished and upgraded in 1996 and was further enhanced with the provision of a purpose built out-patient department.

Chapter 7

Traveller Children

Research has identified Travellers as a group whose health and social status is far less than that of the general population. Because of this, the Eastern Health Board has specific services which aim to provide Travellers with acceptable services which will meet their health and social needs.

The Eastern Health Board's mobile clinic continued to focus on health promotion and preventative health care during 1996. Visiting 41 sites on a regular basis, a service was provided to 2,115 mothers and 2,642 children under 5 years of age. An immunisation service was provided and 1,361 vaccinations were given. 87 paediatric developmental examinations were carried out.

Work continued on developing an improved child health record card for retention by Travellers, for use in 1997. Containing information on hospital and general practice visits together with a developmental record of each child, the record, because of the high mobility of Travellers, will enable immediate access to health information by health professionals in all parts of the country. The Community Mothers Programme continued to be provided on some halting sites.

The Eastern Health Board funds Travellers Family Care which provides residential and foster care services for vulnerable traveller children and their families. An independent review of services for Travellers was commissioned by the Board and will be completed in 1997. This will enable the Board to implement the recommendations of the Task Force Report on Travellers.

St Columba's school and day care centre in the inner city provides day programmes for children of the most marginalised Traveller families. Sixty Traveller children attend St Columba's each day; along with education, meals, washing facilities and recreation programme.

Ballyowen Meadows, the Travellers Families Care residential centre which is funded by the Eastern Health Board, underwent major refurbishment and extension during the year. Along with residential care for Traveller children, the centre will also provide family assessment and day support. The Shared Rearing Project, which is associated with Traveller Family Care, recruits Traveller families to foster Traveller children.

The Community Mothers Programme has been extended to the Traveller community. An evaluation of this service which was completed in 1996 demonstrated positive effects for Traveller families engaged in the Programme.

Research shows that the infant mortality rate among Travellers is nearly three times the national average; whereas recent finding would seem to indicate that the rate of cot death, or sudden infant death syndrome (SIDS) is nearly six times the national average.

In 1987 the ESRI published its survey of income distribution, poverty and usage of state services which showed that the relative position of families with children had significantly deteriorated over the previous two decades. The study showed that families with children, particularly large families, face a higher risk of poverty than other households. The ESRI findings were shocking for a society which sees itself as child-centred because it showed that children in general face a higher poverty risk than adults. The seriousness of these findings for Travellers can be shown when it is examined in conjunction with an earlier ESRI report which stated that:

"(Traveller) family size varied from one to nineteen persons, and averaged 6.1 persons....By comparison average family size in the national population was 4.3" (ESRI Paper No 131)

It is significant that in 1997, designated European Year Against Racism by the European Union, we in Pavee Point have been invited to make a contribution to the review of child care and family support services. In Pavee Point we would argue that many of the problems Travellers face are the direct result of the racism, whether conscious or unconscious, that sedentary people mete out to Travellers.

We believe the UN Convention on the Rights of the Child is a particularly significant document for Traveller Children:

- Article 2 highlights the need to ensure that all children enjoy their rights without discrimination, irrespective of race, colour, sex, language, religion, political or other opinions, national, ethnic, or social origin, property, disability, birth or other status.
- Article 6 states that every child has the inherent right to life, survival and development.
- Article 8 emphasises the parents' primary responsibility for a child's upbringing, but States shall provide them with appropriate assistance and develop child care institutions and services.
- Article 19 requires States to protect children from physical or mental violence, abuse or neglect, including sexual abuse or exploitation.
- Article 24 entitles the child to health care, emphasises preventative measures, health education, appropriate pre-natal and post-natal health care for mothers.
- Article 27 recognises the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Chapter 8

Early Childhood Support and Intervention

The health and social status of individuals is determined by their income level and social class (DHSS 1980). According to Ben-Shlomo and Davey Smith (1997) health increases steadily as one rises through the social hierarchy and:

“Poorer sections of society are more likely to die at a younger age, suffer from more acute and chronic diseases and generally feel less able to partake in healthy living”.

Income level and social class in turn are determined by education. The above authors point out that:

“...education provides one of the few ways of escaping the poverty trap and breaking the chains of disadvantage.”

The authors conclude that:

“educational interventions targeted at high risk populations may have long term benefits.....”

The Perry pre-school study allocated children to either pre-school or no pre-school intervention and followed them until age 27 when it was found that:

“Those allocated to the active intervention were on average more likely to be earning more money, be a homeowner, or a high school graduate, and less likely to have had contact with social services or have had five or more arrests.”

The Eastern Health Board is committed to the development of early intervention services, particularly in areas of acute disadvantage since, as Ben-Shlomo and Davey Smith point out:

“Evidence exists that both intervention programmes in infant, pre-school and school settings can have positive impacts on cognitive development, social emotional development and coping skills. Such outcomes are likely to be associated with both adult health behaviours and risk of morbidity.”

The developmental effect of involvement in the Programme on the visiting Community Mothers continued to be seen: two thirds availed of second-chance education and training. One third of the mothers who were visited also availed of such opportunities. A number have stated that it was contact with the Programme which gave them the confidence to become involved in adult education.

Monitoring of the Programme in 1996 showed that 52% of the parents being visited were lone parents and that the Programme achieved improvements for children in factors such as infant feeding, immunisation, and early reading (90% of parents started reading to their infants during the first year of life). In addition, 90% of Programme infants completed their immunisation schedule during the year.

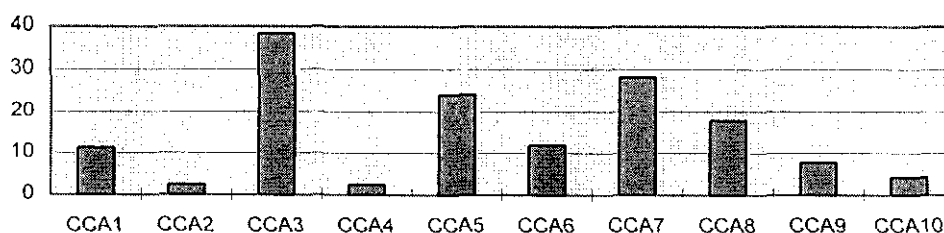
In 1989, a major evaluation of the Programme was undertaken which showed significant gains for children and mothers. Since these children are now aged approximately nine years old, a follow-up case/control study is being undertaken as recommended by this Review, to determine if these early gains have been maintained. The areas which will be examined are: health; nutrition; socialisation; education; child rearing practices; parental school involvement and maternal self-esteem.

Nurseries

A continuum of service provision to meet the needs of children and families is vital in order to meet their varied needs and nursery provision plays a key role in this continuum. Along with day care, nurseries can often be the location also for additional initiatives such as after-school intervention, afternoon programmes, mother and toddler groups, toy libraries and individual work with particular parents and their children. Staff in Eastern Health Board funded nurseries have early childhood qualifications in child care, Montessori education or in nursery nursing.

Providing equity of access to services is an important thrust of the Health Strategy. Alongside this, is the imperative to provide greater support services to districts which are experiencing social and economic deprivation. Bearing this in mind, the following figure shows that provision of nurseries in the region has not yet achieved an equitable status:

No of nursery school places per 1,000 child population in each Community Care Area in 1996



Chapter 9

Child and Family Support and Intervention

It is the policy of the Eastern Health Board that a range of family support services should be available in all Areas, particularly those experiencing acute deprivation. As pointed out in this Review last year, quoting Gibbons (1990):

There is a large literature on the importance of social support in mediating the effects of stress and preventing adverse physical and mental reactions to it. Social support...may have a direct influence on individuals' mental and physical health; or it may have a "buffering" effect against stress, so that those with adequate social support are more able to weather adverse life events. In that case, if family support projects were available to families under stress, they should be more able to cope, and less likely to develop serious and continuing personal problems" (p15).

In addition to early childhood support (addressed elsewhere in this Review), family support services include:

- Family Resource Centres
- Homestart
- Neighbourhood Youth Projects
- Family Centres
- Child Care Workers in the Community
- Family Support Workers

In 1996, the Eastern Health Board allocated an additional £600,000 for additional development of new family support services in deprived communities. These included:

Aosóg, North West Inner City

The north west inner city encompasses an area from Capel Street to Infirmary Road and from North Circular Road to the Liffey Quays. At its heart is the historic Stoneybatter area. The current population is approx 18,000. The area does not have the array of services and facilities which other inner city areas have developed. It has witnessed rapid economic changes in recent years but these changes have not been matched by the development of community infrastructure and supports.

The area is one of high unemployment and high rates of social welfare dependence. There is a high percentage of families with very young children coupled with high numbers of young school leavers. An average of 15% of young children in the area have poor and irregular school attendance.

service and will develop linkages with local agencies such as Barnardo's, Dun Laoghaire Youth Service, Community Mothers, FÁS, resource centres and the Southside Partnership. It is hoped that these linkages will help in the selection, recruitment and training of staff. The first group of workers will be trained and available for work with families by Autumn, 1997.

St Benedict's Child and Family Project, Kilbarrack

Located within St. Benedict's Resource Centre, this project developed from a FÁS/CE scheme which identified children at risk in the Kilbarrack area. These children experienced a combination of the following factors:

- physical abuse, neglect and underlying malnourishment
- behaviour problems: hyperactivity, attention seeking behaviour, apathy
- educational difficulties: low levels of literacy and poor concentration in comparison to peers
- parental difficulties with management and discipline
- poor supervision of children at play and lack of safe, supervised playing facilities

To address these needs, the Eastern Health Board has established a Child and Family Project which is based on the model of Neighbourhood Youth Projects. Its aims and objectives are to

- enable children remain in their families and community while receiving skilled help and support
- provide resources to assist and motivate the community to define and meet the evolving needs of its young people
- develop approaches to working with children and parents which are appropriate to their needs and to help them cope better with their particular circumstances

The project seeks to fulfil these aims by assessing the needs of children and their parents and designing programmes to meet these needs through individual, sibling and group work and through creative, educational and recreational activities. Intensive support will be given to families through home visits, group work and therapy. Liaison with schools, local drug treatment projects and other services will take place. It is hoped that the project will help the local development of clubs and recreational both for the benefit of the locality and to enable children in the project to move on.

An advisory group of those living and working in the area has been established, its members including representatives from the community and from voluntary and statutory agencies. A manager for the service has been appointed and renovations to the premises are underway. Liaison with the local Area's Family Support Service is

Chapter 10

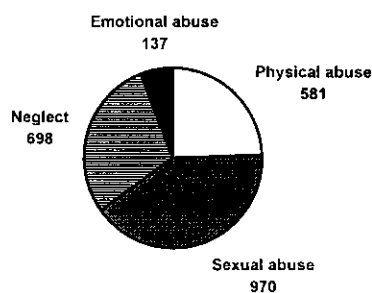
Child Abuse

The rise in the number of cases of suspected child abuse being reported in the Eastern Health Board region in recent years continued in 1996 as can be seen in the following figure:



Reports of cases of suspected child sexual abuse outnumbered those in other categories as the following figure shows:

Categories of child abuse reported in EHB region in 1996



Numbers of suspected cases being reported varied widely across the region. As the following figure shows, Areas 4 and 5 had the highest numbers of referrals:

A series of initiatives will therefore be brought forward to improve the responsiveness of the care services to the needs of children. A Social Services Inspectorate is being established which will facilitate improved service provision and child care practice. A National Children's Council will be established to facilitate the co-operation of the voluntary and statutory sector and consideration is being given to the establishment of an Ombudsman for Children to promote the rights of children and to ensure the responsiveness of services to the needs of children.

With regard to mandatory reporting of child abuse, the document acknowledges the many submissions which were made in response to the consultative document and the consultative forum which was also held. The majority of submissions did not view that the introduction of mandatory reporting would provide greater protection to children or improve the child care services.

"There was widespread agreement that further development of our child care services is required to ensure that children and professionals can report abuse in the knowledge that appropriate investigation, treatment and support services are available to victims. The idea of improved co-operation and co-ordination between professionals and agencies as a means of addressing the problems that currently exist in relation to the reporting of child abuse received much attention and support". (p11).

The initiatives which were proposed in the document in order to ensure increased protection for children and improvements in the child care services are as follows:

- *"Designated officers in the health boards to co-ordinate inter-agency approaches to child protection at community care level*
- *Regional and Local Child Protection Committees, operating at health board and community care area level, to enhance inter-agency and inter-professional approaches to child protection*
- *Multi-disciplinary training, under the aegis of the Regional Child Protection Committees, to increase enhance inter-agency and inter-professional approaches to child protection*
- *The new Social Services Inspectorate to review the 1987 Child Abuse Guidelines and the procedure for the Notification of Suspected Cases of Child Abuse between Health Boards and Gardai*
- *A public information campaign to heighten public awareness of child abuse and of the system to respond to cases of child abuse*
- *The provision of support services by health boards to victims of past abuse*
- *Funding of voluntary agencies dealing with children to be conditional on procedures being in place to deal with allegations of child abuse*
- *Evaluation of the impact of the above measures on the reporting of child abuse"* (p14)

initiatives such as these will facilitate joint working and closer liaison in future and will help to ease some of the difficulties which have emerged such as geographical boundary problems. One Community Care Area for example, has no less than five Garda Superintendents with whom they must liaise and have experienced differences in reporting systems between each. The reporting of underage sexual activity to Garda Síochána also continues to present problems. As identified by *Putting Children First: A Discussion Document on Mandatory Reporting*, mandatory reporting of underage sexual activity to the Gardai may deter teenage girls from seeking medical care during pregnancy.

Northside inter-agency project for adolescent sex offenders

This joint project, which is a collaboration between the Eastern Health Board, St Claire's Unit, Temple Street and the Mater Child Guidance Clinic, was established to provide group treatment for adolescents who have sexually offended and their parents. Studies have shown that between one third and one half of all child sexual abuse is perpetrated by adolescents and that there is an association between offending in adolescence and later in adulthood. It has also been learned from such studies that a juvenile justice response to these teenagers may not be the most effective since their thought processes and behaviour are significantly different to other offenders.

A review has just been undertaken of the first six years of the northside inter-agency project. During that time group treatment has been provided for adolescents whose ages ranged from 13-19 years and their parents. Eighteen adolescents who had completed the programme agreed to take part in the study. Of these, 86% had experienced two or more significant difficulties in their early family life. These included marital problems, financial difficulties, alcohol abuse, family violence or inadequate housing. At the same time, some experienced no such problems but did report emotional loneliness or feeling disconnected from others. Other characteristics of the group included:

- 14% had been received into care because of family difficulties or neglect
- 45% had parents who were separated from each other while two had lost a parent through death
- 64% had experienced physical abuse
- 23% had experienced sexual abuse
- 86% had experienced emotional abuse

In order to assess treatment outcome, three measures were employed as follows:

- Self report of sexual re-offending
- Clinician's assessment of risk
- Evaluation of current risk-taking behaviour

None reported through an anonymous questionnaire that they had re-offended. Clinician's assessment of risk estimated that the majority (64%) were considered low risk of re-offending and 27% were estimated to be of high risk. A small number were impossible to rate and were ranked as "unknown risk". Current risk-taking behaviour

provision of support and teacher training for schools involved in the programme. Uptake of the programme in schools in the region is shown in the following table:

Table 29: Numbers of schools in Eastern Health Board region operating Child Abuse Prevention Programme in 1996				
<i>County</i>	<i>No of schools</i>	<i>Uptake of teacher training</i>	<i>Uptake of parent education</i>	<i>No of schools teaching programme</i>
Dublin	446	445 (99.8%)	425 (95.1%)	407 (91.3%)
Kildare	97	97 (100%)	94 (96.9%)	88 (90.7%)
Wicklow	82	81 (98.8%)	78 (95.1%)	75(91.5%)
Total	625	623 (99.7%)	596 (95.4%)	570 (91.2%)

During the year, school principals have continued to report a positive response to the programme from parents, teachers and children, confirming the findings of the earlier study undertaken by the Department of Education which reported that 98% of parents were in favour of the programme.

In 1996, the Stay Safe programme was modified for use with children in special education. A Stay Safe pack has been produced and contains lesson plans for children with:

- visual impairment
- auditory impairment
- physical disability
- cognitive disability
- emotional and behavioural problems

In-service training has now been provided for all teachers in special schools in the region.

Child prostitution

Concern has been expressed that some young people may be engaged in prostitution in the region. In order to explore the extent of the problem, the Eastern Health Board has established a working group with representatives from voluntary and statutory agencies. The terms of reference for the group is as follows:

- To establish in consultation with other appropriate statutory and voluntary agencies the extent of child prostitution in the Eastern Health Board area and to make recommendations regarding measures that can be taken to address the problem.

Chapter 11

Social Work Service

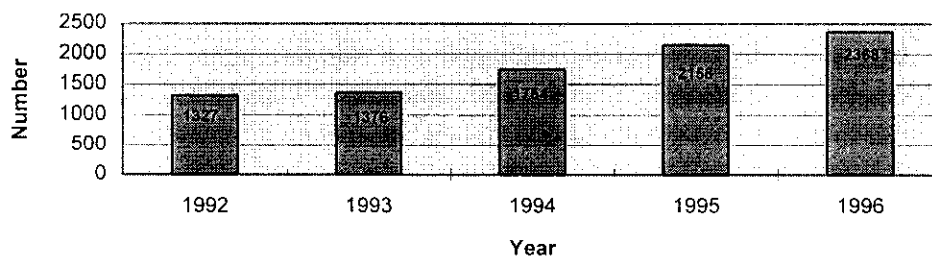
Extensive new legislation relating to children and families has come into effect since 1991. Coupled with critical social change which has also occurred, particularly within the Eastern Health Board region, the context within which social workers operate has significantly altered.

In December 1996, the remaining sections of the Child Care Act 1991 were signed into effect by the Minister of State at the Department of Health. Part VII of the Act places an obligation on health boards to inspect pre-school services in their region. Part VIII of the Act requires Health Boards to establish and maintain a register of voluntary children's homes and to arrange for their inspection. Having been signed into law in 1996 this, and the pre-school inspections, will take effect during 1997. Regulations have also been introduced regarding standards to be maintained in children's homes. In addition, the Department of Health has also issued a Guide to Good Practice in Children's Residential Centres which sets out the optimum standards pertaining to policy, and operational matters in children's homes.

In addition to the full implementation of the Child Care Act 1991, other significant legislation was introduced during the past year which directly impacts on child care services. These include the Family Law Act 1995, the Domestic Violence Act 1996, and the Refugee Act 1996. These Acts place significant responsibilities on health boards and most especially upon social workers.

The dramatic rise in the number of reported cases of suspected child abuse in recent years, as shown in the following figure and as discussed elsewhere in this Review, has also impacted upon the social work service:

Reported cases of suspected child abuse in EHB region 1992-1996



child protection work and the threats of violence which they experience. Research undertaken in general practice has shown increasing levels of violence experienced by doctors; it is likely that such trends are impacting also upon social workers.

In order to equip staff to work effectively and efficiently a Training Officer for the social work service is to be appointed. Although interviews were held during 1996, no appointment was made and the position has been re-advertised.

It has been difficult to keep pace with the needs of the service, such as office accommodation, since the implementation of the Child Care Act and greater numbers of staff.

In order to determine and agree upon the levels of resources required to provide adequate child care and family support services and to agree upon the criteria for allocation of these between Areas, the Eastern Health Board and IMPACT have jointly participated in a review during 1996 in order to:

- assess the adequacy of present resources for the implementation of those Sections of the Child Care Act so far implemented
- assess the adequacy of present resources for the implementation of the new Sections of the Child Act
- assess the training and planning resources which need to be put in place
- identify and cost the additional resources which are likely to be required in the years immediately ahead
- review existing utilisation of resources and identify areas where it may be possible to improve the utilisation of such resources

Having issued a preliminary report, the Review Group engaged the services of experienced international consultants who were requested to:

- examine any criteria in use, or recommended to date, designed to measure need in the Eastern Health Board region for child care and support services
- research which objective criteria designed to measure need for child care and family support services emerge from a literature review in Ireland and abroad
- recommend to the Review Group, on the basis of the above examination and research, criteria designed to measure need in child care and family support services, appropriate to a health board agency
- recommend a review system to measure the ongoing objectivity, equity and fairness of the criteria adopted and the systems necessary to inform such a review

Chapter 12

Children in Care

Foster Care

When compared with previous years, the number of children in foster care in the region increased in 1996 as can be seen in the following Table:

Table 30: Numbers of children in foster care in EHB region showing type of placement : 1993-1996				
Placement type	1993	1994	1995	1996
Long term	542	547	557	548
Short term	215	271	270	345
Day foster care	75	73	45	25
Holiday/weekend	26	30	25	20
Sections 61 (with relatives)	37	52	111	152
Total	895	973	1008	1090

The number of children in short term foster care and being fostered by relatives has increased considerably since 1993. However, the overall number of children in foster care has increased by only 12%. In addition, it can be seen that there has been a fall in the number of children in long term foster care since 1995 and very little increase between 1993 and 1996. The number of foster carers in the region in 1995 was 628, while in 1996 the number was 681.

Social work managers report that the number of available foster carers is not adequate to meet current requirements and it appears that recruitment may not be adequate for requirements in future years. In order to expand the number of foster carers, the Eastern Health Board launched a major fostering campaign in Spring, 1996. This made a considerable impact upon initial fostering enquiries which rose by almost 400 when compared with the previous year. However, these enquiries were not sustained, and a relatively small number of those who made initial enquiries proceeded to completion of a formal application form. The progress of these enquiries can be seen in the following figure. (The figures have been adjusted to exclude fostering by relatives and those wishing to foster particular children):

During the year, the Eastern Health Board continued to implement the policy of ensuring staffing levels were adequate to provide double cover as a minimum in children's homes at all times. It is hoped that this process will be completed in 1997.

Following the signing into law of the remaining sections of the Child Care Act 1991, the Department of Health issued a set of regulations pertaining to residential care. *The Child Care, Standards in Children's Residential Centres Regulations, 1996* are accompanied by a *Guide to Good Practice in Children's Residential Centres*.

The regulations are applicable only to children's group homes, and exclude places such as psychiatric units or residential schools for the physically disabled or for those with learning disabilities.

Children's homes are now required to register and are subject to inspection. The standards required relate to a range of care issues principally:

- Care practices and operation policies
- Staffing
- Accommodation
- Access arrangements
- Fire precautions
- Record keeping

The Eastern Health Board is appointing two senior staff to complete the inspections of the voluntary children's homes in the region. It is assumed that the proposed Social Services Inspectorate to be established by the Department of Health will inspect the homes which are directly managed by the Eastern Health Board. During the last three years there has been a significant increase of such homes. This has arisen as a result of a number of voluntary agencies withdrawing from direct service provision in this area and the need to establish special units for particularly difficult young people.

The *Guide to Good Practice* sets out valuable indicators of what constitutes standards good practice to be achieved. It advises that each children's home should have a written statement which defines the purpose of the centre including the population it caters for and the service it aims to provide.

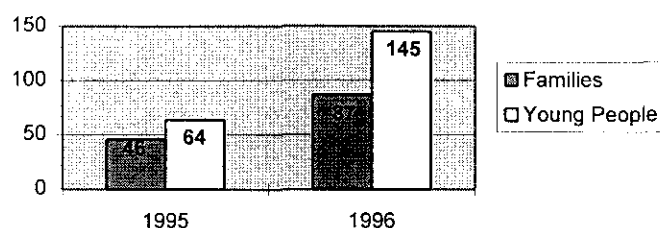
The guide encourages respect for the child's dignity and individuality, it provides practical ways in which the child's right to be heard is protected, and it sets out what is required in relation to child protection. Other areas include sanctions policy, education, health care, living skills, staffing and record keeping.

Task Force on Residential Care

As recommended by this Review a Task Force on Residential Care was established and required to:

- Identify the role of residential care in the context of the totality of Child Care and Family Support Services in the region

Supported Lodgings in EHB region 1995-1996



This success is due to its acceptability to both young people and to the families providing care. Contributing to this success is the adequate payments to families providing care (in contrast to fostering allowances) and the low levels of bureaucracy for those involved. It is important to note that despite its name, supported lodgings imply no diminution in the care provided for young people involved. One Area which has successfully placed 23 children under this scheme undertakes eight assessment visits to families willing to care for children; references are taken up and vetted and a Garda clearance is undertaken. A formal contract is drawn up and the young person's family is as closely involved as possible. A behaviour contract is also formulated which is signed by the young person. The scheme allows young people to stay in their own locality, attend their usual school or training course and stay in touch with their own network of friends. In all cases, the young people live as ordinary members of the host family. Training is being developed for the host families as is a summer activity scheme for the young people.

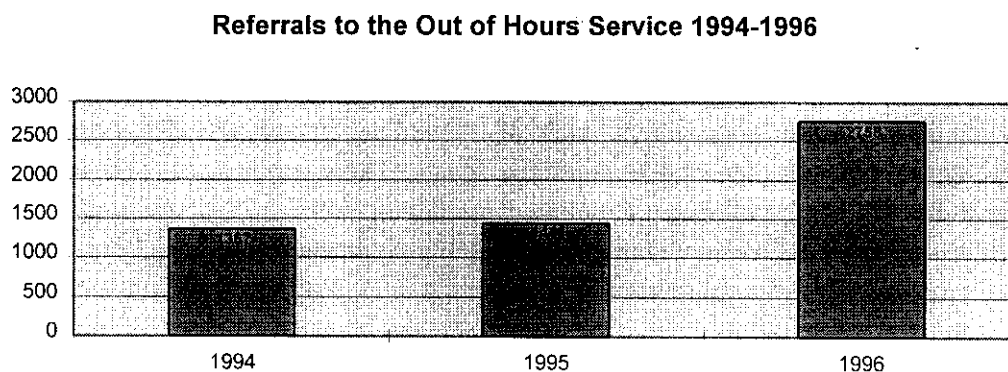
It is important to note that the Area discussed here has one social worker whose sole task is to develop Supported Lodgings. This social worker has pointed out to this Review that otherwise, the task would be far more difficult, if not impossible.

Chapter 13

Out of Hours Service

The Out of Hours Service is an emergency social work and accommodation service for young people which operates seven days each week throughout the year. The service is offered to young people between the ages of twelve and eighteen. For children and young people outside of these age groups, advice and information is given.

The total number of referrals during 1996 was 3,127. Of these, 2,758 were in the age group 12-17 years old. This represents almost 100% increase when compared to the previous year as can be seen in the following figure:



It should be noted that the number of young people involved does not equate with the number of referrals, as some young people may be referred more than once. The planned computerisation of the service will allow for the capture of the number of young people which the referrals represent.

The majority of referrals during 1996 were of males in the 16 and 17 year age group:

Another feature of the service which became apparent during the year was the number of young people being referred directly by the social worker in their own Area. Given the difficulties which are experienced by the Areas in placing this age group and given that emergency beds are available to the Out of Hours service and not to the Areas, such referrals are understandable. However, the purpose of the Out of Hours Service is to manage emergency situations *which arise out of hours*. This Review recommends that direct referrals of young people from the Areas to the Out of Hours Service should cease. Instead, the possibility of some of the existing emergency beds being available to the Areas as part of a central pool from which they can draw should be explored. In addition, Areas should develop a local pool of emergency beds for their own use. This should enable the Out of Hours Service to more fully develop their role in managing situations which arise out of hours and should decrease their function as an accommodation service.

During 1996 the staffing levels of the service were increased to meet the additional demands. Four Team Leaders are now in place and one is on duty each night to directly manage the service. The social work complement was increased from three to six.

Chapter 14

Homeless and Out of Home Children

Current residential provision for homeless and out of home young people includes forty four places in short-term hostels. In addition to the staff of these facilities and their assigned Community Care Area social workers, two outreach workers are employed by the Eastern Health Board to work with homeless and out of home young people. Added to the residential provision are the Emergency Carers and Supported Lodgings schemes. In 1996, 145 young people were placed in Supported Lodgings while 40 were placed with Carers.

The experience of those working with homeless and out of home young people in the region confirms research both in Ireland and abroad that many of these young people come from poor, deprived communities, may suffer psycho-social disorders and in Dublin, may be misusing drugs.

Research in the U.K. and Ireland point to the social forces which underlie children who are homeless or out of home as follows. Parsons (1997), writes of the rising levels of difficulties faced by young people and their families in the U.K. He cites contributory factors such as poverty, higher incidence of psycho-social disorders among young people, unemployment and changes in family structure and composition as giving rise to the growing numbers of children in difficulty.

Poverty

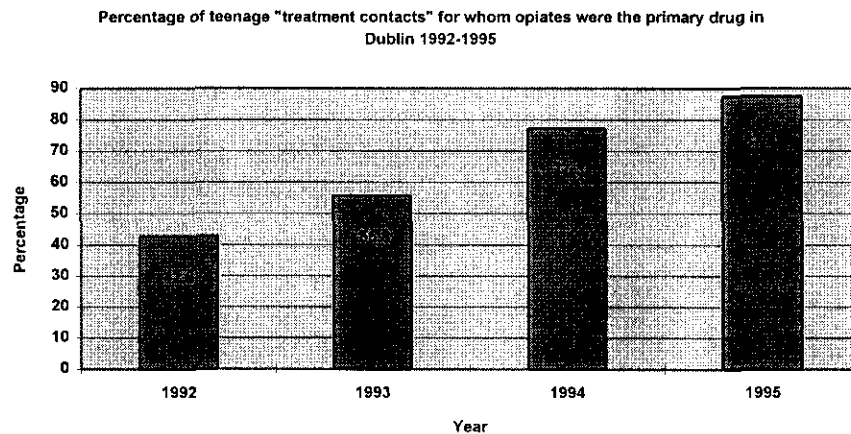
The links between poverty and homelessness are well documented. It is notable that deprived Areas are disproportionately represented among referrals to the Out of Hours service. Almost 70% of referrals to the service during 1996 came from the four most deprived Community Care Areas in the region. The *Report of the Commission on Social Welfare* (1986) described those living in poverty:

"Their....resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities". (p123).

The result of poverty and other social forces may be seen to place so many strains of vulnerable families that young people in those families are unable to participate in such ordinary living patterns as family life.

Children in Ireland have been shown to face a higher risk of poverty than adults. Callan et al (1996) point out that the risk of poverty for children was almost 30% and over 40% at two separate poverty lines.

(heroin) had been the drug of choice for 43.6% of those aged 15-19 years in 1990. By 1994, this figure had risen to 72.3% as demonstrated in the following figure:



This finding is confirmed in *Dealing with the Nightmare* (1997) which examined drug use and intervention in south inner Dublin. In this study (albeit using a small sample) all of the respondents were opiate users and used a variety of other drugs in addition.

Similarly, the Ministerial Task Force pointed out that drug misuse is most prevalent in ten districts of Greater Dublin: parts of the north inner city, south inner city, Ballyfermot, Ballymun, Blanchardstown, Clondalkin, Coolock, Crumlin, Finglas/Cabra and Tallaght. As noted above when poverty was discussed, the Community Care Areas in which these districts are located are those from which the most referrals come to the Out of Hours service.

In a small study done of young people in an emergency hostel during one month of 1996, it was found that 42% were known to be drug misusers. These young people present challenges to service providers; their behaviour can be chaotic and often they present a risk of engaging in drug misuse to others in the hostel. Staff of the hostel in question have attended a six week course in coping with drug misuse and its effects. Other steps may need to be taken in order to provide an adequate service for drug misusers who are out of home. Because of the difficulties they present, young people actively misusing drugs and refusing to engage in treatment services are barred from admission to almost all hostels. Where possible, they are placed in emergency beds when the need arises but this does not fully address their many needs.

Caring for homeless and out of home young people

The social and economic forces addressed above which are impacting upon young people's lives render service provision increasingly difficult. The provision of suitable care for all young people, including those who are out of home is difficult because of a number of factors. Although these are addressed elsewhere in this report, they are appropriate to repeat here as follows:

- unsuitability of existing care provision for some older adolescents
- drug misuse among adolescents, and the reluctance of group homes to admit such young people

These are children who arrive in Dublin, unaccompanied by a responsible adult, who are referred to the social work service. Since August 1995, Community Care Area 6 has provided this service on an emergency basis. This raises many issues for the social work service; the majority of minor asylum seekers cannot communicate in English and social workers have experienced difficulty in establishing the particular political, social or family circumstances which have led to the asylum seekers arrival in Dublin. Although basic emergency needs such as clothing, food and shelter have been met, Area 6 social work team points out that a more comprehensive service must be provided for this group encompassing:

- language/interpreting service
- age appropriate accommodation which takes into account the physical, cultural, religious, social, linguistic and psychological needs of this group
- health care
- education/training
- legal aid
- family links
- guardianship

In 1995, three children presented from Albania, Romania and Ethiopia. In 1996, thirteen children presented, of whom 12 were male. The countries from which they came are shown as follows:

Table 31: Country of Origin of Asylum Seeking Children in 1996	
<i>Country of Origin</i>	<i>Number of Children</i>
Kosova, Serbia	9
Angola	2
Zaire	1
Romania	1

The children's ages ranged from 14-17 as follows:

Table 32: Age of Asylum Seeking Children in 1996	
<i>Age</i>	<i>Number of Children</i>
14 year old	2
15 year old	3
16 year old	3
17 year old	5

The numbers, both of adult and unaccompanied child, asylum seekers in the region are continuing to grow and an Eastern Health Board multi-disciplinary working group is being formed to examine their service needs. The group includes a Director of the Child Care and Family Support Services; social work managers from Community Care Area 6; a Superintendent Community Welfare Officer from the Homeless Unit; the Senior Social Worker from the Crisis Intervention Service; public health doctor and a representative from the programme with responsibility for the homeless. It is expected that their recommendations will be issued and implemented shortly.

Chapter 15

Family Refuges

The Child Care Dimension

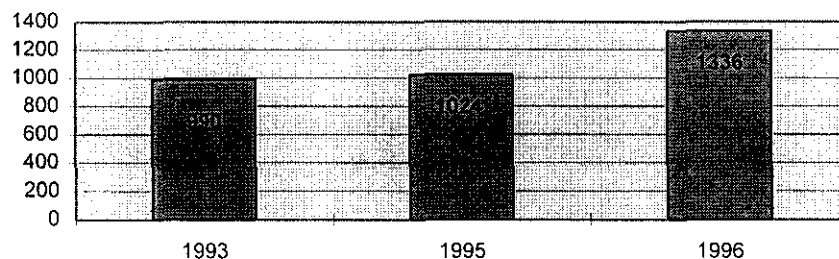
"Women who are being abused are mothering in a crisis situation..."

Women's Aid

The Eastern Health Board directly manages two services for women and children who are out of home due to domestic violence and other causes. These are located at Haven House and in the Women's Refuge, Rathmines. In addition, the Board funds refuges in Ballymun, Bray and Coolock. The managers of both Haven House and the Women's Refuge were asked to assess the adequacy of aspects of their service during 1996.

There was an increase in the number of children who were cared for in Haven House and the Women's Refuge, Rathmines during 1996 when compared to other years as shown below:

**Number of children in Haven House and Women's
Refuge 1993-1996**



While domestic violence is by no means restricted to any one social class, it is clear that poverty compounds its effects. In an area based survey carried out in tandem with a national survey, it was found that "the long-term ill health effects of domestic violence living in poverty and on low incomes is greater than for the general population as a whole" (Kelleher and Associates and O'Connor, 1995: 26).

It has been pointed out that definitions of domestic violence "should have at their centre the core concepts of force and coercion" (Kelleher and Associates and O'Connor, 1995). While the common perception of domestic violence is one that includes only physical abuse, it is important to remember that this is just one manifestation and that others are equally pernicious.

Mothers report that their children become fearful and withdrawn, experience sleeping problems and exhibit poor school performance (Kelleher and Associates and O'Connor, 1995.). In addition, a wide range of psychological problems have been documented: depression in the case of older children, stress, anger, low-self esteem brought on by the feeling that the child is somehow responsible for the situation and fearfulness. From a behavioural point of view, it has been noticed that such children tend to adopt excess responsibility or that they may treat their mothers or others in the violent manner they have witnessed in their homes (Women's Aid fact sheet).

Women's Aid points out that:

"There is a growing body of research which suggests that children are generally significantly affected by witnessing violence towards their mothers, whether or not they have been physically abused. The problems experienced by (these) children.....can include depression, anxiety, hyperactivity, difficulties with concentration and with sleeping, eating problems, heightened aggression and somatic symptoms....."

The interrelationship between domestic violence and child abuse has also been documented. While there is no evidence to suggest that their mothers are more likely to inflict violence upon the children, their risk of being abused by their fathers is elevated. Research carried out in a refuge found that "28% of the women interviewed ...reported that their children were severely beaten by their partners" (Casey, 1987 in Women's Aid fact sheet). Other research has shown that "men who beat their wives also physically abused children in seventy per cent of cases in which children were present in the home" (*Zero Tolerance*, Women's Aid).

In addition, the report points out that a woman who is herself being abused is very vulnerable when it comes to protecting her children.

Domestic violence should therefore be seen as a serious risk factor not only for women, but for children also. It is important that when children present to refuges with their mothers that adequate play, education, medical, nursing, social work and counselling services are in place to meet their needs. In addition, staff should be properly inducted into the service and should be trained to work with the effects of domestic violence on women and children.

Education, medical and nursing services were seen to be adequate in both services. Whereas arrangements for play were seen to be adequate in the Women's Refuge, there is still room for improvement in Haven House, in spite of the appointment of a child care worker. Arrangements for counselling are adequate in the Women's Refuge but need to be addressed in Haven House. In both services, linkages with Community Care Area social work teams require improvement. Consideration could be given to the allocation of a social work post on a shared basis between the two services. This would address the need for a counselling service in Haven House and would improve linkages with social work teams in local areas. The allocation of a sessional child psychologist might also be considered.

Chapter 16

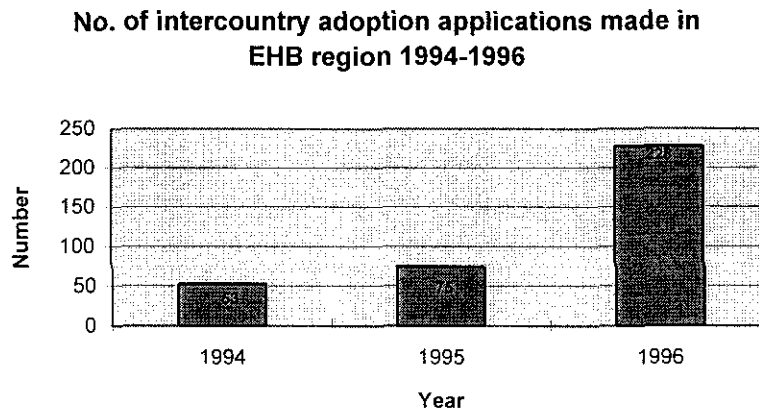
Adoption

In recent years, the number of Irish babies being placed for adoption has reduced and because of this, the Eastern Health Board's Saint Louise Adoption Society is not accepting applications from prospective adopters. Assessments are still being made of people whose applications are already on file; during 1996, nine of these were approved for adoption. Six babies were taken on to the adoption list during the year and all were placed.

In contrast, there is an ever increasing number of enquires from adopted children who wish to trace their birth mothers or from birth mothers who wish to trace their children. The demand for such information has created a backlog of tracing cases requiring attention.

Intercountry adoption

Following media coverage of children in Chinese orphanages in late 1995 and early 1996, there has been a surge of applications from people wishing to adopt foreign children as can be seen in the following figure:



There are currently over 200 applications waiting for assessment. Because of the numbers of new applications, and because the duration of assessment varies, it is difficult to give people waiting to be assessed an exact time as to when their assessment will be reached.

Waiting can be a frustrating experience for applicants. Indeed, during 1996 a case was taken to the Supreme Court stating that The Eastern Health Board was not undertaking assessments "as soon as practicable", as the law demands. The Supreme Court found in the Board's favour and also endorsed the Board's need to prioritise its work.

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Child Care Advisory Committee

The Child Care Advisory Committee was established in accordance with Section 7 of the Child Care Act 1991. Its purpose is to advise the Board on the performance of its functions under the legislation. The membership of the Committee ensures that the various branches of the child care services, including voluntary organisations and the child care professions, are represented.

The Committee met on ten occasions during 1996. The Committee decided to concentrate on providing advice to the Eastern Health Board in relation to two specific areas: Family Support Services and Young People and Substance Abuse. Two sub-committees were established and reports were submitted which were adopted by the Board. These reports appear in the following pages as an Appendix to this Review of Adequacy of Child Care and Family Support Services.

The membership of the Committee which was appointed for the 1996-1998 term is as follows:

Board members:

Cllr Ivor Callely TD (Chairperson)
Mr Gerry McGuire (Vice-Chairperson)
Dr James Reilly

Officers:

Dr Ailish Quinlan, A/Director of Community Care & Medical Officer of Health
Ms Sheila O'Malley, Supt. Public Health Nurse
Ms Olga Garland, Head Social Worker

Adoption and Foster Care Services:

Ms Pat Whelan, Irish Foster Care Association
Ms Marilyn Roantree, Head Social Worker

Residential Care:

Ms Mary O'Connell, Tabor Society

Services for pre-school children:

Ms Peggy Walker, Irish Pre-School Playgroups Association

Education services:

Mr Brendan O Murchu, Department of Education

Services for homeless children:

Sr Catherine Prendergast, Daughters of Charity of St Vincent de Paul

Child and adolescent psychiatric services:

Dr Paul McCarthy, Clinical Director, Child Psychiatry

Substance Misuse

The Child Care Advisory Committee established a sub-committee on substance misuse in order to bring attention to both the need for prevention and to the service requirements for young substance misusers under eighteen years of age. Alcohol and all illegal substances were to be incorporated into the sub-committee's remit.

Methodology

In addition to its meetings and deliberations, a review of available literature including reports of the Eastern Health Board was undertaken and key agencies in the field were invited to make presentations to the sub-committee. The participating agencies were: Neighbourhood Youth Project, St Vincent's Trust, the Merchant's Quay Project and personnel from the Eastern Health Board AIDS/Drugs Service. The sub-committee would like to take this opportunity to thank the representatives of these agencies for their generous participation.

This interim report is based upon the above meetings, literature, presentations and from the experiences of staff working with children and families.

Characteristics of Drug Misuse among Young People

Because of the nature of drug misuse, it is generally acknowledged that it is notoriously difficult to obtain definitive data on the incidence of drug misuse. The data which is relied upon instead are the numbers presenting for treatment and inferences are thus able to be drawn regarding the incidence of misuse.

The Health Research Board in its recent publication *Treated Drug Misuse in the Greater Dublin area - a Review of the Five Years 1990-1994* has shown that there has been a striking increase in the numbers of young (<19) first time attenders during the span of the report. In 1990 young people represented 35% of "first contact" attenders for treatment, but by 1994 this number had increased to 51%. Having discussed the declining average age of those attending for treatment, *The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* which was recently published, concluded that "the drugs problem is becoming a youth problem". (p9).

With regard to the location of drug misuse, the Ministerial Task Force pointed out that it is most prevalent in ten districts of Greater Dublin: parts of the north inner city, south inner city, Ballyfermot, Ballymun, Blanchardstown, Clondalkin, Coolock, Crumlin, Finglas/Cabra and Tallaght. Since just one areas outside Dublin was referred to by the Task Force (north Cork City) we may also safely conclude that if the drugs problem is becoming a youth problem, the "heroin crisis" (p9) is also very much a Dublin problem.

The health status of drug misusers is poor. O'Kelly (1996) has undertaken a longitudinal study of the health of all (82) intravenous drug misuse in one D.E.D. in Dublin. This cohort was identified by O'Kelly in 1985 when they were aged 16-25 and it was shown that heroin was used by more than half the group before the age of nineteen. When they were followed up in 1995, 65% have developed HIV. The real incidence may be even higher since only 80% of the cohort has been tested. O'Kelly points out that:

"Among the 53 who have tested positive, the consequences have been grim: 18 have died, seven have AIDS and 32 have continued to inject drugs".

The reasons given for beginning to misuse drugs and for returning to them after periods of abstinence included peer pressures, family problems, boredom, lack of self esteem, ignorance of the effects of drugs and their easy availability. Regarding the current cohort of young people living in the area, O'Kelly concludes:

"The general area has also seen a recent rise in the numbers of young people injecting or smoking heroin for the first time. It is of great concern that the conditions of deprivation, easy availability, ignorance or hopelessness which originally led to the drug use problems in Dublin's inner city have not been eradicated and continue to claim victims".

Prevention

In the past, prevention of drug misuse focussed upon the provision of detailed factual information to young people about drugs and the hazards of their misuse. These have now been found to be ineffective; it has also been found that it is difficult to communicate "health messages" to large groups in the wider population (Morgan et al).

Now, health education in the area of prevention emphasises the importance of empowering young people through enhancement of self esteem, decision making ability and assertiveness training. In this way it is hoped that young people will develop the skills necessary to negotiate their way through situations when they are presented with the opportunity to misuse drugs and alcohol.

The Psychological Services of the Department of Education has developed such a programme for second level schools *"On My Own Two Feet"*. Students participating in this programme were shown in the evaluation to have substantially and significantly higher levels of self esteem when compared to the control group. The programme students also had less positive attitudes to substance misuse and stronger beliefs in the negative outcomes of any such misuse.

The authors conclude that *"attention needs to be given to our expectations of what schools can reasonably be expected to achieve, given the importance of other kinds of social and cultural influences"*. For example, they remark that there is

"abundant evidence of profound ambivalence concerning the use of alcohol in Irish society".

Issues identified by the Sub-Committee

There is evidence of increasing numbers of young people using drugs which include alcohol, ecstasy, hash and heroin.

Drug use by young people is impacting on their ability to access and to maintain constructive involvement in school, training centres, youth programmes etc.

Some young people are acknowledging that their drug misuse is causing them difficulties and they are motivated to attend for treatment. However, they have difficulty in accessing help because of waiting lists in existing services and lack of age-appropriate specific services separate from services designed specifically for adults including detoxification, rehabilitation and counselling.

Many young people who are attending existing services designed for adults do not perceive the need for treatment but are attending for needle exchange or maintenance programmes. It is necessary therefore that new developments include a service geared at harm reduction.

There is also a group of young people who may be termed "recreational" drug misusers. Whereas their parents are concerned at this misuse, the young people themselves do not see any cause for concern.

The reported levels of alcohol consumption by young teenagers and indeed by young parents was noted. Alcohol appears to be available for sale on the black market in local suburban communities. This is providing increasingly easy access to alcohol for children and teenagers.

Concern was expressed regarding new alcohol products which contain lemonade. These, along with alcohol-free beer are seen to blur the distinction between alcoholic and non-alcoholic drink. There appears to be a correlation between early consumption of alcohol and drug misuse among some groups of young people.

People working in agencies providing services for young people e.g. schools, training workshops, residential units and field staff etc are expressing a desire to work with age appropriate service for young drug misusers and are expressing frustration at the current gaps in such a service.

There is evidence that young people who are drug using are also sexually active and not practising safe sex resulting in increased risk of spread of infection and unplanned pregnancies.

There appears to be an increase in pregnant teenagers who are drug using, presenting particular risk for their babies and themselves pre and post natally. There is a need for a service specifically targeted at this group of young women, taking into account both their stage of development and their need for support in carrying out their parenting roles.

Recommendations

- All provision should be part of a locally based, integrated service and this involves inter-agency co-operation in order to be effective. All agencies must take collective responsibility for meeting the needs of young drug misusers.
- All service provision should be evaluated.
- Inter-agency and inter-disciplinary training for staff to recognise behaviours and addictive patterns and to intervene appropriately and at an early stage and also to encourage appropriate use of specialist services should commence.
- Parental and extended family involvement is crucial to the success of programmes for young people and all services should be designed to include this.
- The Department of Education should be requested to consider the feasibility of extending *On My Own Two Feet* programme to all second level schools.
- The possibility of the Eastern Health Board designing a programme for parents to complement and re-enforce the schools' *On My Own Two Feet* programme should be explored.
- A pilot project in suburban areas to provide a comprehensive range of age appropriate intervention and treatment and for those young people who seek treatment should be established.
- A pilot project should be established to provide a service specifically targeted at young women who are pregnant and drug misusing, taking into account both their stage of development and their need for support in carrying out their parenting roles.
- Residential and step-down detoxification service specifically for adolescents are required and should be established.
- Employment of outreach workers to identify and link with young people who are misusing drugs and who are not linked with any service should be considered.
- Services for young people should be holistic and not merely focus upon the young person's addiction; they should attend to the entire spectrum of the young person's needs, including their medical and psychiatric needs.
- Consideration should be given to a legislative provision for compulsory detoxification in extreme and acute cases where the young person's life is at risk.

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Murphy D., 1996 *Adolescent Heroin Misuse :Review of literature in the context of developing a treatment programme in Dublin's North Inner City* (Unpublished dissertation thesis)

Office of the Taoiseach 1996 *The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*

O'Kelly F.D., Bury G., 1996 "An Analysis of the Effects of HIV Infection in a Cohort of Intravenous Drug Users" Irish Medical Journal May/June Vol. 89 No. 3

Family Support Services

Issues and Challenges

1. Introduction

The Child Care Act 1991, which is due to be fully implemented by the end of 1996, makes statutory provision for the establishment of family support services for the first time. Section 3(3) states (inter alia) that a health board shall *"provide child care and family support services, and may provide and maintain premises and make such other provision as it considers necessary or desirable for such purposes"*.

Fundamental to the provision of family support services is a belief in and a commitment to the importance of the family in a child's development. Family support services also provide opportunities to support the development of the relationship between children and their parents which research indicates is critical to the long lasting effectiveness of intervention.

There is a particular case to be made for family support services which seek to prevent problems arising within families or which have the capacity to identify and to intervene at an early stage when problems do arise. This is effective in terms of both the human and the financial costs of failing to intervene in this way. However because of the extreme demands of critical concerns we have seen investment in crisis, emergency and custodial services take precedence over investment in the lower profile but essential family support services. It is recommended that a separate budget be provided to develop a comprehensive range of family support services and to protect them from being continually siphoned off for short term emergency purposes.

2. Family Support Services Models

Practitioners and writers have identified four broad models of family support services:

<u>Client Focused Model</u>	Focus on professionals working with referred clients. Community involvement is minimal.
<u>Neighbourhood Model</u>	More 'open door' approach is used with some activities on offer. Community participation is encouraged.
<u>Community Development Model</u>	Focus is on empowering local residents and encouraging collective action. Community ownership is considered important.

(iv) Working with Parents and Children Together:

The experience of providing family support services illustrates the importance and difficulty of working with parents and children together. Providing services to children is relatively easy, engaging their parents can be more difficult. Parents must be involved from the start if they are to be worked with successfully. If this does not happen it will be hard to remedy. Variety of approach is important as well. Sometimes parents need a break and space away from their children, in other situations parent and child need to be worked with together.

Overall what is important is that the process, the contract, is negotiated and clear from the outset.

(v) Variety and Continuity of Service:

Over the years family support projects have grown and changed with the communities they serve. Some centres which started primarily as a day nursery for pre-schoolers now work with children from babies up to the teenage years. This approach recognises that the 'pressure points' in the lives of families are constantly changing.

Related to this is the concept of continuity of approach. This recognises that some families require ongoing support as their children develop. A number of the day nurseries now offer an after school support group for nursery 'graduates' in their first year of primary school. Similarly, some centres now run creche services for babies who then can move into the day nursery if necessary. The provision of a diverse range of services also demonstrates the services responsiveness to the changing needs of the children and families it serves.

(vi) Staffing and Personnel:

If a family support service is to be responsive to different needs it requires staff with a range of skills. Having staff who can between them work comfortably with children and adults is important. Staff from different disciplines and backgrounds can bring a positive, varied approach to the work.

In addition to paid staff, voluntary workers and those on temporary employment schemes can not only broaden the range of service options but help integrate a service into the community it serves. However this will only work well with careful planning, proper screening and adequate training. When these are in place temporary and voluntary workers can be invaluable in assisting full time staff.

(vii) Working in Partnership with other Agencies:

As many families experience a whole range of difficulties it is obvious that a number of supports is often required. Services tend to be more effective where co-operative approaches exist between other agencies. These approaches can be as broad as running a service jointly with another agency or as specific as working with one other person in meeting the needs of a particular family.

As in many other areas the groundwork for this type of approach should be set from the outset. Involving other groups in the development of a service is more likely to lead to collaborative work. This involvement can be formalised by establishing local steering committees, involving a range of agencies in work reviews etc. Overall it is important for providers to remember that they need to create a welcoming approach not only to service users but to other agencies in the community.

4. **Recommendations**

- (i) **It is recommended that this paper be adopted as the Eastern Health Board's policy with regard to family support services.**
- (ii) It is recommended that a separate budget be provided to develop a comprehensive range of family support services and to protect them from being siphoned off for emergency purposes.
- (iii) The Child Care Advisory Committee acknowledges the 1996 Eastern Health Board Child Care and Family Support Services Service Plan's statement that *"repeated studies have shown that early intervention can ameliorate the effects of social disadvantage"* and agrees that such preventive services *"can offset the need to place children in care"*. The provision of family support services can also represent a more appropriate and effective approach in working with very vulnerable children and their families.

Accordingly, it is recommended that the Eastern Health Board establish, in 1997, two family support services, one in inner-city Dublin and the other in an outlying suburban estate, the areas to be selected on the basis of an assessment of need. Noting the success of the team approach adopted by the community ward units for the elderly it is recommended that these family support services be inclusive of a range of professional disciplines and relevant agencies, both statutory and voluntary. It is also recommended that provision be made from the outset for the evaluation of these new services.

- (iv) The Family Support Services Sub-Committee of the Eastern Health Board Child Care Advisory Committee is willing to make a subsequent proposal for the development of a family support service model with the primary objective of reducing the incidence of children coming into care from a specific area and would be prepared to be further involved in this development.

Service Model

Emphasis is on providing a range of quality services relevant to different family members needs. Users access services voluntarily.

While some family support projects fall clearly into one of the above models there are others which use a combination of approaches.

3. **Making Family Support Services Work: Key Principles and Issues Arising**

Family support services concentrate on strengthening the functioning of, and relationships within families, primarily those experiencing disadvantage. To achieve this a range of activities can be provided and these may include full day care, community pre-schools, drop-in services, after schools programmes, parenting programmes and specialised counselling.

While there is considerable diversity in family support services the experience of practitioners and relevant literature indicates the importance of the following if projects are to be successful.

(i) Meeting Real and Recognised Need:

In establishing a family support service it is important that genuine efforts are made to consult a wide range of people in the community about needs and priorities. If services are to be effective there must be evidence that they are responding to what people are saying. Obviously priorities are influenced also by the requirements of funders and services already existing in the area.

(ii) Accessibility:

Ideally services should be located near to their target group. It is expensive and time consuming to have to transport children/families to centres. At a practice level it means that contact with parents, where children attend a service, is diminished as is the potential for community participation.

As against this, services that are located in a 'neutral space' have the potential to serve a number of neighbourhoods without being owned by any one of them. It is also the case that some parents, in particular, prefer the anonymity of attending a centre outside their immediate neighbourhood.

(iii) Early Intervention:

It is particularly important to provide quality early childhood experiences in day nurseries especially for children from disadvantaged backgrounds. Other services such as creches for babies and after schools programmes for 4 - 6 year olds complement this approach. At a time when so many services are 'crisis driven' the concept of quality early intervention is an important one that needs to be maintained. There is ample evidence that these services have particular significance for young children and young parents at a critical stage in their lives.

- There is a need for legislative clarification of the position of agencies who are requested by young people under eighteen to provide needles, condoms or methadone without parental consent or knowledge.
- There is need to clarify the legal status of alcohol/lemonade drinks.

Morgan et al recommend that all interests should be involved in attempting to change attitudes to substance misuse and that those involved in this change should include parents and community groups as well as schools.

Current Services for Young Drug Misusers

The sub-committee welcomed the new initiatives which have come on-stream for young drug misusers. These include:

- Availability of staff at community drug treatment centres for crisis intervention work with parents and young adolescents.
- Extension of hours at satellite clinics to provide specific programmes for young heroin smokers. These will include the services of general practitioners, nurses, counsellors and a consultant psychiatrist. Counselling, family and group therapy and a detoxification programme will be available.
- Establishment of an inner-city programme for adolescents who are dependent or at risk of dependence on opiates. Each young person is engaged on the programme for six months and there is a requirement that the young person is prepared to participate in follow-up work. Occupational, recreational, educational, therapeutic and medical interventions are involved in the programme.
- Funding of community and voluntary agencies who provide intervention programmes for young drug misusers and provision of services in partnership with local communities.

The sub-committee welcomes the envisaged close collaboration between the AIDS/Drugs Service and Child Care and Family Support Services.

The report of the Health Research Board shows that there is an increasing proportion of teenagers whose primary drug was an opiate. This grew from 56% of the total in 1990 to 77% in 1994. The substances being misused by young people who presented for treatment is shown in the following table showing changes which have taken place between 1990 and 1994:

Substance	1990		1994	
	<15	15-19	<15	15-19
Opiate/Opioids	7.1	43.6	10.0	72.3
Hypnot/Sedatives	7.1	4.5	2.5	0.6
Hallucinogens	-	1.0	17.5	6.8
Vol Inhalants	28.6	11.9	25.0	0.4
Cannabis	50	36.1	42.5	19.3
Other	7.1	3.0	2.5	0.7

There was a slight upward trend of injecting as the route of drug administration among teenagers presenting for treatment.

Half of the group in the Health Research Board study were found to have left school at the age of fifteen or earlier and unsurprisingly, there were exceptionally high levels of unemployment. These levels were seen by the Health Research Board as "totally out of proportion to the levels in the population" (p63). As was noted above, drug misuse in Dublin in a phenomenon of poor, deprived areas and this is the international experience with some limited exceptions.

The association between poverty and drug misuse is incontrovertible. Murphy (1996) has reviewed the literature on adolescent heroin misuse and cites many studies which link heroin use to social deprivation. One study reviewed by Murphy showed "consistent, significant and positive" correlations between rates of known opioid use and six socio-economic deprivation indicators:

- unemployment
- unskilled workforce
- single parents
- council tenancy
- overcrowding
- larger numbers of children

Similarly in the United States, heroin misuse among young people was found to be more prevalent in communities experiencing economic deprivation:

"....these areas were characterised by a sense of futility which was thought to be conducive to experimentation with narcotics." (p52).

Research in Ireland reviewed by Murphy confirms these findings. One study showed that the proportion of drug misusers from the north inner city of Dublin is three times higher than would be expected from its population size.

Support services for children and their families:

Ms Margaret Dromey, Treoir

Mr Owen Keenan, Barnardo's

Probation and Welfare Service:

Mr David O'Donovan, A/Principal, Probation and Welfare Service, Department of Justice

Garda Siochana:

Inspector Joseph Delaney

Kelleher and Associates and O'Connor, M. (1995). *Making the Links: Towards an integrated strategy for the elimination of violence against women in intimate relationships with men*. Dublin.

Kilkenny Incest Investigation; May 1993. Dublin:Stationery Office

McCarthy D., McCarthy P., 1997 *Dealing with the Nightmare : Drug Use and Intervention Strategies in South Inner City Dublin* Dublin:Community Response/Combat Poverty

Murray C., 1997 *Pavee Children : A Study on Childcare Issues for Travellers*; Dublin: Pavee Point

Parsons C., 1996 'Permanent Exclusions from Schools in England in the 1990s' in *Children and Society* Vol 10 pp 217-224

Report of the Commission on Social Welfare (1986) Dublin: Stationery Office

Whelan C., 1994 'Poverty, Unemployment and Psychological Distress' in B. Nolan and T. Callan (eds) op cit

Women's Aid, 1996 *Zero Tolerance : A national strategy on eliminating violence against women* Dublin: Women's Aid

Women's Aid. *The Effects of Violence in the Home on Children*. Women's Aid Fact Sheet.

Women's Aid. *Domestic Violence: the Social Context*. Women's Aid Fact Sheet.

Notwithstanding the judgement, an additional social worker was assigned to the Inter-country Adoption Team, bringing the staff total to five. However, the number of applications continues to rise and this has the effect of extending the waiting period.

Although this is a source of disappointment for individual applicants, the Board's work in the area of inter-country adoption must be seen in the context of other responsibilities, including increasing need for investigation of child abuse. Added to this are the many people whom the Board placed for adoption who must also wait for their requests for background information to be taken up.

The Women's Refuge does not accept women who are misusing drugs but will admit women who are on maintenance programmes. The client mix in Haven House should be reviewed as this service is coping with increased numbers of chaotic drug misusing women.

Consideration should be given to the provision of ongoing inservice training for all refuge workers in the region. This training should include the needs of children in these circumstances and staff should be rostered for such training.

Children's services in the refuges should be closely monitored to ensure adequacy in the light of the increasing numbers of children being accommodated and our knowledge of the impact of domestic violence upon them.

Accident and Emergency Departments: Identifying and managing cases of assault on women

The Eastern Health Board funded the appointment of a worker in 1994 to develop and extend a pilot project in hospital Accident and Emergency Departments. This project, which had been initiated jointly by St James's Hospital and Women's Aid, Dublin focusses on training programmes for hospital personnel and the introduction of procedures and protocols for identifying and managing cases of assault on women. Initial training programmes have now also been introduced in Holles Street and the Rotunda maternity hospitals and in the A&E Departments of Beaumont, St Vincent's, and the Meath hospitals. Guidelines for Accident and Emergency staff in hospitals on the identification and management of violent assaults on women are being developed by Women's Aid.

Domestic violence is understood to encompass mental, physical and sexual violence and these are defined as follows:

- mental violence: includes threats of physical violence, cruelty involving verbal abuse, isolation from family and friends, damage to personal property and deprivation of family income.
- physical violence: is understood to mean any behaviour resulting in physical injury, such as hitting, kicking or beating
- sexual violence involves the forcing of sex onto the victim.

While domestic violence is by no means restricted to any one social class, it is clear that poverty compounds the problems mentioned above. In an area based survey carried out in tandem with the aforementioned national survey, it was found that "the long-term ill health effects of domestic violence living in poverty and on low incomes is greater than for the general population as a whole" (Kelleher and Associates and O'Connor, 1995: 26).

A national study carried out in 1995 revealed that of the victims of domestic violence reported the following: physical injury, miscarriage, loss of confidence, depression, increased use of medication and alcohol, problems with sleep and increased social isolation. Such findings are echoed in recent research carried out in the Accident and Emergency Department of St. James' Hospital, Dublin, which adds that panic attacks and attempted suicide may also result from domestic violence (Cronin and O'Connor, 1993).

Not only is the physical and mental health of the mother at risk in a violent household, but her parenting capacities may be severely limited, a situation that has been referred to as "mothering in a crisis situation".

"Women who are being abused are mothering in a crisis situation and it is imperative that social workers have specific training on abuse within families that will allow them to give a realistic and adequate response to the woman."
(Zero Tolerance, Women's Aid).

Such a crisis may not come to the attention of the social services as abused women are often afraid to contact social workers for fear that their children may be taken away from them (ibid.). This crisis in parenting is but one repercussion of domestic violence on children living in a violent household. At the most fundamental level, it has been pointed out that

"witnessing abuse is, in itself, an abuse of the rights of the child. Witnessing violence and abuse and the denial of a safe place to play, learn and develop, can only have a very damaging effect on the emotional and physical well-being of the child" (Women's Aid fact sheet).

- aggressive, violent behaviour of some young people and the reluctance of group homes to tolerate such behaviour
- reluctance of families in the region to engage in fostering
- reluctance of local communities to accept group homes in their locality
- cost of group home care

Thus, on some occasions during 1996, the Out of Hours service had young people whom they were unable to place, in spite of there being empty beds in the region. These situations arose because of one or a combination of the following:

- the young person was barred from all facilities because of chaotic drug misuse
- the young person was barred from all facilities because of violent and aggressive behaviour
- the young person refused all available accommodation

Because of these factors, bed and breakfast facilities were used for 236 young people in the region during 1996. It is important to note that they were not placed alone in such facilities but were accompanied by a child care worker or nurse.

Census of homeless and out of home young people

Estimating the number of young people who are homeless and out of home is particularly difficult because of the transient nature of the problem and the transient lifestyle of some young people. The Eastern Health Board and voluntary agencies involved: Focus Point, Arrupe Society, Crosscare and Sherrard House have collaborated in previous years in the compilation of a type of census of young people who are found by those agencies to be homeless or out of home. Difficulties with data gathering have led to a review of the system and a new computerised system is being devised by the Board with the co-operation of the voluntary agencies. For that reason, it is not possible for this Review to estimate the numbers of young people in the region who were homeless or out of home during 1996. However, it is estimated that each year, 400 young people are out of home in the region.

When the census is compiled, it is important that the data will assist the Eastern Health Board to fulfil its statutory obligation as defined in Section 5 of the Child Care Act as follows:

Where it appears to a health board that a child in its area is homeless, the board shall enquire into the child's circumstances, and if the board is satisfied that there is no accommodation available to him which he can reasonably occupy, then, unless the child is received into the care of the board under the provisions of this Act, the board shall take such steps as are reasonable to make available suitable accommodation for him.

Asylum seekers

In 1996 an increase was experienced in the number of unaccompanied minors from overseas who are asylum seekers in this country.

Deprivation was shown by the study to also have been experienced by families below the 60% income line as follows:

- 33% had severe debt problems
- 40% could not afford new clothes
- 37% could not afford two pairs of strong shoes
- 25% could not afford a warm waterproof coat
- 33% did not have a roast or equivalent on Sundays
- 21% did not have a meal with chicken, meat and fish every second day

Children at risk of poverty and deprivation live in households which are headed by an unemployed person and/or headed by a single adult. The risk of poverty was shown by the study to have increased for such families since 1987. Children and young people will demonstrate the effects of poverty since, as Parsons notes: *"There is an association between social dislocation, poverty and difficulties....."* (p183). Poverty (and attendant problems such as psycho-social difficulties and drug misuse) give rise to the social dislocation and difficulties experienced by young which have been witnessed in services caring for the most marginalised young people in recent years.

Psycho-social difficulties

In writing of the psychological distress caused by poverty, (Whelan 1994) notes that 40% of the wives of unemployed men in poor households were above the distress threshold, compared with only 13% of married women with husbands at work. Although Whelan does not address the distress threshold of children and young people in such households, it can be assumed that these levels of distress in their mothers will impact upon the young people in the home and that the wider society is witnessing this distress. Commencing his analysis as to the cause of greater levels of difficulty being experienced by young people today, Parsons states:

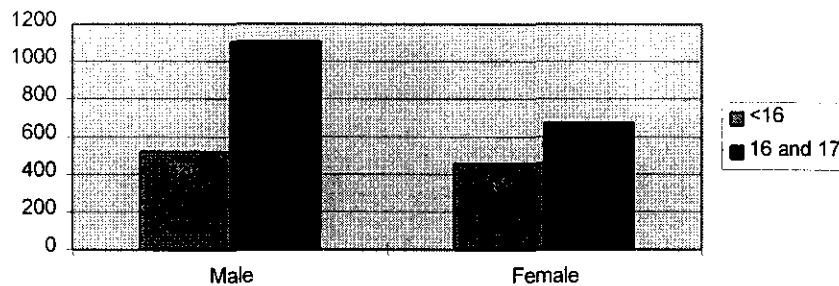
".....It must be concluded that there has been a real rise in psycho-social disorders of youth in the post war period.....There are more behaviourally difficult children and young people". (p182).

Some young adolescents with very disturbed behaviour have presented to services such as the Out of Hours in recent years and this trend was even more noticeable in 1996. The behaviour of these young people can place themselves and others at risk. Although not presenting in great numbers, when they do present, their needs and the effects they have on the service in which they are placed, are overwhelming.

Drug misuse

Compounding the experience of poverty and psycho-social disorders is the effect of the growth of drug misuse which has been witnessed in Dublin in recent years. As pointed out by the report of the Child Care Advisory Committee (attached as an Appendix to this document), drug misuse in Dublin can now be seen as a heroin problem, located among poor, inner city adolescents. *Treated Drug Misuse in Dublin 1990-1994* showed that among young people presenting for treatment, opiates

**Referrals to the Out of Hours Service in 1996
showing age and gender**



Young people who were referred to the service came from each Community Care Area in the region. Areas 9 and 10 had the lowest number of referrals (11 and 46 respectively). 73% of referrals during the year came from only four Community Care Areas: 4, 5, 6 and 7. It is recognised that these Areas are the most deprived in the region and experience the most acute social problems.

Possible outcomes for young people referred to the service include:

- retention within their own network
- placement in an emergency bed or hostel
- placement in bed and breakfast, with support staff where possible

Where possible, retention of the young person within their own network of family, extended family or friends may be the best option. This may involve protracted, time consuming assessment and negotiation by the social worker. Perhaps because of the large, increased volume of referrals which the service experienced during 1996, retention within their own network was possible for only 11.5% of referrals. 13.3% were placed in bed and breakfast facilities, while almost half of referrals were placed in hostels.

The service experienced difficulty in placing all young people during the year. On some occasions the apparent contradiction existed whereby, although emergency beds were available, there were young people without suitable accommodation. This arose because of a nucleus of young people being excluded from all available accommodation due to their drug misuse or violent, aggressive behaviour, or because the young person refused to avail of the accommodation which was offered in hostels. Under these circumstances, there was no option but to place the young people concerned in bed and breakfast facilities. In these circumstances, the young person is accompanied by a nurse if possible; however, it has been difficult to engage nurses for such duties as they are reluctant to accompany young people whose behaviour has caused difficulties elsewhere.

Meeting the needs of young people who are drug misusers or who have psychiatric or profound behavioural difficulties is a significant challenge facing the service. These issues are also addressed in the section of this Review which discusses homeless and out of home young people.

- Establish which children currently require residential care in the region and to estimate need over the next five years
- Establish the current purpose and function of each children's home within the region
- Define and agree on the purpose and function of each children's home
- Devise an appropriate management structure for all children's homes taking account of decentralisation/regionalisation
- Establish the staffing and training needs and their cost implications
- Prepare a time-frame for the implementation of the recommendations of the Task Force

Membership of the Task Force includes senior professional and administrative staff from the Eastern Health Board's Child Care and Family Support Services, including residential care. Phase II of their work will involve extensive consultation with voluntary agencies.

High Support Units

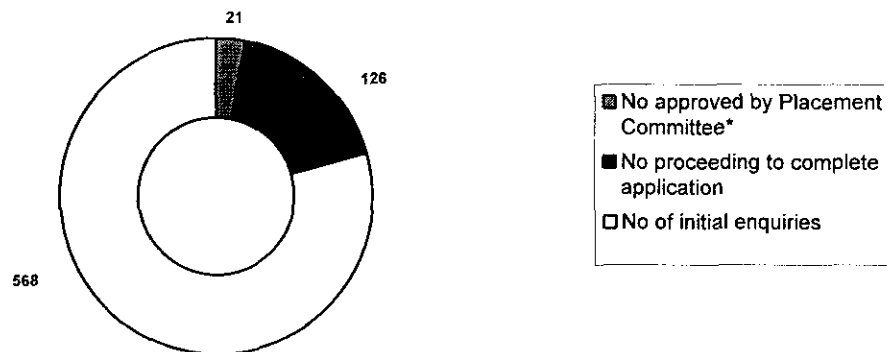
A number of young people have been identified who require special care and treatment, including education, within the region. In order to provide such care, two High Support Units were opened in 1996 providing care for twelve young people. The young people are placed in the Units as a result of individual High Court orders which allows the Eastern Health Board to restrict the liberty of the young people in their own interests and authorises the Gardai to return the young people to the Units if they abscond.

This was a significant service development for the Eastern Health Board. Extensive recruitment and induction of staff took place. Detailed policies and procedures were presented and approved by the High Court. As the liberty of the children is restricted, the Eastern Health Board has introduced a number of measures to protect and promote the rights of the young people involved. These include the appointment of a Staff Consultant, a management advisory group which includes representation from an outside agency, regular children's meetings and a complaints procedure.

Supported lodgings

Supported lodgings, which began in the region in 1995, has proved to be successful in providing care for young people who would otherwise be difficult to place. This growth is shown in the following figure:

Processing of fostering enquiries in EHB region in 1996



The ease with which some Areas are recruiting host families for Supported Lodgings is in sharp contrast with fostering recruitment and there are some possible explanations for this. Allowances for fostering fall far below those for the Carers scheme and for Supported Lodgings. In addition, the shortage of social workers which some Areas are experiencing (almost 25% of posts in some cases in 1996) can be seen as a contributory factor in lack of growth in fostering. When staff shortages exist, available staff must concentrate on emergency referrals and more long term work, such as generating and assessing fostering applications, does not get priority. In addition, the assessment procedures under which fostering operates are now almost twenty years in place and it may not meet current needs.

This Review last year contained a submission from the Irish Foster Care Association which spoke of the "anger and frustration" of foster carers at levels of payment to them. The Association pointed out that, at a time when many women are re-entering the workforce, foster care does not represent an attractive economic alternative. In addition, the Association called for:

- A streamlined system of re-payment for out-of-pocket expenses which are incurred in caring for foster children
- Publication of a booklet outlining the entitlements of foster carers
- Empowerment of foster carers to call for a review when a placement is in difficulty
- Improved training for foster carers
- Practical help such as respite care or support from a child care worker in the home when necessary
- Improved levels of information about each child prior to placement
- Improved access arrangements for birth families
- Greater liaison and co-operation between social workers and foster carers

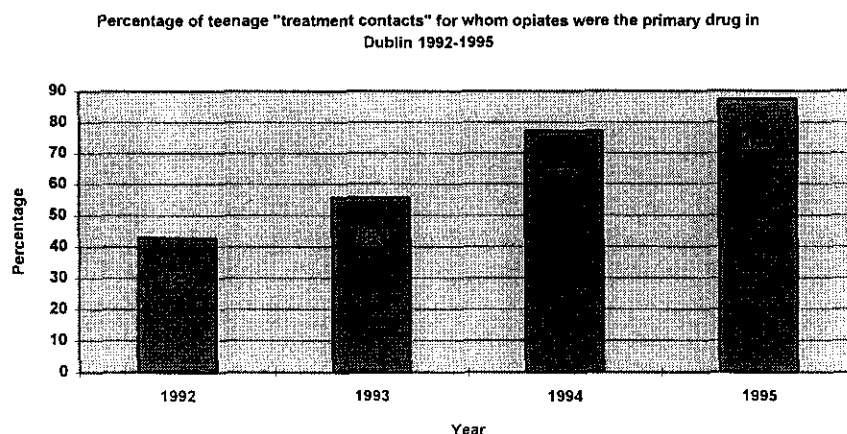
Residential Care

In December 1996, 305 children in the region were being cared for in children's homes. These homes are managed by voluntary agencies, funded by the Eastern Health Board, or in homes which are directly managed by the Board itself.

It should be noted that this research is the first attempt to establish objective criteria which will identify children not in receipt of adequate care and attention according to Section 3 of the Child Care Act 1991.

Both new legislation and rising numbers of cases of suspected child abuse have greatly increased the volume of court work to which social workers must attend. Previously, one half day each week was dedicated by the Children's Court to Eastern Health Board work. This has now been increased to two full days each week and has necessitated the Eastern Health Board entering negotiations with the Courts in order to secure accommodation in court to facilitate interviewing clients, telephone calls etc. Interim Care Orders have proved to be time-consuming: these require the re-appearance of all parties in court for review every eight days, unless parents consent to a longer adjournment. Reviews often re-hear all the evidence in a case and as a result, numerous members of staff are required to be present. At the same time, parents do not attend in many instances as they may be awaiting Legal Aid or may prefer to await the full hearing before coming to court. Greater flexibility, such as longer adjournments, would release many hours of social work time. This Review also notes the cost of legal fees which Interim Care Orders incur.

Alongside legislative change, rising numbers of suspected child abuse cases, the region has experienced unprecedented levels of drug misuse, particularly of heroin, among young people:



Social workers in the region are experiencing the impact of this increase, especially since the Child Care Act 1991 placed responsibility for young people up to age eighteen upon health boards. (Hitherto, young people ceased to be the responsibility of health boards at sixteen.) In addition to adolescents who may be difficult to engage because of chaotic drug misuse, the service also has responsibility for babies and children who may be at risk because of their parents' drug misuse.

Under these circumstances, recruitment to social work posts is difficult. It must be acknowledged that far greater numbers of social workers have been recruited since the enactment of the Child Care Act. The recruitment process was streamlined and social work managers report that new systems which were put in place have proved to be effective. Nevertheless, shortages have been experienced to the extent that some teams had vacancies in 25% of their posts during 1996. Nationally, the number of places in colleges for social work training may not be keeping pace with requirements. More focused human resource planning may be required. In addition, social work in health boards may not be attractive to graduates because of the stressful nature of

among the group was found to be similar to that of a matched control group in the community to whom they were compared. Whatever risk category a young person was assigned to after the programme, it was deemed that all had undergone tangible change as a result of their participation. The study recommends that an aftercare programme be initiated, in particular for those considered to be at high risk of re-offending.

Assessment of allegations of sexual abuse and treatment of victims

There are two units in the region which are responsible for the validation of allegations of sexual abuse. These are based at two of the children's hospitals: children from the north side of the region attend St Claire's Unit in Temple Street Hospital while those from the south side, including Wicklow and Kildare, attend St Louise's Unit at Crumlin Children's Hospital. The units are staffed by social workers, psychologists and psychiatrists and by relevant medical personnel. A treatment service for children who have been sexually abused is based at St Louise's Unit.

During 1996, long waiting times were experienced by children requiring assessment at the Units. This requires analysis and attention.

Child Abuse Prevention Programme

This programme is a primary school based approach to the prevention of child abuse. Within a school, implementation involves:

- **Teacher training:** outlines the content and teaching methods of the Stay Safe programme. Background information on child abuse and bullying is provided as it responding to disclosure of abuse, referral procedures and Departmental guidelines. Follow up training for staff is provided on request. A pre-service training module which has been developed is in use in teacher training colleges. In the Eastern Health Board region, inservice training is provided by a network of nine teachers who are available to the programme on a part-time basis.
- **Parent Education:** parental involvement is an essential part of the programme. Parent education is provided by CAPP personnel to schools which are implementing the programme. This involves providing information on child and bullying, outlining the content of the Stay Safe classroom lessons and detailing available services. A parents' information booklet has been distributed to over 250,000 parents to date.
- **Personal Safety Education for Children:** The Stay Safe programme is a developmentally staged set of lessons which can be used with primary school children from senior infants to sixth class. The programme seeks to enhance children's self protective skills by participation in lessons on safe and unsafe situations, bullying, inappropriate touch, secrets and stranger danger.

The Eastern Health Board has appointed a social worker with responsibility for development of good liaison between local schools and Community Care Areas, and

The Eastern Health Board has established a multi-disciplinary working group to prepare a protocol to be followed by staff working in the Board. The protocol will provide information and guidance in relation to all aspects of the Board's policy on child protection, within the national framework as outlined in the Department of Health's *Child Abuse Guidelines* (1987) and *Notification of Suspected Cases of Child Abuse between health boards and gardai* (1995).

The protocol includes:

- Statement of principle in relation to child protection
- Recognising child abuse: physical, sexual, emotional abuse and neglect
- Risk assessment
- Notification of allegations of child abuse
- Investigations and management of allegations of child abuse including guidelines on interviewing parents and children; medical examinations; recording information; parental involvement
- Case conferences
- Confidentiality
- Inter-agency collaboration

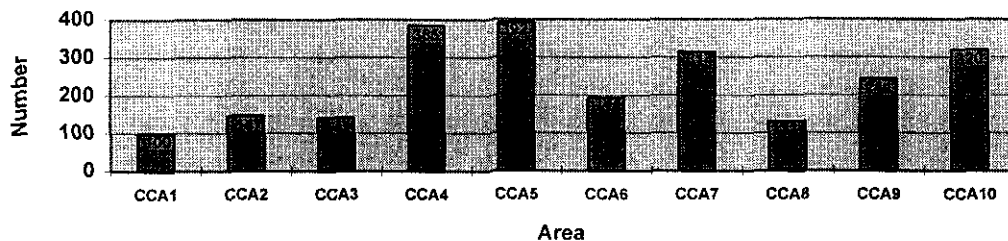
A draft protocol will be issued in 1997 and information and training programmes will be arranged following the adoption of the protocol. Discussions are taking place with a number of key voluntary agencies in the region regarding the adoption of notification procedures within those agencies.

A leaflet has been produced which is being issued to all members of staff, regardless of grade, profession, discipline or location. This defines abuse and outlines the steps which are essential for staff members to take should they suspect that a person under the age of eighteen is being physically, emotionally or sexually or suffering from neglect. These steps include notification to the Director of Community Care or Social Work Manager or duty social worker. Contact names, addresses and phone numbers of those in each of these posts are also included.

Interagency training has commenced in the region between Gardai and Health Board staff. In Wicklow, this began with a series of planning meetings between each agency which were attended by Garda representatives, including a Garda training officer, the Director of Community Care, Senior Public Health Nurse and Senior Social Worker. Three training days were devised which covered: the role of respective professionals; legal framework of investigating child abuse; preparation of a file for the Director of Public Prosecutions; the role of the child sexual abuse validation units and a case study exercise. All health board personnel and the majority of Gardai in Co Wicklow who are involved in child abuse work, have now participated in joint training. The level of satisfaction reported by participants was exceptionally high.

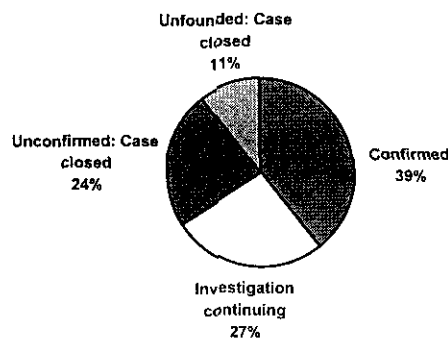
Joint training between Garda Siochana members and Eastern Health Board staff now takes place in three Community Care Areas. One Area has established a group to examine and resolve issues which arose during joint training. It is hoped that

Reported cases of suspected child abuse in each Community Care Area 1996



Regardless of the outcome, each investigation represents a considerable time investment for social work staff. The outcomes of investigations in 1996 are shown in the following figure:

Outcome of child abuse investigations in EHB region 1996



Mandatory reporting

In February 1996 a national discussion document was launched *Putting Children First - A Discussion Document on Mandatory Reporting of Child Abuse*. Subsequently, *Putting Children First: Promoting and Protecting the Rights of Children* was published by the Department of Health. The document, emphasising that the government has ratified the United Nations Convention on the Rights of the Child, spelled out the key principles of the Convention which are that:

- all of the rights enumerated should be ensured for each child without discrimination
- the best interests of the child should be the primary consideration in all actions concerning children
- the right of children to express views freely and to have such views given due weight, according to age and maturity, should be assured.

taking place to ensure involvement of the parents of children attending the project. The Project will cater for children aged between five and twelve and will open its doors to families and children in April 1997.

Rialto Family Centre

This centre, which will commence in 1997, is an early childhood support and intervention project and is addressed separately in this Review.

Aosóg developed following the identification of the need for:

- a preventative approach to difficulties faced by families and children
- non-crisis childcare provision
- an integrated, inter-agency approach to working with families

The emphasis in Aosóg is on prevention and its aim is to provide a professional service for children aged seven to twelve years which will enable them to explore and develop personal and life skills in a safe environment through individual, group and family work.

The target group will be:

- children who have dropped out of the formal school system but who, with support, will be able to return to mainstream education
- children at risk of dropping out of school
- children and families who need support

The project is managed by a voluntary committee with representatives from the community, Eastern Health Board staff, school attendance officer, home school liaison officer, teacher, youth worker and the local development project. Staffing of the project will include a Project Leader and two Project Workers with part-time administrative and housekeeping staff. The Project Leader has now been appointed and recruitment for other staff is underway. The Project will commence with a summer programme and individual children will then begin in September. Referrals can be made by parents, social workers, child care workers, school principals, home school liaison officers and school attendance officers.

Family Support Workers in Dun Laoghaire

Family Support Services have been developed in a number of Community Care Areas over the past number of years. Staff are specially recruited from the local community and before being allocated to work with individual families, they undergo a specially designed training programme. The service is preventive in its approach and staff are assigned to families when there are concerns about the care of the children. Specific plans are drawn up for the intervention in each family and the primary objective is to assist the parent to develop the potential of the children and to enhance the quality of life in the family. Families are empowered to care for their children and to maintain and nurture links with the extended family and with the wider environment. Help and support is given with childcare, budgeting and general household management. As the service is delivered in the family's own home and for the most part by local people, it is seen as accessible and acceptable.

It has been decided to establish this service in Community Care Area 1 and the project is at the planning stage. A number of local women and men from within the community will be employed to work intensively with dysfunctional or multi-problem families. One social worker has been assigned on a half-time basis to establish the

This Review recommends that future nursery school provision in the region be matched more carefully to meet need.

Up to 90% of agreed running costs of the nurseries are met by the Eastern Health Board. Parents contribute towards the cost of their child's place in the nursery; in cases of hardship the cost is met by the Community Welfare Officer. Fundraising also takes place in many instances to make up the balance of the budget.

Last year, this Review noted the difficulty which had arisen in relation to the pre-school provision by the Department of Education in deprived areas. Such pre-school places are free of charge, unlike the nurseries - an important factor in poor areas. It was noted also that a stigma may now attach to nurseries which are seen to be reserved for children at risk - a stigma which the Early Start Scheme does not suffer. All services provision which is targeted and which is not universally available can become stigmatising and their acceptability to consumers consequently unattractive. This Review looks forward to the deliberations of the Department of Education's Early Start Monitoring Committee to which a submission, highlighting these issues, has been made by the Eastern Health Board.

Inspection of pre-school services

Under Part VII of the Child Care Act 1991, regulations came into effect in December 1996 setting out the requirements to be complied with by those providing pre-school services. These regulations ensure the health, safety and welfare of children and promote their development and they apply to:

- pre-schools
- playgroups
- day nurseries
- creches
- some childminders
- other similar services catering for children under six years of age

Under the regulations a person carrying on a pre-school service is required to give notice to the health board before 30th June 1997. Notification of intention to open a new pre-school must be given the the health board at least twenty eight days prior to the commencement of the service. The inspection arrangements will be put in place by the Eastern Health Board during 1997.

Rialto Family Centre

The Review of Adequacy of Child Care and Family Support Services in 1995 contained a report from the Child Care Advisory Committee which recommended the establishment of early childhood intervention services in the region. Also in 1995, the Rialto Area Action Plan recommended such a service for the Rialto area. The combination of these two factors and the fact that early childhood support and intervention is in line with the policy of the Eastern Health Board, led to the Board agreeing to fund the Rialto Family Centre. The aims of the centre are to:

- provide a range of services for children 0-7 years, their carers and the family as a whole
- create a caring safe and stimulating environment for children and their families
- provide outreach to families in the community through networking with statutory and community groups in the area
- develop the capacity of other community groups and projects to provide quality childcare
- review and evaluate the project on a regular basis and to develop accordingly

The project plans to fulfil these aims through direct and indirect services such as individual and group work with children 0-7, also with parents/carers and the family as a whole. Issues will be explored through creative, educational, supportive and recreational means.

A co-ordinator has been employed and two part-time community childcare workers are being appointed. An office has been opened to provide administrative support and as a community focal point. The project is linked to the local Area Partnership, Canal Community Partnership through the Rialto Network.

Community Mothers Programme

The Community Mothers Programme is an effective method of offering parents support in their child rearing task. It is based on a home visiting strategy in which trained Community Mothers or Family Development Nurses help to empower parents, to enable them to achieve their potential and develop their skills. The Programme has achieved a great deal of success in areas where it has been implemented. Parents, especially those living in areas of social stress, have been helped by the Programme to improve the quality of their parenting. There is some evidence that levels of child abuse are lower in participating families and for the Community Mothers themselves, the sense of achievement is considerable.

During 1996, twelve hundred parents received monthly support visits from Community Mothers and Family Development Nurses. Visiting by Community Mothers was extended to all Areas; ante natal visits were increased by ten percent and home support visits to breastfeeding mothers were also increased. A Family Development Nurse has been identified to develop the Programme in Area 3 during 1997.

- Article 30 draws attention to the rights of a child belonging to minorities to enjoy his or her own culture.
- Article 32 obliges States to protect the child from economic exploitation and work that may interfere with education or to be harmful to health and well being.

In Pavee Point we believe that in the implementation of this Convention and the Child Care Act, it is essential that the specific needs of Traveller children are explicitly included and addressed.

All interventions to assist, protect and promote the well being of Traveller children should ensure that Traveller identity is respected and not undermined. This is particularly important in the treatment of Traveller children with disabilities and Traveller children in need of institutional care.

Where appropriate Travellers should be trained and involved in the delivery of the range of services to Traveller children. Also Travellers, Traveller organisations should participate in the development of any policies, strategies or services that are being devised to cater for the needs of Traveller children.

In collaboration with Pavee Point, the Eastern Health Board continued to develop a Primary Health Care Project for Travellers in the Finglas/Dunsink area. As a result of the project successful programmes in child health, oral health, and environmental health have begun. The first report on the project was launched by the Minister for Health in June.

Travellers were designated as a special needs group by the Senior Clinical Dental Surgeons with responsibility for special needs. A flexible dental service was offered to Traveller children through the Dental Treatment Services Scheme. Similarly, a flexible clinic for travellers is based at Roselawn Health Centre and in 1996, 264 Traveller adults and 19 children were treated there. The Senior Clinical Dental Surgeons attended a Traveller oral health orientation day at Pavee Point. Also in conjunction with Pavee Point and the local Public Health Nurses, a pilot project is in operation in one Dental Area to improve dental services for Travellers.

Pavee Point, in co-operation the Eastern Health Board and other agencies, initiated a project in 1996 with the objective of establishing and providing an accredited Primary Health Care training programme for Traveller women to work within their own community.

Pavee Point

It is the policy of this Review to request voluntary agencies to contribute their views on service provision for children. This year, Pavee Point has kindly responded to our request as follows:

"We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer: 'Tomorrow'. His name is: 'Today'.

Gabriela Mistral

Thus does the study Pavee Children (1997) open. This is a study on child care issues for Travellers recently published by Pavee Point. This quote is particularly pertinent for Traveller children. Traveller children, as a minority within a minority, are particularly vulnerable in Irish society. A census of the population of Ireland carried out in 1986 highlighted the striking difference in age structure between the Traveller population and the national population. The median age of Travellers is 14 years compared to the national figure of 27 years. An estimated 80% of Travellers are under 25 years, with 50% under 15 years and 40% under 10 years. These percentages have been attributed to the high birth rate and low life expectancy of Travellers (only 5% of Travellers live to 50 years). Given the fact that the majority of Travellers families experience marginalisation and exclusion, low social status, poor living circumstances and inadequate accommodation facilities, it is inevitable that Traveller children live in circumstances which are not conducive to growth, development of self esteem or pride in their own Traveller identity.

Service Locations

Within available resources, services are based at the following possible locations:

Table 26: Locations of Child & Adolescent Psychiatric Services in EHB region		
<i>Eastern Health Board</i>	<i>Mater Child & Family Services</i>	<i>Hospitaller Order of St John of God</i>
Castleknock Ballyfermot St James's Hospital Kill, Co Kildare	Mater Hospital Ballymun St Frances Clinic, Temple Street St Joseph's Adolescent Unit, Fairview	Orwell Rd., Rathgar Ballybrack Blackrock Tallaght Bray Wicklow

Service provision

Child and Family Centres provide a range of clinic-based services. Children with a wide range of problems are seen and these include: psychiatric illnesses, psychological difficulties, inappropriate behaviour, speech and language delays and disorders, difficulties of co-ordination or perception and early learning difficulties. The professionals who work in the centres include psychiatrists, psychiatric nurses, psychologists, psychiatric social workers, speech therapists and child care workers. During 1995, the team at Kill in Kildare has been augmented and a satellite clinic is evolving in Athy. These developments will help to ensure equity of access to the service throughout the region.

Special Schools are operated jointly with the Department of Education. Responsibility for the provision of these is divided as follows:

Table 27: Provision of special education within EHB region (day service)		
<i>Eastern Health Board</i>	<i>Mater Child & Family Services</i>	<i>Hospitaller Order of St John of God</i>
Phoenix Park Ballyowen Meadows James Connolly House Warrenstown House Courthall	Mater Hospital	St Peter's, Rathgar

These schools cater for children with mixed emotional and conduct disorders, young autistic children and mildly mentally handicapped children. The Board also provides support to the special school Benincasa by the provision of care staff. It should be noted that the Ballyowen Meadows and James Connolly House Schools have transferred from their original locations to a new modern complex at Beech Park,

Drug misuse can affect many generations of the same family. The mother of one drug misuser reports:

"They both are helpless, and they have hepatitis. The daughter who died of AIDS was spotless clean. She had had six children by the time she was 21. Four are in care. The youngest, twins, both died of the AIDS virus, one when it was a month old, the other at 4. Her husband is also dead. I had her other children for a while but I couldn't cope. There were nine children here under 10". (p58)

The lack of hope in the future is striking among the drug misusers interviewed in the study. When asked about future plans one replied:

"If I am still on the gear, I have no future only end up in a pine box. There are only two things in gear, prison and death. That is all you get out of it".

Challenges for service provision

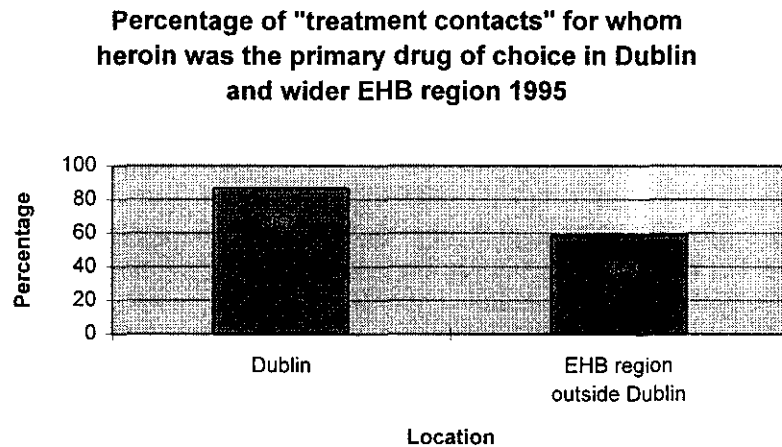
Reports from different parts of Child Care and Family Support Services in 1996 speak of greater difficulties arising from rising heroin and other drug misuse.

Drug dependant babies: Superintendent Public Health Nurses contacted during this Review reported that the impact of drug misuse on their service grew during the year. Of those contacted, seven Areas said that this impact was greater. A growing number of babies are being born to addicted young mothers and these babies suffer drug withdrawal symptoms at birth. The babies require seven-day visiting each week for six weeks or more in order that medication be administered to alleviate the withdrawal symptoms. Because of the babies' circumstances, their general welfare also requires close monitoring. In addition, their grandmothers need support as they will be caring for their addicted daughter (the baby's mother) who is often still a teenager, along with a highly dependant baby.

Homeless and out of home young people: As discussed elsewhere in this Review, services for homeless and out of home young people are experiencing difficulties in finding residential placements for young people who are misusing drugs. In a small study done of young people in an emergency hostel during one month of 1996, it was found that 42% were known to be drug misusers. These young people present challenges to service providers; their behaviour can be chaotic and it is felt they present a risk of introducing drugs to others in hostels and group homes.

Family refuges: The Women's Refuge in Rathmines can no longer allow admission to those who are actively misusing drugs; addicts who are on a maintenance programme however are accepted. Haven House has described the impact of drug misuse upon their service as "worse" in 1996 compared to previous years. Women addicts who are barred from other hostels and bed and breakfast facilities are accepted in Haven House. The resultant client mix is not be the most favourable environment for children.

Within the Eastern Health Board region, there are differences to be seen between the greater Dublin area and the rest of the region:



Within Dublin, the report of the Ministerial Task Force pointed out that drug misusers came primarily from:

- North inner city
- Ballymun
- Blanchardstown
- Finglas
- Cabra
- Coolock
- South inner city
- Ballyfermot
- Clondalkin
- Tallaght
- Crumlin
- Kimmage/Walkinstown

Profile

The findings of the Health Research Board provide a profile of the typical misuser. Drug misusers in Dublin as we have seen above, are heroin misusers and they are also young. Of those from Dublin who presented for treatment in 1995:

- 65% were under 25 years of age
- 31% were teenagers
- 63% had left school at or before the age of fifteen
- 87% were unemployed

The Ministerial Task Force pointed out that: *"One fact which is not in dispute is that incidence of drug misuse is occurring more and more frequently among younger people"*. (P28) Drug misuse increasingly seems to begin between the ages of 15 and 19 as can be seen below:

senior clinical dental surgeons within the dental team, has been demonstrated to be effective in work on fissure sealant programmes, oral health promotion and with special needs groups.

Fluoride mouth rinsing programmes continue in schools in Wicklow, Kildare and Dublin where the public water supply is not fluoridated. A new fluoridation plant has been installed in the Kilberry, Kildare. A major refurbishment of the Leixlip water purification plant, which is the largest supply source to Dublin city and county, involved the replacement of the entire fluoridation plant. In Co Wicklow, fluoridation plant has been upgraded at Blessington, Enniskerry, Laragh and Cronroe.

Orthodontic Services

Service commenced at the new Eastern Health Board's Regional Orthodontic Department at St. James's Hospital in September 1996. This is significantly reducing waiting times in the region for orthodontic treatment. Eight Senior Clinical Dental surgeons have been recruited and, under the supervision of a Consultant Orthodontist, they are carrying out comprehensive orthodontic treatment on a full-time basis. In addition a Dental Hygienist, two Radiographers and ten Dental Surgery Assistants are now employed in the Department.

Since the opening of the Regional Orthodontic Department, all Category 1 patients on the waiting list have been assessed and, where appropriate, their treatment has commenced. There is no longer a waiting list for Category 1 patients and these are referred directly to the Regional Orthodontic Department for orthodontic assessment. The Category 2 waiting list was reduced from 11,365 at 1st September to 5,680 at 31st December 1996.

Approval for two Consultant Orthodontists for the region was received from the Department of Health. However, the Local Appointments Commission was successful in recruiting only one consultant who took up appointment in July, 1996. A further Regional Orthodontic Department has been approved and will be located on the campus of Beaumont Hospital.

Treatment has been offered at the Unit to those who have fulfilled Department of Health guidelines relating to the provision of orthodontic treatment. It should be noted that demand for orthodontic treatment very often does not reflect clinical need and therefore a treatment needs index, which gives priority to children with the greatest clinical need, is used to determine the necessity for referral for orthodontic assessment/treatment.

To ensure equity for all in relation to assessment and treatment, it was agreed that national criteria for assessment of need would be applied to those on the waiting list. Between September and December 1996, appointments were issued to 8,351 individuals and the progress of these offers is shown in the following figure:

In some Areas children from very deprived backgrounds have difficulty in availing of services, and again alternative ways of providing input to this group need to be examined.

In some Areas therapist have difficulty in accessing social work services for children with severe communication problems, who have difficulty in attending for speech and language therapy because of social circumstances.

Specialist Posts

The provision of a specialist Senior Post for Child Psychiatry in Area 1 is welcomed. In many where therapists are providing a specialist service, for example in the School for the Deaf and in the Language Unit and Classes, posts should be upgraded to senior level.

Conclusion

During the year referral numbers have increased, and while an increased number of children were assessed during the year, the number awaiting assessment at the end of the year has also grown. The number of children with severe communication problems continues to increase.

The demand for speech and language therapy provision to children with special needs, in special schools and classes is also growing. Balancing the needs of all client groups within current resources places increasing demands on therapists.

Computerisation should provide a broader range of statistics on which to base future developments and should also allow us to examine the varying needs of Community Care Areas.

Issues of accommodation, equipment budgets and provision of clerical support should be examined at local level.

Increased provision of psychological service to children with speech and language impairments needs to be examined. Dedicating an agreed number of sessions in each Area to speech and language therapy referrals might be considered.

potential saving in terms of speech and language therapy provision. The impact of WILSTAAR will be monitored in Area 8 and the system may then be introduced to other Areas.

A speech and language service to children with Cochlear Implants in St. Joseph's School for Deaf Boys is now in place five sessions a week. The number of children receiving cochlear implants is on the increase, and all children require intensive speech and language therapy input following implantation. Therefore the need for this service is likely to increase. Provision of this service within the school has highlighted the need for a service to children with hearing impairment.

Adequacy of Services

The continued increase in the number of referrals and the severity of disorders has a major impact on service provision. Difficulty in providing regular weekly, or more intensive input is reported in many Areas. The fact that children with moderate or mild difficulties are waiting for long periods following assessment is unacceptable and ultimately leads to an exacerbation of the problem.

In many Areas therapists are required to provide a service to a wide range of locations, apart from Community Care Clinics. For example in Area 6, 5 sessions are provided to James Connolly Memorial Hospital, a further 5 sessions are allocated to St. Joseph's School for Deaf Boys, 6 sessions to the Child and Family Centre in Castleknock and 7 sessions to Scoil Chiarain School for children with learning disabilities. Only one full time post is fully devoted to community care clients. A similar situation applies in many other Areas where there are a number of special schools and services receiving input.

Accommodation

Lack of adequate accommodation is a problem in many Areas. In some cases services cannot be provided on a full time basis because rooms are not available. For example in Crumlin a full time service is required, but the room allocated to the speech and language therapist is not available on a full time basis. In many Areas clinics are provided on the basis of availability of accommodation, and not solely on need.

Equipment Budgets

Many Areas do not have access to a budget for equipment. Provision of a specific annual budget, developed in consultation with the Principal in each Area would allow for a phased development of an appropriate range of assessment and intervention materials.

Clerical Support

All Areas consider the level of clerical support to be inadequate. Therapists spend time on tasks such as filing, issuing appointments, putting data on computer, photocopying etc.

Many Areas report an increase in the number of children presenting with severe problems. This may be due to a number of factors:

- greater awareness of communication problems and the role of the speech and language therapist
- referral of children with multiple problems to the community, rather than to specialist clinics
- other agencies' policy of transferring children to community care
- in some Areas referral of children with autistic spectrum disorders
- improved survival of premature babies who subsequently present with significant developmental problems

Unfortunately, because of the length of waiting lists for therapy, only those with the most severe problems can be seen in some Areas. Children with severe problems are likely to require more long term input, with the result that waiting times for those with less severe problems are constantly increasing. The longer these children wait for input, the greater the impact of their communication problem becomes.

Provision of more diagnostic clinics and services which can offer intensive input to children with severe problems, would have a significant impact on waiting lists.

Following assessment and diagnosis, therapists plan programmes of intervention for children and their families. This may involve direct intervention, advice on management of the child's communication problem, implementation of a programme with parents, or a combination of these approaches. The nature of intervention will depend on a number of factors – the type of disorder, the client group, the age of the client and the work setting. For example in the case of a child who is non-fluent the therapist may work mainly with the parents, in the case of an autistic child the therapist may work initially with the family and care staff involved. In many cases therapists will work directly with children.

Depending on the nature of the child's problem, weekly therapy, or intensive therapy may be required. In some cases intervention will be on an individual basis, in other situations group therapy will be recommended.

In the region all Areas have difficulty in providing the optimum level of service to children. In many cases it is not possible to provide therapy on a twice weekly basis, even for children with very severe problems. In some Areas a period of continuous weekly therapy, for example for a six month period is not possible, because of the pressures of waiting lists. Therapists operate fixed term therapy, or block therapy, as a means of caseload management, not necessarily because this is in the best interest of the individual client.

In block therapy, or fixed term therapy, children are offered a set number of sessions – for example six or eight sessions, and are then placed on a waiting list to attend another block of therapy at a later stage. While this type of intervention is suitable for children with certain types of disorder it does not meet the needs of children with

for Child Psychiatry in Area 1, in Trinity College and for Adult Services in Area 2, and for Mental Handicap Services in Area 8.

The majority of therapists in the Eastern Health Board are involved in provision of services to children. Children are seen in a range of settings, including health centres, special schools, child psychiatry/ child and family clinics, pre-schools and special classes in normal schools.

Table 23: Numbers of children referred, assessed, and awaiting assessment in 1996			
<i>Area</i>	<i>No. of children referred</i>	<i>No. of children assessed</i>	<i>No. awaiting assessment at year end</i>
1	304	277	230
2	324	274	99
3	256	261	123
4	372	351	380
5	365	336	364
6	476	282	146
7	305	236	376
8	697	670	231
9	520	474	173
10	359	314	197

Referrals

The total number of children referred for assessment in the region in 1996 was 3978, which represents a 9% increase in referrals since 1995. While there is a continued upward trend in referrals, numbers remain significantly less than the expected levels for the population of the region, based on epidemiological studies here and in the U.K.

There has also been an increase of 10% in the total number of children assessed during the year. Numbers awaiting assessment at the end of the year – 2319, represent an increase of 4%.

Referrals come from a number of sources, public health nurses, Area Medical Officers, parents, psychologists, school medical examinations, teachers and general practitioners. Most Areas operate an open referral policy, while some Areas do not accept referrals from parents and teachers without a supporting medical referral. Principal therapists support an open referral policy as the best method of ensuring access to the service.

Throughout the region there is emphasis on early intervention, encouraging referrals before school entry at 4+. The following table indicates the numbers referred in the 0-4 and 4 – 18 age ranges.

are experiencing increased need to supervise Public Health Nurses who are in contact with such families.

Communication between social work teams and the Public Health Nursing service should be improved. A number of Areas have formalised this communication in order to improve co-operation and liaison: monthly child protection management meetings are held and in some cases joint visiting to children who are giving cause for concern take place. In at least one Area the monthly child protection management meetings are attended by the Gardai, a development which is welcomed by the Area. It is hoped that these initiatives will become standard practice in each Area; the appointment of a Training Officer to the Child Care and Family Support Service should facilitate this.

The need for greater access to support services for vulnerable families was noted by the Superintendent Public Health Nurses. These include family support workers, day nurseries, child care workers. A common risk assessment tool which is used by both social workers and Public Health Nurses was requested by one Area.

Current support services for families which are managed by Public Health Nurses such as Community Mothers, breastfeeding support groups and parent and toddler groups which operate in almost all Areas were also brought to the attention of this Review.

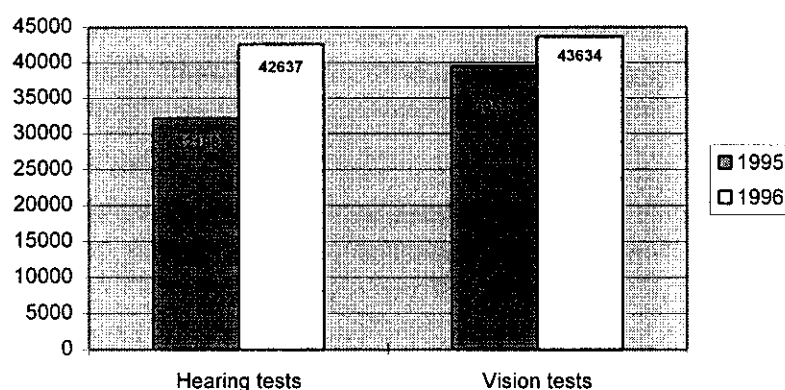
Visiting schedule

Area 8 has piloted a scheme of visiting babies by appointment with the parents. In addition, the introduction of a flexible working week in the Area was intended to increase the efficiency of visiting. Ineffective visits have now been reduced in this Area to 14%; this is in contrast to more than 30% of visits being ineffective in some other Areas.

Drug misuse

Almost all Areas recorded greater impact of drug misuse upon the service during the year. Higher numbers of addicted babies are being born; to ease their withdrawal, the Public Health Nurse must visit on a daily (seven day) basis for almost six weeks to administer their medication. In addition, drug misuse causes other difficulties in families which requires greater support and increased visiting from the Public Health Nurse. Greater levels of alcohol misuse was also noted by one Area.

Number of hearing and vision tests carried out in schools in EHB region 1995 and 1996



Public Health Nursing Service

Recruitment and retention

Six Areas reported difficulties regarding recruitment and retention of Public Health Nurses during the year. Permanent posts remain vacant and leave is difficult to cover. One Area noted that the flexible working week which was introduced during 1996 greatly facilitated retention of staff who would otherwise have left the service.

Training

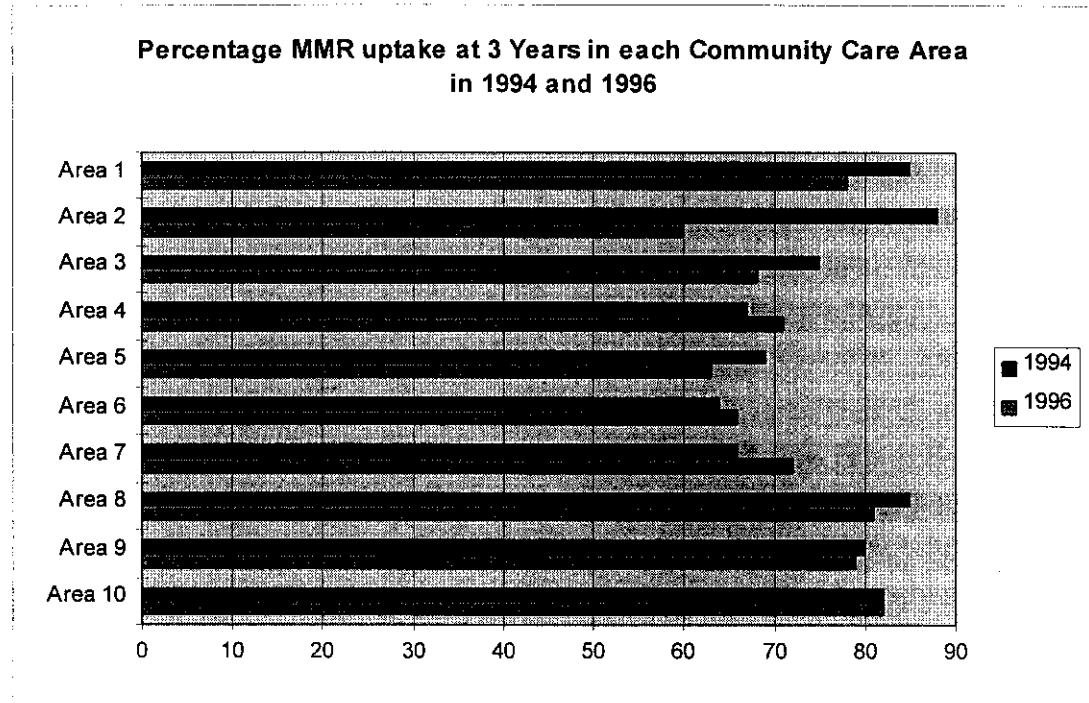
Superintendent Public Health Nurses who were contacted for this Review reported that adequate numbers of staff availed of either locally based or centrally organised in-service training during the year. Training in the following topics was undertaken:

- lactation certification
- audiometry
- hospital-based paediatric seminar
- infant nutrition
- metabolic screening and disorders
- Child Care Act
- court procedures

Joint workshops between Public Health Nurses, Area Medical Officers and social workers in relation to children at risk and the Child Care Act took place in two Areas during the year. In addition, a number of Public Health Nurses are attending the Advanced Diploma in Child Protection and Welfare at Trinity College.

Guthrie tests

Guthrie tests, which must be carried out soon after a baby is born are increasingly becoming the responsibility of Community Care services and of the Public Health Nursing service in particular. These tests are vital to discover which babies must be



A small study of general practitioner satisfaction with the new immunisation scheme was undertaken for this Review. Respondents were members of the Eastern Health Board's General Practice Unit. Almost all of these general practitioners described their overall experience of the first year of the scheme as positive. They also reported that in their experience, parents are happy with the scheme, especially with its convenience and flexibility. The role of the practice nurse in implementation of the scheme was seen as very important for its effectiveness, as was computerisation. It was felt that if practice nurses are not employed, general practitioners should consider employing them on a shared basis in order to improve immunisation uptake. Similarly, where computers were not available, improved manual record keeping systems were seen as important. When asked how the scheme could be improved, general practitioners called for a faster, single, centralised system of payment. A more flexible system of vaccine collection (perhaps open during lunch hours) was also requested.

With regard to improving uptake rates, the co-operation of Public Health Nurses was cited by many as crucial in order to fully brief general practitioners on babies who should be attending for immunisation. A parent-held appointment card may be useful to act as a reminder along with a re-vitalised publicity campaign. It was also felt that the Eastern Health Board should target for special support those general practitioners whose uptake rates lag behind those of their colleagues.

Developmental examinations

All babies are entitled to a free paediatric developmental examination at nine months of age in order to detect medical problems or developmental delay. The following figure shows that poor uptake of these examinations is most striking in those Areas which experience most deprivation:

References

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Table 19: Children (0-15 years) covered by medical cards (GMS) by Community Care Area as a proportion of total child population in each age group (November 1996)			
Community Care Area	Age Group (%)		
	Under 5	5-9 years	10-14 years
1	18.6	17.7	15.9
2	24.6	24.2	20.3
3	27.2	24.7	22.2
4	35.3	31.4	31.9
5	42.2	39.7	44.7
6	33.7	32.6	33.5
7	47.4	43.5	34.7
8	26.2	25.4	23.2
9	26.0	22.1	26.2
10	36.9	32.9	33.5

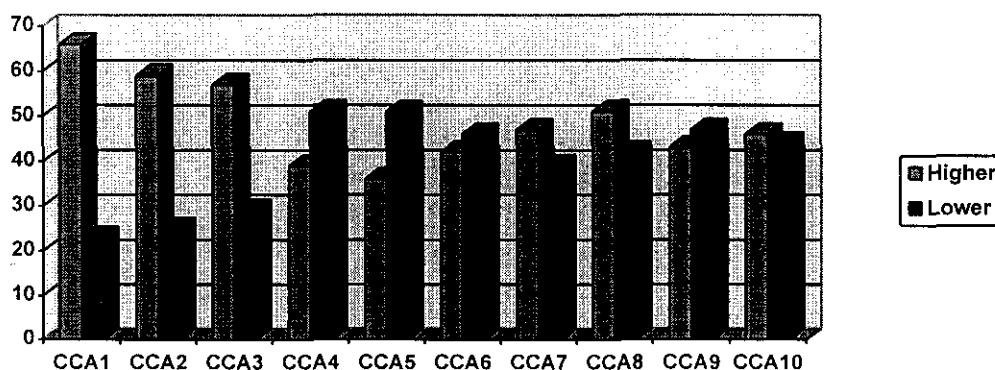
Note: Denominator used - census 91

Table 19 shows that the proportion of children living in Community Care Areas 5 and 7 covered by a medical card is more than double the rate in Area 1.

Social Class

The social class distribution varies considerably between Community Care Areas. Figure 8 details the social class breakdown by Community Care Area. For the purposes of presentation, social class codes 1 to 3 have been categorised as "higher" and social class codes 4 to 6 have been categorised as "lower". Social class 7 (unknown) is not presented.

Figure 8: Percentage of persons per Community Care Area in higher (1-3) and lower (4-6) social class group.



Source: Health Information Unit, Eastern Health Board. Small area population statistics 1991.

which they live". Since then, the concept has evolved from a focus on income or expenditure to multi-dimensional disadvantage, and from a focus on individual or household to a recognition that it is within the local community that the disadvantage is experienced.

One of the instruments used at European level to monitor the extent and the nature of social exclusion and poverty is the European Community Household Panel Survey. A household survey was carried out in Ireland by the Economic and Social Research Institute (ESRI) in 1994 as part of this European survey (Callan, Nolan, Whelan et al, 1996). The findings were compared with those of a similar household survey carried out by the ESRI in 1987. The main findings of this work were:

- (1) Income poverty: Compared with 1987, the proportion of persons below the 50% poverty line (i.e. the line set at half-average income) had increased by 1994. However, when the **depth** of poverty shortfalls as well as the numbers below the line were measured, it showed a consistent fall in aggregate poverty between 1987 and 1994.

The authors found that the risk of being below the 50% line had increased for single-adult households, and about one third of poor households in 1994 were headed by an unemployed person. Children face a higher risk of being below the income lines than adults, and households with 4 or more children are at particularly high risk, as are lone parent households.

- (2) Non-monetary indicators of deprivation (19 in all) were developed and used to identify those experiencing generalised deprivation or exclusion due to lack of resources. Examples of these indicators include: new not second-hand clothes; a meal with meat, fish or chicken every second day; two pairs of strong shoes; a car; a bath or shower; a dry, damp-free dwelling. Compared with the 1987 survey, the percentage of households doing without the various items or activities had generally fallen by 1994.

Households with an unemployed head continue to be the most substantial group among the poor when a combination of income and deprivation information is used.

As recommended by the Commission on Social Welfare, priority was given from 1987 to raising what were then the lowest social welfare rates, for Unemployment Assistance and Social Welfare Allowance. Rates for these schemes thus increased a good deal more rapidly than mean incomes between 1987 and 1994.

The proportion of the population in each D.E.D. of the Eastern Health Board having a medical card is a good indicator of material deprivation. It can be used as a health need indicator as it is means tested and takes account of the elderly and children in the population. 29% of the Eastern Health Board population have a medical card (December 1995). The D.E.D.s where over 50% of the population had a medical card at the end of 1995 were calculated. This highlights the areas of greatest material deprivation. They are:

It is worrying to note that between 1993 and 1995 in the EHB region that opiates were responsible for 18 childhood poisonings requiring hospital admission (HIPE). The medicines included under this code are 'heroin, methadone, codeine, morphine and opium unspecified'. It is very likely that these 18 poisonings were due to methadone. Prescription medicines have been shown to be more likely to be involved in poisoning than over-the-counter medications (Wiseman et al, 1987). The most common drugs implicated are those commonly prescribed, i.e. analgesics, antipyretics, antibiotics, sedatives, hypnotics, antidepressants, respiratory agents and antihistamines (HIPE)².

Medicine packaging in Ireland - The Current Situation

In January 1997 a survey of medicine packaging at community pharmacy level was undertaken by the Department of Public Health, Eastern Health Board (Laffoy, 1997). The results show that many medicines with high accident association indices are neither packaged in CRCs nor in blister packs. It is of concern that many well known cardiac, respiratory, anti-inflammatory, tranquilliser and anticonvulsant preparations are only supplied to pharmacies in 'loose' containers. The most worrying finding was that one paediatric iron suspension was presented in an ordinary screw-cap.

Medicine dispensing in Ireland

Dispensing of medicines in child resistant containers (CRCs) is currently not a professional requirement for pharmacists in Ireland. The Pharmaceutical Society currently recommend a voluntary code. This is despite the fact the, then, National Drugs Advisory Board strongly recommended in 1982 and 1985 that:

'CRCs be used for all medicinal products whether over-the-counter or dispensed by the pharmacist' (National Drugs Advisory Board, 1982).

'all medications dispensed by the pharmacists should be provided in a CRC unless the prescriber specifically requests otherwise' (National Drugs Advisory Board, 1985).

The Use of CRCs in the UK, USA and Northern Ireland

A professional requirement for the use of CRCs exists in the UK, Northern Ireland and the USA. Up to 1989 there was a voluntary code for the use of CRCs in the UK but it was found that 66% of pharmacies did not use them 'openly flouting the voluntary agreement' and forcing the Pharmaceutical Council to implement the professional requirement (Council Statement, 1989).

The effectiveness of CRCs

Although accidental poisoning is now an uncommon cause of death it leads to many hospital admissions and unnecessary illness. Before the advent of CRCs attempts at prevention were largely educational with little noticeable effect.

The Virus Reference Laboratory reported two new cases of congenital rubella infection in November 1996, one of which occurred in the Eastern Health Board region. The last cases confirmed by the VRL had occurred in 1989.

An increase in the number of clinical notifications of rubella in the EHB was noted in 1996. The cases occurred mainly among males aged 15 to 24 years who would not have received MMR at age 11-12 years.

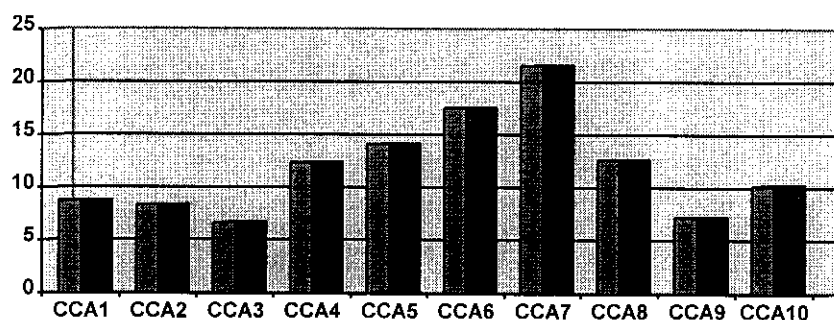
These figures indicate the need for a continued and active immunisation programme, attention to the immune status of women in child-bearing years and the ongoing surveillance of rubella infection if further cases of congenital rubella are to be prevented.

Meningococcal Infection

One hundred and twenty seven cases of suspected meningococcal disease were notified in the Eastern Health Board region in 1996. These comprised 83 definite (65%), 19 presumed (15%) and 25 possible cases (20%) of disease. There were six deaths attributed to the disease in the period. The incidence in the Eastern Health Board is high compared to the European average rate.

The crude meningococcal disease rate was 10.2 per 100,000 population and the crude case fatality rate was 4.7 per cent. The majority of cases occurred in babies and young children with a second smaller peak occurring in late adolescence. In 1995 the number of notifications of meningococcal disease was 153, giving a rate of 12.3 per 100,000 population.

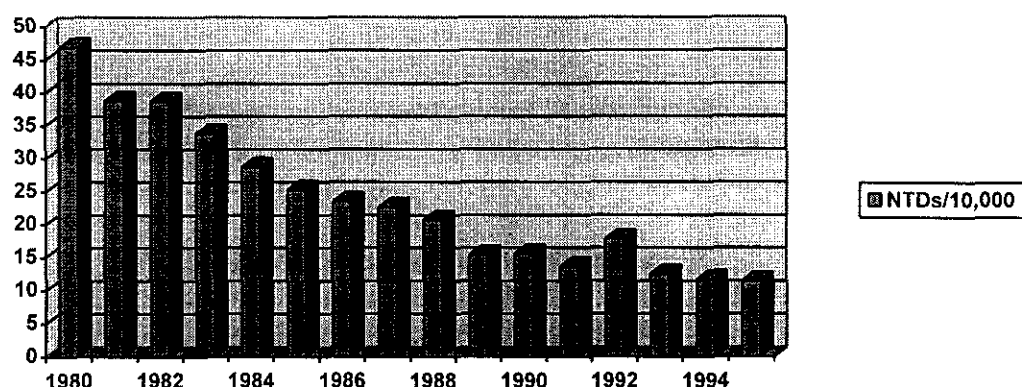
Figure 7: Meningococcal infections in EHB - notification rate per 100,000 total population by Community Area 1996



Smoking in pregnancy

The hazards of smoking in pregnancy are well recognised. Maternal smoking in pregnancy has significant adverse effects on fetal growth and pregnancy outcome. The effects of smoking in pregnancy extend well beyond infancy with a reduction in growth and educational achievement. There is now strong evidence of an increased risk of sudden infant death syndrome associated with maternal smoking, and also with postnatal exposure to tobacco smoke.

Figure 5: Neural tube defects - rate per 10,000 live and stillbirths classified by birth year.



A hospital based survey on women's knowledge and use of peri-conceptual folic acid was carried out among women attending public antenatal clinics in 3 Dublin maternity hospitals in 1996. 54% of those interviewed had heard of folic acid, 21% knew it prevented spina bifida, 6% took folic acid supplements before conception and 57% of pregnancies were unplanned. The authors concluded that the knowledge and usage of folic acid was poor among pregnant women. (Sayers G, Scallan E, McDonnell R, Johnson Z. Paper presented at Irish Perinatal Society Meeting. April 1997).

Communicable diseases

Communicable diseases are no longer so important for children in terms of mortality but are still responsible for considerable morbidity. Their importance also lies in the fact that many of them are preventable either by immunisation or by improving hygiene or social conditions and by education.

Table 17: Notifications of communicable diseases received by EHB in 1995 and 1996 - listing of most frequently notified diseases.		
<i>Disease notified</i>	<i>Number of notifications</i>	
	1995	1996
Gastroenteritis <2 years	1621	1129
Salmonellosis	148	145
Measles	134	141
Meningococcal infection/meningitis	153	127
Pertussis	86	101
Infectious mononucleosis	71	110
Hepatitis A/viral hepatitis unspecified	61	95
Meningitis - pneumococcal, Hib, and bacterial unspecified	54	32
Rubella	50	333
Mumps	18	241
Food poisoning (unspecified)	n.a.	130

Source: EHB Communicable Diseases Surveillance System

In the late 1980's, international epidemiological research identified a number of risk factors for SIDS. In March 1992, the Department of Health launched a health education campaign entitled "Reduce the risk of cot death". The recommendations of this campaign were based on study findings which indicated an increased risk of SIDS in infants placed prone to sleep, infants of mothers who smoked and infants who are heavily wrapped. The guidelines also encouraged breastfeeding. Research has shown that over one quarter of the risk of death due to SIDS is attributable to maternal smoking (Royal College of Physicians, 1992).

The National Sudden Infant Death Register aims to establish the incidence of SIDS in Ireland and collects specific epidemiological data on SIDS cases. The most recent report of the Register contained the following results:

- The SIDS rate in Ireland for 1995 was 14% lower than the rate in 1994 (0.7 versus 0.8 per 1,000 live births). However, the 1996 rate (provisional) of 0.9 is higher than the 1994 rate.
- There was a higher rate of parental unemployment and medical card ownership among SIDS families than the national average. This raises questions that require further investigation.

Parents of SIDS cases in Ireland were interviewed and information regarding these risks was obtained. In 78% of cases, mothers smoked during their pregnancy, with 68% of fathers smoking during this time. After the baby was born, 77% of mothers smoked while 68% of fathers smoked. This is much higher than the smoking rate of 29% in Ireland in 1994. There is much scope for improvement in this well recognised risk for SIDS. Examination of the usual sleeping position of all cases revealed that for only 1 case (4%), prone position (i.e. lying on their stomach) was their usual sleeping position. This figure is lower than in previous years (in 1992 this figure was 19%). Table 14 outlines the SIDS rate for Ireland and for the EHB.

Table 14: SIDS number and rate per 1,000 live births for Ireland 1980-1996 and for EHB 1992-1996				
<i>Year</i>	<i>Ireland</i>		<i>EHB region</i>	
	Number of SIDS	Rate per 1,000 live births	Number of SIDS	Rate per 1,000 live births
1980	144	1.9		
1985	139	2.2		
1990	98	1.8		
1991	84	1.6		
1992	59	1.1	27	1.4
1993	37	0.7	15	0.8
1994	40	0.8	15	0.8
1995	33	0.6	14	0.8
1996*	45	0.9	23	1.3

* Provisional figures

Source: CSO, Report on Vital Statistics 1980-1988; CSO, Yearly Summary, 1992 and 1995; National Sudden Infant Register 1992-1996

Table 10: Principal causes of death of infants (<1 year) for Ireland and EHB 1996				
Cause of death	Ireland		EHB region	
	Number	% all infant deaths	Number	% all infant deaths
Congenital anomalies	105	37.8	38	33.6
Conditions originating in the perinatal period	109	39.2	46	40.7
Infectious diseases including meningitis and pneumonia	15	5.4	6	5.3
Other causes	49	17.6	23	20.4
Total	278	100.0	113	100.0

Source: Central Statistics Office, Vital Statistics

Note (1): This classification system does not specify Sudden Infant Death Syndrome (SIDS). See below for SIDS figures recorded by SID Register.

Note (2): Since these data are based on small numbers they should be interpreted with caution

Childhood Deaths

Beyond the infant stage, injury and poisoning becomes an increasingly significant cause of death in children. In the age group 5 to 14 years injury and poisoning is the most common single cause of childhood mortality. These deaths are to a large extent avoidable.

Table 11: Principal causes of death of children 1-4 years of age for Ireland and EHB 1996				
Cause of death	Ireland		EHB region	
	Number	% all deaths 1-4 years	Number	% all deaths 1-4 years
Congenital anomalies	16	24.2	8	38.1
Infectious diseases including meningitis and pneumonia	11	16.7	1	4.8
Injury and poisoning	12	18.2	7	33.3
Other causes	27	40.9	5	23.8
Total	66	100.0	21	100.0

Source: Central Statistics Office, Vital Statistics

Note: Since these data are based on small numbers they should be interpreted with caution

Table 12: Principal causes of death of children 5-14 years of age for Ireland and EHB 1996				
Cause of death	Ireland		EHB region	
	Number	% of all deaths 5-14	Number	% of all deaths 5-14
Injury and poisoning	37	40.7	15	53.6
Malignant neoplasms	18	19.8	4	14.3
Infectious diseases including meningitis and pneumonia	7	7.7	3	10.7
Other causes	29	31.9	6	21.4
Total	91	100.0	28	100.0

Source: Central Statistics Office, Vital Statistics

Note: Since these data are based on small numbers they should be interpreted with caution

Table 7: Premature births (<37 weeks) and low birth weight babies (<2,500 gms) in the EHB region in 1996 by Community Care Area				
Community Care Area	<37 weeks gestation		<2,500 gms birth weight	
	Number	% all births*	Number	% all births*
1	110	6.2	85	4.8
2	85	4.6	80	4.4
3	66	4.7	65	4.6
4	162	8.1	152	7.6
5	142	6.6	146	6.9
6	150	6.3	140	5.9
7	133	7.5	104	6.2
8	188	6.4	167	5.7
9	123	5.4	120	5.3
10	70	4.6	74	4.8
Total	1229	6.1	1132	5.7

Source: RICHs (EHB computerised child health records)

*calculated on basis of births for which gestation/birth weight recorded

Note: As numbers are small in some of these categories, they should be interpreted with caution as small differences in numbers can result in large variation in rates.

Table 7 shows that the Community Care Areas with the highest proportion of low birth weight births correspond to those with the highest proportion of children covered by medical cards, with the exception of Wicklow (see table later). A study carried out in the Eastern Health Board (Johnson, Dack and Fogarty, 1994) found that the best predictor of low birth weight was the proportion of the population covered by medical cards.

In 1992 (the most recent year for which national perinatal statistics have been published) low birth weight babies (<2,500 gms) represented 4.1% of total births. The corresponding Eastern Health Board figure is considerably higher at 5.7% in 1996.

Breastfeeding

The prevalence of breastfeeding in Ireland and the E.H.B. is low at 33.9% and 38.2% respectively (Table 8).

Table 8: Percentage of mothers breastfeeding, EHB and Ireland, 1988-1992					
	1988	1989	1990	1991	1992
EHB	37.5	38.4	37.3	37.3	38.2
Ireland	32.3	32.8	31.7	31.9	33.9

Source: Perinatal Statistics 1992, Department of Health.

The rate of breastfeeding varies considerably with social class, as represented by father's occupation, being lowest in unskilled manual worker's families (Figure 2). The age of the mother is also associated with the rate of breastfeeding, the rate being lowest in younger mothers (Figure 3).

Table 5: Non-marital births in the EHB region as a % of all births for 1992 and 1996 by Community Care Area				
Community Care Area	Non-marital births 1992		Non-marital births 1996	
	Number	% all births*	Number	% all births*
1	273	15.9	335	19.1
2	269	19.4	473	25.5
3	248	18.5	371	26.3
4	539	26.4	744	37.2
5	527	27.0	774	36.4
6	487	22.7	784	33.2
7	599	35.5	760	44.8
8	599	20.3	706	24.6
9	244	9.5	507	22.3
10	289	18.3	368	24.1
Total	4074	21.4	5822	29.3

Source: RICHs (EHB computerised child health records)

*calculated on basis of births for which marital status recorded

There was a downward trend since 1980 in the number of marriages registered in Ireland with an annual marriage rate per 1,000 of the population of 6.4 in 1980 falling to 4.4 in 1993. This decline appears to have levelled out, with a marriage rate of 4.6 in 1994 and 4.4 in 1995.

The category of "unmarried mother" encompasses three family types. (Flanagan and Richardson, 1992). "Firstly the unmarried mother who returns to the parental family home is often incorporated back into her nuclear family thus resulting in a three tier family structure akin to traditional extended families. Secondly, a number of unmarried mothers choose to live alone and rear their child thus simultaneously falling into the category of lone parent. And thirdly, an increasing number of unmarried mothers are choosing to cohabit."

Thus, non-marital births are a poor indicator of deprivation or social/health need. They are no longer considered to be a risk factor per se as many are in the context of stable two parent families. More emphasis is now being placed on births to teenage mothers. Teen mothers, by virtue of their age, have completed a lower level of education and correspondingly are more likely to achieve lower levels of income. They are also less mature in terms of parenting skills.

A questionnaire study was carried out of teenage mothers attending a public adolescent antenatal clinic in Dublin to examine their socio-demographic characteristics and sexual behaviour (Fitzpatrick, Fitzpatrick and Turner, 1997). 80.8% said that they had just one sexual partner to date and 87.5% said that they were involved in a continuing relationship with the father of the baby. Conception occurred within the first year of the relationship in 91.6%. 88.2% were from social classes 3 to 5, 12.5% were still at secondary school. Of those who had left school, 80% had not sat the Leaving Certificate and 10% had not undertaken any state examinations. 55.8%

The number of children in each Community Care Area in 1991 is detailed by age group in Table 2. This shows that the largest proportion of children in the Eastern Health Board live in Area 8 (16.5%), while the smallest proportion live in Area 3 (6.1%).

Table 2: Age breakdown of children under 18 years of age in the EHB region by Community Care Area (1991)						
<i>Community Care Area</i>	<i>0-4 years</i>	<i>5-9 years</i>	<i>10-14 years</i>	<i>15-17 years</i>	<i>Total number</i>	<i>% total E.H.B. child pop.</i>
1	8,494	8,913	10,383	6,625	34,415	8.9
2	6,354	6,222	7,197	4,926	24,699	6.4
3	6,363	6,363	6,600	4,021	23,373	6.1
4	11,777	14,274	16,057	8,652	50,760	13.2
5	9,897	11,184	10,971	6,214	38,266	9.9
6	11,104	12,198	12,467	7,286	43,055	11.2
7	7,804	7,507	8,553	5,511	29,375	7.6
8	14,881	16,912	19,756	12,124	63,673	16.5
9	10,893	12,844	13,170	7,827	44,734	11.6
10	8,032	9,309	10,043	5,759	33,143	8.6
Total	95,599	105,752	115,197	68,945	385,493	100%

Table 3 indicates that in 1991 Kildare had the highest proportion of its population represented by children under 18 years at 36.5%. Community Care Area 5 had the highest proportion of children under 5 years at 9.3%, compared with 7.7% for the Eastern Health Board as a whole. The corresponding national figure was 7.8% in 1991. In 1986 children under 5 years represented 9.2% of the national population. Children under 5 years represent a major need in terms of service usage.

Table 3: Percentage of population in each Community Care Area represented by children in each age group (1991)					
<i>Community Care Area</i>	<i>% pop. in area 0-4 years</i>	<i>% pop. in area 5-9 years</i>	<i>% pop. in area 10-14 years</i>	<i>% pop. in area 15-17 years</i>	<i>Total % pop. in area < 18 years</i>
1	6.8	7.1	8.2	5.3	27.4
2	5.4	5.2	6.1	4.1	20.8
3	7.1	7.2	7.4	4.5	26.2
4	8.1	9.8	11.1	6.0	35.0
5	9.3	10.6	10.4	5.9	36.2
6	8.1	9.0	9.1	5.3	31.5
7	6.7	6.5	7.4	4.8	25.4
8	7.9	9.0	10.5	6.4	33.8
9	8.9	10.5	10.7	6.4	36.5
10	8.3	9.6	10.3	5.9	34.1
Total	7.7	8.5	9.3	5.5	31.0

Review also draws attention to high levels of heroin misuse among young people in the region and the effects of this is detailed throughout the Review.

Perhaps the most acute social exclusion in the region is experienced by Traveller children. We were pleased that Pavee Point, the voluntary agency which works on behalf of and in partnership with Travellers, accepted our invitation to detail the health and social status of Traveller children for this Review. Also outlined in that section are the services which are in place, some in partnership with Pavee Point, which are designed to support Traveller children and their families. Our Board is fortunate in the range of excellent voluntary agencies, such as Pavee Point with which we work in partnership. I thank these agencies for their continued dedication and I look forward to continuing, close partnership with them.

Finite resources must be husbanded to provide maximum effectiveness; it is important that resource allocation is targeted towards those parts of our region which experience the greatest inequity of health and social status. Our Board was pleased to participate in a joint Eastern Health Board/IMPACT review which was established in May 1996 to determine and agree upon the levels of resources required to provide adequate child care services and criteria for allocation of such resources throughout the region. This Review Group has just completed its work and its report will be issued shortly.

Difficulties were experienced in recruiting and retaining sufficient numbers of suitably qualified social work staff during 1996. It is becoming more evident that the pressures and responsibilities of those working in child care, both field and residential, are not attracting sufficient numbers of new graduates to opt for child care as a career choice. In this regard one must acknowledge the dedicated staff who have persevered to provide a quality service under difficult circumstances.

As well as managing this greatly increased rate of referrals to all services, our Board is committed to expanding preventative services and I am pleased that it was possible to open additional support services in six Community Care Areas. During 1996, our Board was pleased to make a comprehensive submission to the Commission on the Family in which we detailed the risks to the health and social gain of children and families and the services which we have put in place to meet their needs. Since there are multi-faceted causes to many of the difficulties facing children and families, our Board's submission recommended a multi-sectoral approach to their resolution involving income support, education, local authorities and the legal system.

The challenge for us as service providers is not to lose sight of the importance of early intervention and preventative services while dealing with current, pressing concerns. It is for this reason that the Review takes the opportunity to highlight the less 'high profile' areas of family support, early intervention and preventative work. These services seldom feature in public debate on child care and yet they are an essential element in preventing our services from becoming solely crisis driven.

In December 1996, the remaining sections of the Child Care Act 1991 were signed into effect by the Minister of State at the Department of Health. Part VII of the Act places an obligation on health boards to inspect pre-school services in their region.

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