



EASTERN HEALTH BOARD

REPORT ON CHILD CARE AND FAMILY SUPPORT SERVICES

January, 1994

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**REPORT
ON
CHILD CARE
AND
FAMILY SUPPORT SERVICES**

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REVIEW OF CHILD CARE AND FAMILY SUPPORT SERVICES

Introduction

Under Section 8 of the Child Care Act 1991, a health board is required to have a report prepared annually on the adequacy of the child care and family support services available in its area.

In particular, a health board is to have regard in the report to the needs of the following categories of children who are not receiving adequate care and protection:-

- (a) children whose parents are dead or missing,
- (b) children whose parents have deserted or abandoned them,
- (c) children who are in the care of the board,
- (d) children who are homeless,
- (e) children who are at risk of being neglected or ill-treated, and
- (f) children whose parents are unable to care for them due to ill-health or for any other reason.

The Child Care Act 1991 is the most significant legislation in relation to child care since the foundation of the State. The main provisions of the Act are as follows:

- (i) The raising of the age of a child to 18 years;
- (ii) the placing of a statutory duty on health boards to promote the welfare of children who are not receiving adequate care and protection;
- (iii) strengthening of the powers of health boards to provide child care and family support services;
- (iv) improved procedures to facilitate immediate intervention by health boards and the Gardai where children are in serious danger;
- (v) provisions to enable the courts to place in the care of or under the supervision of health boards children who have been assaulted, ill-treated, neglected or sexually abused or who are at risk and to order that children be represented by their own lawyers or by guardians ad litem;

inviting them to contribute their views. Responses have been received to date from the organisations listed in **Appendix B**.

Ongoing consultation and co-operation with both statutory and voluntary agencies also takes place in relation to specific initiatives for particular groups. To this end, staff from our Board work closely at local level with the Home School Liaison service of the Department of Education sharing information and formulating a joint response to families which need extra support. In two community care areas, our Board is also participating in a joint pilot initiative by the Department of Health and the Garda Síochána. The scheme is working towards a standard procedure for the notification of cases of suspected child abuse between health board staff and members of the gardai. This procedure is in line with a recommendation of the Report of the Kilkenny Incest Investigation. With regard to traveller children, our Board is also involved in discussion with local authorities and voluntary agencies in order to monitor and improve the services offered to this group.

These responses and our Board's general review of needs will be considered in conjunction with (i) present services and resources (ii) the new obligations imposed and to be imposed under the Child Care Act (iii) statistical and other data on the extent and kind of needs to be met.

The following are the provisions of the Act brought into effect by Ministerial Order to date:

Section	Title
Section 1	Short Title
Section 2	Interpretation, including the definition of a child as a person under 18 years
Section 3	Functions of the health boards
Section 5	Accommodation for Homeless Children
Section 6 (part of)	Provision of Adoption Services
Section 7	Child Care Advisory Committee
Section 8	Review of Services
Section 9	Provision of Services by Voluntary Bodies
Section 10	Assistance for Voluntary Bodies
Section 11	Research
Section 66	Superannuation of certain staff
Section 69	Powers of Minister
Section 71	Prosecution of Offences
Section 72	Function of Chief Executive Officers
Section 73	Expenses
Section 74	Sale of Solvents
Section 79	Repeals (part of)

Our Board realised many years ago that the avoidance of removal of children from their families and community should be our primary objective and to that end we fostered the setting up of a network of day nurseries to provide day care, of which there are now over 40 with more planned.

Also set up was a network of Family Resource Centres to deal on a day care basis with parents as well as children. More of these are planned and in the pipeline.

We have for many years been promoting the Community Mothers Programme and other initiatives designed to improve parenting skills and these are to be extended as part of our developments envisaged under the Child Care Act. The assignment of child care workers to work in family homes and the establishment of a Home Maker Service and its continuing extension have also effected an improvement in parenting and home management skills in families at risk of disintegration.

The Eastern Health Board sponsored the development of the Child Abuse Prevention Programme (C.A.P.P.). Its development by professionals in our child psychiatric service was encouraged, fostered and funded, as was its implementation by teachers and social workers from our service in schools in our area and its extension to schools all over the state.

The board is at present, in consultation with social workers and their managers, developing the first comprehensive computerised social work case management system. This is a very significant development which will be of use to our Board and indeed all Boards.

Our experience in the development of these services has been and will be invaluable in undertaking the extensive development of new services.

DEMOGRAPHIC AND SOCIO-ECONOMIC TRENDS

The Eastern Health Board region comprises counties Dublin, Kildare and Wicklow. The area is divided into ten community care areas: eight in Dublin and one each in Kildare and Wicklow (Figure 1).

The population of every Health Board region in the country fell between 1986 and 1991 with the exception of the Eastern Health Board which increased by 12,238 to 1,244,476, an increase of 1%. However this population increase was not evenly spread. Seven of the community care areas had a net increase while three had a net fall (Table 1).

Table 1: Total population in each Community Care Area of the EHB in 1986 and 1991 showing net change and percentage change.				
Community Care Area	Total population 1986	Total population 1991	Net change in Population	% Change in Population
1	123,089	125,543	2,454	2.0
2	114,558	118,530	3,972	3.5
3	86,593	89,097	2,504	2.9
4	148,781	145,227	-3,554	-2.4
5	103,264	105,740	2,476	2.4
6	137,145	136,350	-795	-0.6
7	120,213	115,499	-4,714	-3.9
8	187,806	188,600	794	0.4
9	116,247	122,645	6,398	5.5
10	94,542	97,245	2,703	2.9
All EHB	1,232,238	1,244,476	12,238	1.0

Table 1 shows that Kildare had the largest increase in population (5.5%) while Community Care Area 7 had the greatest fall (-3.9%).

Community Care Area 8 remains the biggest and most populated area of the Eastern Health Board while Area 3 has the smallest population.

In the region in 1991 there were 385,493 children, under the age of 18 years i.e. 31% of the total Eastern Health Board population (Table 2). In 1986 the corresponding figure was 415,012 i.e. 33.7% of the total Eastern Health Board population at that time.

The proportion of children in each Community Care Area is outlined by age group in Table 2.

Table 2: Age breakdown of children under 18 years of age in the EHB by Community Care Area (1991)						
Age Group						
C.C.Area	0-4	5-9	10-14	15-17	Total No.	Total %
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	6,389	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 No	95,599	105,752	115,197	68,945	385,493	

The largest number of children live in Community Care Area 8 (16.5%) while the smallest number live in Community Care Area 3 (6.1%).

Children under 5 years represented 7.6% of the total Eastern Health Board population in 1991 compared with 8.8% in 1986 (Table 3). This reflects trends in the national population in which children under 5 years represented 9% of the population in 1986 and 8% in 1991.

Table 3: % Population of EHB by age group in 1986 and 1991							
Year	Under 1	1-4	5-14	15-24	25-44	45-64	65+
1986	1.7	7.1	19.1	19.3	27.7	16.3	8.8
1991	1.5	6.1	17.8	18.7	29.1	17.4	9.4

Table 5: Number of births in EHB and Ireland							
	1986	1987	1988	1989	1990	1991	1992
EHB	21,336	20,892	19,633	18,513	19,238	19,655	19,049
Ireland	61,419	58,864	54,300	51,659	52,954	52,690	51,584
% of all births in EHB	34.8%	35.5%	36.2%	35.8%	36.3%	37.3%	36.9%

The infant mortality rate has been considered of great significance in public health. A high rate has been taken to indicate unmet health needs and unfavourable environmental factors - economic conditions, nutrition, sanitation and medical care. For the last number of years, the infant mortality rate has been dropping, an indication of social improvement and good ante-natal care (Table 6).

Table 6: Infant mortality rates for EHB and Ireland 1984 - 1992									
	1984	1985	1986	1987	1988	1989	1990	1991	1992
Area EHB	10.1	8.9	7.7	7.3	9.6	7.5	7.2	8.9	7.5
Ireland	10.1	8.9	8.7	7.4	9.2	7.5	8.2	8.2	6.6

Teenage and Non-Marital Births

Of particular importance in planning appropriate services for children is the proportion of babies born to teenagers and to single parent families.

Many studies indicate that babies born to teenagers and single mothers begin life relatively disadvantaged when compared to those born to married women in their twenties and early thirties. Such disadvantages range from medical to social problems.

Table 8: Births to teenage mothers in Dublin compared with all births (1993) by Community Care Area

Community Care Area	Number of births	Number of teenage births	% of all births in C.C.A.
1	1,654	60	3.6
2	1,606	48	3.0
3	1,434	52	3.6
4	1,998	111	5.6
5	1,889	118	6.2
6	2,184	151	6.9
7	1,839	120	6.5
8	2,859	117	4.1
Total	15,462	777	5.0

Conclusion:

A simple analysis of the birth rate over time in itself gives limited insight into the needs of children in our area. Of greater importance in determining need and identifying those at risk are the changing social, environmental and economic circumstances.

A major cause of infant death and morbidity is premature birth. There are strong grounds for believing that geographic, social class and age group are causative factors in premature births (1).

One of the main targets of W.H.O.'s document "Health for All by the Year 2000" (2) is to reduce the actual differences in health status between countries and between groups within countries by improving the levels of health of disadvantaged nations and groups. By identifying areas of greatest need, resources can then be directed with the aim of reducing inequality and improving health status.

3. HEALTH AND WELFARE NEEDS OF CHILDREN

Unemployment

Research by the Economic and Social Research Institute (ESRI) in 1990 and 1991 found that there has been a sharp increase in the risk of poverty among households with children, especially for large families. The most significant single finding associated with the risk of childhood poverty was the adverse effect of increased unemployment (3). Households with children were about 15 times as likely to be below the poverty line as those without children. Therefore a much greater proportion of children than adults were found to be in households below the poverty line (4).

The numbers of people in the Eastern Health Board region on the Live Register on 31 December 1993 is presented in table 7.

Table 9: Number of persons on the Live Register by sex and age group for the Eastern Health Board in December 1993.						
	Female		Male		Total	Total
	Under 25	25 and over	Under 25	25 and over	December 1993	December 1992
Dublin	11,628	21,080	16,736	44,405	93,849	92,812
Kildare	1,078	2,017	1,485	4,331	8,911	9,061
Wicklow	903	1,910	1,446	4,150	8,409	8,386
Total EHB	13,609	25,007	19,667	52,886	111,169	110,259

Statistics on unemployment rates are available by county and by local office. Consequently it is difficult to extrapolate them to Community Care Areas or to District Electoral Districts within these areas. However these data do give the proportion of males and females, under and over 25 years of age who are unemployed.

In Dublin at the end of 1993 there were 65,485 (14%) people over 25 years unemployed; the corresponding figure for Kildare was 6,348 (11.5%), while for Wicklow 6,060 (13.8%) people over 25 years were unemployed. This group are more likely to have child dependants than those under 25 years of age. Given that

Accidents are the main cause of death in children over one year of age. They are the major cause of potential years of life lost. Many childhood accidents can be prevented. DED's identified where there were more accidental deaths than expected: are Mountjoy - Ballybough - East Wall areas on the north side of Dublin and Kilmainham - Clondalkin - Ballyfermot and Tallaght on the south side.

In the United Kingdom indices of material deprivation (e.g. The Jarman and Townsend Indices) have been developed. In Ireland the proportion of the population with GMS cards is a good indicator of material deprivation. Some 29.5% of the Eastern Health Board population have a GMS card. The district electoral divisions with over 50% of their population in possession of a GMS card were calculated. This highlights those areas of greatest material deprivation. They are as follows:

Community Care Area 2	-	Royal Exchange A & B
Community Care Area 3	-	Merchants Quay A, Ushers B, C and E
Community Care Area 4	-	Tallaght: Fettercairn, Jobstown, Killinardin
Community Care Area 5	-	Clondalkin: Rowlagh, Kylemore
Community Care Area 6	-	Blanchardstown: Mulhuddart, Tyrrelstown
Community Care Area 7	-	Ballybough A, Ballymun A, B & C, Mountjoy A, North Dock C, Rotunda A
Community Care Area 8	-	Priorswood B & C

No DED in Community Care Areas 1, 9 or 10 had 50% or more of its population in possession of a GMS card. Table 10 shows that almost 50% of children living in Community Care Area 7 have a GMS card, the highest proportion of all areas, while in Community Care Area 1 the proportion of children with GMS cards is below the average figure. The total numbers of Eastern Health Board residents with a GMS card is presented in Appendix C.

This table shows that while the greatest proportion of children in Community Care Area 5 were receiving the allowance, the largest number were in Community Care Area 4.

Recipients of supplementary welfare allowance (SWA) provides further information on need. Table 12 analyses SWA recipients by community care area for one week in June 1992.

Table 12: SWA recipients and their adult and child dependents for one week in June 1992.			
C.C.A.	Recipients of S.W.A.	Adult dependents	Child dependents
1	872	147	515
2	2,819	152	546
3	1,192	145	693
4	1,467	584	2,131
5	2,148	499	2,292
6	2,064	458	1,874
7	3,274	885	2,392
8	1,935	919	2,778
9	1,165	421	1,411
10	990	418	1,136
Totals	17,926	4,628	15,768

This table shows that proportion of recipients with the largest number of child dependants was greatest in Community Care Area 4 and Community Care Area 8 and smallest in Community Care Area 2. However Community Care Area 7 had the greatest total number of recipients.

Summary

Demographic and socioeconomic indicators can give a good picture of health and welfare needs of children in our area.

The childhood population in the Eastern Health Board area is changing. The Board is now responsible for more older children because of (i) the age of 'a child' has increased from 16 to 18 years and (ii) the birth rate is dropping. The changing demography presents the Board with additional challenges in meeting needs.

Several factors affect the physical, social and mental health of children. This chapter highlights many of them and the areas in greatest need: the proportion of teenage mothers and single parent families, unemployment rates and areas with greatest material deprivation.

PUBLIC HEALTH NURSING SERVICE

Public Health Nurses plays a vital role in the delivery of primary health care. They are assigned to a defined geographical district and carry out a variety of preventative services including child health, school health and immunisation. Other duties include child surveillance and the identification of vulnerable children, health education/promotion, liaising with pre-school community-based facilities and participating in case conferences relating to child welfare issues.

Table 13: Number of families on PHN register and number of visits made.		
Year 1992	No. of Families on Public Health Nurse Register	No. of Home Visits by Public Health Nurse
Area 1	5,741	21,589
Area 2	3,963	19,758
Area 3	4,039	22,850
Area 4	6,690	36,142
Area 5	5,615	30,410
Area 6	6,839	30,754
Area 7	5,282	30,632
Area 8	9,355	33,017
Area 9	6,162	20,899
Area 10	4,382	10,875

The public health nursing service is undergoing change. Refresher courses run by the Eastern Health Board currently reflect the developing needs in the area of child care and protection. The concept of the generalist nurse carrying out 'combined duties' in the district should be retained as far as possible. However, it is probable that, while retaining overall responsibility for patients, babies and young children, public health nurses will come to rely more and more on less qualified and non-professional assistants to help with the care of the elderly and to leave them more free to concentrate their multiple skills on the primary job of child and family development and in the identification of children not receiving adequate care and protection.

IMMUNISATION

The Eastern Health Board provides a comprehensive immunisation service for children through the area medical officers and general practitioners. At birth, vaccination against Tuberculosis (BCG) is offered; at 2, 4 and 6 months Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza b vaccines are given. Measles, Mumps and Rubella (MMR) vaccine is given at 15 months by general practitioners. On primary school entry, boosters of Tetanus, Diphtheria and Polio are given. A second dose of MMR is now offered to all 11 year old boys and girls. Rubella vaccine which was formerly given to girls only at this age is now no longer routinely administered.

Table 14: Vaccinations in EHB region in 1992			
Vaccinations by EHB Medical Officers	Dublin	Kildare	Wicklow
BCG	17,342	1,287	868
Hib (1.10.92-31.12.92)	10,415	1,797	170
DPT completed	15,008	1,605	1,047
DT (completed)	2,759	326	381
Polio (completed)	17,724	1,777	1,454
Rubella vaccinations (for 11-14years)	6,459	1,090	1,002 (from Sept. '92 to Dec. '92 only)

The following Table gives the uptake of primary vaccination at 2 years of age for Dublin in 1992.

Table 15: Uptake of primary vaccination at 2 years 1992	
Diphtheria	75%
Polio	75%
Pertussis	61%

While the uptakes of primary vaccination are less than satisfactory, they do not take account of vaccinations, except MMR, undertaken privately by general

CHILD HEALTH EXAMINATIONS

(i) Domiciliary Visits:

All babies receive an initial visit by a public health nurse within a few days of receipt of birth notification. This is followed by a second visit at approx. 3 months or earlier if deemed necessary. Further visits are made, including a screening examination at 18 months, up to 3 years of age. Visiting beyond this timescale will continue in cases of vulnerability and handicap.

(ii) Nurse Advisory Clinics:

Clinics are held regularly in health centres and parents may bring their child, without appointment, for advice, screening and monitoring of progress.

(iii) Paediatric Developmental Clinics:

Clinics are held in health centres where children at approx. 9 months of age receive a developmental examination by appointment with the Area Medical Officer. The main objective is to detect and refer for treatment any child who has a remediable defect.

Table 17: Uptake of appointments for Paediatric Developmental Clinics by Community Care Area.					
Year 1992	No. of Clinics	No. of appointments offered	No. attended	% attended	No. needing further attention
Area 1	307	2,687	1,751	65%	265
Area 2	259	2,185	1,625	74%	687
Area 3	243	2,217	1,293	58%	324
Area 4	376	3,092	2,081	67%	337
Area 5	325	2,650	1,581	60%	134
Area 6	299	2,446	1,698	69%	753
Area 7	213	2,234	1,305	58%	308
Area 8	432	3,996	2,874	72%	638
Area 9	702	2,798	2,091	75%	
Area 10	445	3,496	2,972	85%	970

(iv) Area Medical Officer's Referral Clinics:

Clinics are held by appointment in health centres to which infants and children up to 6 years of age are referred by the public health nurse for examination.

COMMUNITY MOTHERS PROGRAMME

The quality of parenting is important in early development. The Early Childhood Development Unit in the University of Bristol developed a child development programme, whereby health visitors give parents of young children support and guidance on health and development matters. Since parents are regarded as the experts on their own child, they are encouraged to solve their own problems in child rearing. Five health authorities in England and Wales and the EHB in Ireland have had encouraging results with this programme.

In Ireland, however, proper use of scarce resources indicated that the programme should not continue directly through public health nurses only. It was therefore decided to recruit non-professionals in the person of successful experienced mothers to implement the programme instead of health professionals. Accordingly, a community mothers programme was launched in Dublin in 1983.

The community mothers programme aims at using experienced volunteer mothers in disadvantaged areas to give support and encouragement to first time parents in rearing their children using the child development programme. Potential community mothers are identified by the local public health nurses and interviewed to assess suitability.

Once accepted, the community mother undergoes four weeks of training, during which the concepts of the programme are explained. She also meets other community mothers, and they exchange ideas and explore ways of delivering the programme. After training, each community mother works under the guidance of a family development nurse (a public health nurse on special assignment), who serves as a resource person, confidante, and monitor. Each community mother aims at supporting five to 15 first time parents.

The community mothers programme is a well designed intervention programme whose essential feature is the empowerment of the parent who is regarded on equal terms and not given advice by the community mother. Instead the community mother shares her own experiences with the new mother and raises her self esteem and confidence in herself as a parent.

Today, the Community Mothers Programme operates through ten Family Development Nurses who have 160 Community Mothers regularly visiting some 800 client mothers in their homes.

As part of the resources for the implementation of the Child Care Act, the Department of Health has recently approved a further extension of the Community Mothers Programme including seven additional Public Health Nursing posts. That development will proceed as soon as nurses have been identified and assigned to this specialised prevention work.

HEALTH PROMOTION

Health Promotion is a comprehensive term that includes personal and community development but also any form of environmental change that promotes personal health and well being. It's a positive concept implying more than avoidance of illness. The Eastern Health Board is involved in many initiatives to promote the health of children including:

- 'Health is Lookin Good' health message competition
- smoking prevention
- HIV/AIDS education and drugs awareness
- nutrition intervention programme
- Community Mothers Programme
- positive intervention with early school leavers
- avoidance of dental decay
- accident prevention
- health promoting school (strengthening the capacity of schools to be safe and healthy settings for living learning and working).
- teenage pregnancy primary prevention programme
- child abuse prevention programme
- community development projects
- physical exercise

The Eastern Health Board in conjunction with the Institute of Community Nursing has launched a Health Promotion Pack. The resource pack has been prepared for nurses and other health professionals to help them in promoting health and healthy lifestyle in schools and in the community generally.

Health Promotion is not just the responsibility of the health sector. Intersectoral co-operation is necessary. The Eastern Health Board has forged links with many groups and organisations in the promotion of children's health, notably the Dublin Healthy Cities Project, Irish Cancer Society, Health Promotion Unit of the Department of Health, local authorities, many primary and post primary schools, community groups and voluntary groups.

DAY NURSERIES

The purpose of day nurseries is to provide an alternative to residential care for young children whose parents are unable to care for them during the day. They also provide day care for children whose development may be gravely at risk due to physical or mental illness in the family or general deprivation.

As such, day nurseries are to the forefront in assisting the Board to achieve its prime child care target of enabling children to stay in their own family home where at all possible.

It is estimated that at any one time, not less than 50% of all children who come to the attention of the Board are maintained in this way, together with other supports.

Our Board grant aids 44 voluntary organisations to provide day nursery places for 1,500 children in our area.

It is our intention to continue to develop preventative child care facilities including day nurseries as new funds permit in order to ensure that an adequate number of home support places are available in each community care area.

The following is a list of the organisations and locations providing Day Nursery Care.

AREA 1

Loughlinstown Day Nursery
Health Centre
Loughlinstown Drive
Co Dublin

Dun Laoghaire Day Nursery
St Mary's Dominican Convent
Convent Road
Dun Laoghaire

Monkstown Day Nursery
Monkstown House
Monkstown Grove
Co Dublin

AREA 2

Day Nursery
c/o Y.M.C.A.
Aungier Street
Dublin 2

Miss Carr's Home Day Nursery
c/o 16 Northbrook Road
Leeson Park
Dublin 6

AREA 6

St Mary's Day Nursery
8 Henrietta Street
Dublin 1

Finglas Day Nursery
Social Service Centre
Wellmount Road
Dublin 11

St Helena's Day Nursery
St Helena's Road
Dublin 11

Roselawn Day Nursery
Roselawn Health Centre
Blanchardstown
Dublin 15

AREA 7

St Louise's Day Nursery
North William Street
Dublin 1

Our Lady's Nursery
Sillogue Avenue
Ballymun
Dublin 11

St Brigid's Day Nursery
Mountjoy Square North
Dublin 1

Ballymun Day Nursery
Holy Spirit Girls N.S.
Sillogue Road
Ballymun
Dublin 11

AREA 8

Bonnybrook Day Nursery
St John Vianney Boys N.S.
Bunratty Drive
Coolock
Dublin 5

Kilmore Nursery
9 Cromcastle Green
Kilbarron Park
Coolock
Dublin 5

Darndale Day Nursery
c/o O.L.I.N.S.
Darndale
Dublin 17

Edenmore Day Nursery
St Monica's School
Edenmore
Dublin 5

Grange/Kildonagh Nursery
49 Swansnest Court
Kilbarrack
Dublin 5

Mead Day Nursery
Donaghmede House
Donaghmede
Dublin 13

Kilbarrack/Foxfield Nursery Day Centre
Coil Iosagain
Greendale Road
Dublin 5

HOME MAKER SERVICE

Home Help Service is provided through 37 Voluntary Organisations (and through Community Welfare Services in parts of Co. Wicklow and in all of Co. Kildare. Up to 5,500 persons were being assisted by up to 3,500 Home Helps at end of 1991. Family cases account for an overall 9% of total assisted but this is higher in areas of new housing developments.

A number of organisations have full time or part time Home Makers as part of their Home Help Service. The only 'dedicated' Home Maker Service in the Board's areas is in Community Care Area 8 where a Home Maker organisation was established in the mid 1980's and at present five Home Makers are assisting fifty five families. A service was commenced in Co. Kildare in 1991 and to date operates through the Community Welfare Services. These particular services and the service provided through the general Home Help Service provide practical assistance and encouragement, through its full-time and part-time Home Makers, to families and individuals under stress. Their role is essentially that of teaching and guiding on a one to one basis. Home Makers try, through encouragement and support, to help develop the practices and skills necessary to make and maintain a reasonable home. Families needing Home Makers Services are referred by a number of sources. Board's medical, nursing, social work and community welfare services identify families requiring intervention.

Although the expenditure in Home Help has increased over the years, there continues to be great demand for additional funds for Home Help Services including family and Home Maker Services. In 1992 the Board endeavoured to maintain the 1991 level or end of year level of services. The level of increase in expenditure in recent years cannot be sustained. Development of Home Maker Services as with the overall Home Help Service is limited by the funds available in the current year.

Many Community Development Groups and Women's Groups include in their Programmes/Services some Home Management Programmes. Crosscare (The Catholic Social Service Conference) and the Society of St. Vincent De Paul, also have some programmes.

FAMILY RESOURCE CENTRES

Currently our Board is directly responsible for 3 Family Resource Centres - Geraldstown House, Ballymun, St Helena's, Finglas and St Dominic's, Tallaght. These are community based services, are readily accessible and provide a range of group activities and programmes. The programme of activities include Mother and Toddler Groups, parenting courses, personal development courses, after-schools groups and teenage groups. Research studies have confirmed the effectiveness of such centres in reaching vulnerable families and enhancing their coping skills.

It is recommended that at least one family resource centre should be available in each community care area. Accessibility and community involvement are key features of family resource centres; consequently, due to the size of the community care areas, more centres will be required in the future.

Our Board funds a number of family centres which are managed by voluntary or religious organisations. These centres generally cater for families where problems have already arisen. Intensive therapeutic intervention programmes are devised for each family. Increased provision of these specialised family unit will be required.

NEIGHBOURHOOD YOUTH PROJECTS

The interim report of the Task Force on Child Care Services (1975) recommended the establishment of Neighbourhood Youth Projects (NYPs). Two Neighbourhood Youth Projects were set up by EHB in 1979 in Dublin's North Inner City Area. The objectives of the NYP are as follows:

- To enable the young people involved to remain in the community while receiving skilled help directed towards resolving or ameliorating severe personal/family problems which are innate potential for development;
- to provide a resource to mobilise the potential of the neighbourhood to define and to meet the evolving needs of its younger people;
- to develop an approach to working with young people at risk.

A review of the Neighbourhood Youth Projects was commissioned by the EHB in 1992 and the recommendations will inform the future development of these projects.

A neighbourhood youth project, funded by the Eastern Health Board, has recently opened in Blanchardstown. An increase in the number of Neighbourhood Youth Projects will be required especially in areas with a large young population - at least one in each community care area is considered to be necessary.

CHILD ABUSE PREVENTION PROGRAMME

The Child Abuse Prevention Programme was set up in 1987 as a response to the increasingly apparent problem of child abuse and bullying. At that time there was no suitable prevention programme available for children in Irish schools and both parents and teachers were seeking guidance and help with these issues. The programme, which is currently being introduced into primary schools, aims to prevent child abuse by (1) equipping parents and teachers with the knowledge and skills necessary to protect the children in their care, and (2) teaching children a personal safety skills course, called Stay Safe, to help them deal with various potentially dangerous or threatening situations.

The CAPP programme is a four stage approach to preventing child abuse, involving:

- (a) **Teacher Training:** An in-service training course on child abuse prevention and the Stay Safe teaching package was provided for all primary school teachers.
- (b) **Parent Education:** Parent information workshops are held to explain the Stay Safe programme and give parents an opportunity to view and discuss its contents. The parents' role in this learning process is discussed.
- (c) **Classroom Lessons:** The Stay Safe pack consists of a teachers' handbook, lesson plans for junior and senior cycles, childrens' worksheets and a video cassette. Children are then taught safety skills in the normal classrooms context and these skills are reinforced through discussion with their parents.
- (d) **Community Awareness:** Liaison meetings are held with health care staff and additional training for relevant groups within the community.

Progress

The CAPP programme was piloted and evaluated in a number of schools in the Dublin area in 1988-89. Following the successful outcome of pilot study the Departments of Education and Health agreed to fund its introduction into the Eastern Health Board area during the school year 1991-2. Three social workers and three teachers were seconded by the departments to facilitate teacher training and parent education. There are 637 primary schools in the Eastern Health Board region employing approximately 8,500 teachers. Teacher training was completed by June '92. 100% of schools availed of this training. To date 80% of schools have held parent information meetings and over 70% are teaching the Stay Safe lessons. Over 60,000 children have been taught all or part of the Stay Safe lessons.

SPEECH THERAPY SERVICES

Speech and Language Therapy is concerned with the assessment, diagnosis and treatment of speech, voice and language disorders. It is also involved in disorders of communication and swallowing. Since the early '80's, the service, in the main, is part of the Community Care Programme and there is a Principal Speech and Language Therapist with a minimum of three basic grades assigned to each of the ten Community Care Areas. Referrals to the service are from General Practitioners, School Medical Examinations, Public Health Nurses, Psychologists and parents. Treatment is provided at health centres, special classes in schools and child psychiatric centres. Referral numbers by age group for 1991 in the Board's area were as follows:-

Table 19: Referrals for Speech Therapy in EHB Region	
Age	Number
0 - 4	1,780
5 - 9	880
10 - 14	224

The Board also provides an assessment service for children with severe speech and language disorders including receptive and expressive language impairment and severe dyspraxia. Intensive therapy is provided for 30 children aged 2 1/2 to 6. Language classes are located in certain national schools and provide intensive therapy for children with severe speech and language impairments. Staff assigned to this area include a Principal, Senior and six basic therapists. Clinical locations are at the Language Unit, Ballinteer and classes in St. Patrick's National School, Drumcondra, Good Shephard National School, Churchtown, St. Martin's National School and Social Ard Mhuire in Tallaght.

The Board is currently examining the needs for this service in the area of mental handicap.

The Board is continually seeking to strengthen this service by maintaining a close relationship with the training body, Dublin University, by providing placement opportunities for students and sponsoring some in training.

DENTAL SERVICES FOR CHILDREN

The undermentioned children are eligible for dental treatment:-

- (a) Pre-school and national school children in respect of defects noted at child health examinations
- (b) Medical Card holders and dependent children of care holders
- (c) Children adjudged by the Chief Executive Officer to be unable to provide this service without experiencing hardship
- (d) Children up to the age of 16 will be entitled to dental services in the near future - legislation is being drafted at present to include this group.

For ease of administration our Board is divided into eight dental areas, each area being the responsibility of a Principal Dental Surgeon.

The service is based on screening children in 607 National Schools in selected classes each year. Those found with defects are referred for treatment as necessary to their local clinic. Fissure sealant programmes are also a feature of the service with a major input in dental health by Dental Health Educators. The Board has a total of 116 surgeries with 81 dental surgeons providing treatment for children. The number of children (aged 14 and under) eligible for treatment in our area is 287,254. With the increase in age to 16 a further 55,700 will become eligible.

The Board holds emergency pain clinics in all areas which can be availed of by children and adults alike. There are no waiting lists for child dental services.

We also provide orthodontic treatment. As demand for this service far outstrips our ability to recruit sufficient dentists with the appropriate post graduate qualification there are waiting lists. Children seeking Orthodontic treatment are categorised according to Department of Health guidelines and priority for treatment is afforded to Category 1 and 2 - those most in need clinically.

A recent survey carried out nationally on adult oral health by Prof. O'Mullane and Dr. H. Whelton of U.C.C. showed when a comparison was made between the Eastern Health Board and the remainder of the country that the level of oral health in the Eastern Health Board area is generally better than in the rest of the country.

TRAVELLERS

The total number of travelling families nationally as per the 1991 annual count was 3,671. The number in the Eastern Health Board area was 1,021. Various studies and reports have shown that, in terms of health status, the traveller population compares unfavourably with the national population. For instance, according to the Travellers' Health Status Study, 1986, infant and perinatal mortality rates were significantly higher for travellers. In addition, fertility rate of travellers in 1987 was 34.9 per 1,000, more than double the national average and the highest in the European community. Travellers have more than double the national rate of stillbirths and infant mortality rates are three times higher than the national rate. Travellers of all ages have very high mortality rates compared to the Irish population. They also have higher rates of morbidity for all causes of death but the incidences of death are significantly higher among travellers for: accidents; metabolic disorders in the 0 - 14 age group; respiratory ailments and congenital problems.

Other problems noted in relation to travellers health status include low rates of immunisation, insufficient take up of ante-natal and child development clinics and low birth weight babies.

Health Services

Staff of the Eastern Health Board work closely with staff of the local authorities and voluntary agencies and meet regularly to focus attention on the needs of travellers with a view to achieving improvements in their living conditions and health status. Outreach work has also been recommended as a solution to the problem of travellers' health. Since 1985, our Board has been operating a mobile clinic serving sites throughout the whole of Dublin in order to enhance the level and delivery of service to travellers. The mobile clinic augments services provided by public health nurses and area medical officers based in health centres close to the sites visited. A computerised child health information system specially designed for the children attending the mobile clinic has recently been introduced. A personal health record card has been developed and made available for retention by travellers. We will continue to develop these services to meet the most pressing needs of the travelling community and will of course have regard to the needs expressed by travellers themselves.

Traveller Families Care

Trudder House was established in 1974 as an emergency response to the problem of travelling children sleeping rough in the city of Dublin. These children were involved in substance abuse and serious delinquency. Trudder was primarily a response to a serious social problem. It housed up to 24 boys ranging in age from 7 to 18 years.

4. After Care Community Support Team: to link with children and their communities to prepare for a support through the move back into family life or independent living.
5. Shared Rearing: develop the fostering network among the travelling community and provide for emergency, short and long term placement of children with alternative travelling families.
6. Traveller Families Care is also closely linked with Exchange House, which provides a primary community based response to travellers with multi problems. Exchange House provides social work support, employment, training and drop-in service. It also provides a range of presentation programmes in the area of parenting skills, gender issues, family violence and addiction problems.

DOMESTIC ADOPTION AND INTER-COUNTRY ADOPTION

Adoption is a service for children. It was introduced into this country by the Adoption Act, 1952. There is a strict legal framework which governs adoption and adoption practice. Primarily adoption is a choice made for a child by the birth family, usually the mother. The Status of Children Act, 1987 has implications for adoption because it confers rights on the natural father of the child who is now entitled to apply to a court to become a joint guardian of the child and the father's intentions in relation to the child need to be ascertained.

The 1991 Adoption Act, which was passed primarily to meet the need of adopters who wish to adopt abroad has also had implications for national adoption. This Act was a response to the national pressure by people who wished to go abroad to adopt, and internationally as a response to a need to regulate inter-country adoption.

Under the terms of this Act, all those wishing to go abroad to adopt are entitled to an assessment. This has to be carried out by health boards.

Home Adoption

In home adoption the client groups are all the parties to the adoption:

- a) the birth parent/s
- b) the child
- c) the adoptive parents

Work with each of these groups is carried out in each community care area.

a) The Birth Parents

The counselling of the birth parents is an integral part of the adoption service which requires a skilful exploration of the options available and the implications of parting with and placing the child for adoption. This counselling requires time so that the final decision is in the best interests of the birth parent/s and the child. Many parent/s do not choose adoption when they have time to explore the issues for themselves. Because of the pressure of child protection work on some of the community care teams, area social workers have had difficulty in finding time to do this work and as a result birth parent/s are sometimes referred to other agencies. It is, however, important that this work is maintained in the Health Board if we are providing a full adoption service.

b) The Child

Where a child is placed with an agency for adoption, it is important that there is a range of potential parents available. The children all have different needs and it is important to look carefully at meeting those needs. It can be difficult at times to

We also look at social attitudes and their expectations of the child to be placed with them, their openness to giving on-going information about the child to the birth family and in later years being open to the adult adoptee's need to perhaps search for and meet the birth parent/s.

Post Placement - Tracing Service

There has been an increasing number of enquiries for tracing during 1992 and 1993. In the main the requests come from adult adoptees wishing to find their birth mother. There is also a large number of enquiries from birth mothers seeking to find their adopted child and also a smaller number of enquiries who wish to find a sibling who was also placed for adoption. Usually there is a waiting list for the uptake of these enquiries. This is due to pressure of other work.

This piece of work is often slow and a service is offered to the various parties involved. The inquirer is seen and given an opportunity to discuss the request and to explore all the implications for them. The mother, or other party, is also given an opportunity to discuss and explore the issues from their point of view when they are contacted. Most of these enquiries proceed to a meeting or a reunion, if the other person can be contacted. A service is also available to adoptive parents if they request it at this stage. A practice manual has just been published for social workers undertaking this work.

An on-going post placement service should be available to all adopters from the making of the Adoption Order until adulthood. This should be offered by the placing agency. We are aware of a number of adoptions that break down and there is a small, although significant number of adolescents, who have come into care when their adoption placement disrupts often to the degree where there is no further contact between the adoptee and her/her adoptive parents.

The numbers of applicants for inter-country adoption is increasing and the need for a post-placement service will become more acute.

Inter-Country Adoption

The client group for inter-country adoption is that of the potential adoptive parents only. Because of the lack of home adoptions and expectations that were raised by the experience of adoption in Romania in 1990 and 1991, and by the passing of the 1991 Adoption Act, there is a great and continual interest in inter-country adoption. In the period from July 1991 until the 24th January 1994, there have been to date 433 individuals or couples who have made enquiries regarding inter-country adoption. Following an information meeting on what is involved in the process, 184 of those have proceeded to make applications.

Cost of Adoption Service

It is difficult to assess the cost of the delivery of the adoption service in the Eastern Health Board. The following have to be considered in evaluating, in financial terms, the services in adoption offered by this agency:-

- a) The counselling of pregnant women and men who are looking at the choices available to them in making a decision for their child - the majority of pregnant women counselled do not place their children for adoption, given the shift in social attitudes over the last 10 years.
- b) The care of the baby/child in the pre-adoptive foster home while awaiting placement and the social work time involved in facilitating access for the birth parent/s and the child.
- c) The time taken to complete the assessment and preparation of couples/applicants for both adoption and inter-country adoption.
- d) The placement of children.
- e) The request for post-placement services from both birth parent/s and adoptive parents.
- f) The tracing service from adult adoptees or birth parent/s requesting to meet their grown up child.

In addition to the social work time, all adoption and inter-county adoption work has implications for the administrative backup. There is also an implication for social work supervision time as all assessment work needs to be supervised by a social work manager. The adoption service in the Eastern Health Board is delivered by the 10 community care teams and, bearing in mind the number of applications that have to be processed, the number of tracing enquiries, and the demand for counselling of pregnant women, there are staffing and supervision implications for this task to be completed and delivered as an adequate and comprehensive service.

It is often the case that, due to pressure of the child protection services on the area teams, some community care areas have not been in a position to offer a counselling service for women who are trying to make a life long decision for their child's future and for themselves. It is intended to improve this situation as part of our development programme.

FOSTERING

Fostering is a statutory service which is regulated by the Boarding Out of Children Regulations in the Eastern Health Board. Fostering service is delivered by the Fostering Resource Group and social workers in the community care area teams. The Fostering Resource Group was established in 1977 and is a centralised specialist team, comprising of five social work posts and senior social worker. Most area teams have fostering workers. In 1993, eight additional post were allocated to fostering in the area teams.

Fostering, or family placement, is an integral part of the alternative care placements available for children and young people who come into care in the Eastern Health Board.

As far as possible, children under 10 are placed with foster families in their own communities so as to ensure the least possible disruption for the child and the child's family, especially where rehabilitation of the child in his or her own family is the first aim as is usually the case.

There are four main types of foster placement - long term, short term, day fostering, and holiday and weekend. These are related in the main to the length of placement. In addition, there are specialist foster care schemes - Shared Care for Travellers, Carers for Young People (14-16 years) and Emergency Carers for Homeless Young People. A new scheme for relatives/neighbours was initiated in 1993.

Recruitment

Foster care is a service for children and we recruit foster carers to meet the needs of this population. Recruitment is organised in two main ways - locally, through local campaigns, advertisements in local newspapers - and centrally, through monthly information meetings, press interviews etc. In 1992 and 1993, 197 people attended such meetings and 12% applied to foster children.

Table 21: Placement patterns in EHB 1985 - 1993			
Year	No. children in care	No. in foster placements	% of care pop. in foster care
1985	976	585	59%
1986	1024	633	61%
1989	1132	779	69%
1990	1033	785	70%
1992	1234	812	66%
1993	1349	895	66%

Supporting Foster Parents

It is clear that fostering is demanding and foster families need support to allow them continue to meet the needs of children, and respond to the demands of the tasks to be done. This support is given primarily by their social worker. Each foster family has their own social worker who visits them and looks at issues that arise to help the family deal with a situation and to look at what fostering is bringing up for them as a family. Social workers also organise other supports as is necessary - e.g. child guidance, medicals etc. Support also includes the foster care allowance, which covers maintenance. Additional supports, such as Home Help, and extra allowances e.g. equipment, school books/uniforms etc. are provided on an individual basis. This allowance needs to be examined with a view to increasing it in order to attract people to fostering and as a recognition of the demanding task that is done and service that is provided to children and their families. In addition, it is good practice that each child in care has a social worker to help them with the many difficulties which they encounter as a result of their earlier life experience and the separation from their parents.

Support groups are run in some areas. Uptake of these groups is not consistent throughout the Board. It is as if the demands of fostering diminishes the availability of foster parents for attendance at support group.

Disruptions

Fostering, like most other relationships, can be difficult and sometimes comes to an end in an unplanned way. This is difficult for all those involved. In 1992 and 1993 there were 15 and 20 disruptions - which represent 5.7% in 1992 and 3.6% in 1993. Of the children involved 65% were male and 40% were over 14 years of age.

Further analysis is required into the area of disruption.

Developments

Given the new Child Care Act and the emphasis on prevention, support services to families must be developed. Foster care, e.g. day foster care, could well be expanded if the allowances were sufficiently enhanced as an incentive.

Under the provisions of the new Act, the health boards will meet the placement needs of 16-18 year olds. After care must also be addressed. Undoubtedly this service can be developed within the framework of fostering. Some of this work has already been done in particular cases.

moving to a family and this can take time to work through. This is an area that needs to be explored and needs extra supports in terms of allowances, staff support etc.

Again, as in foster care, we must be flexible, towards the needs of an individual child e.g. a child care worker to stay overnight with a family or to intervene regularly.

We have been able to place extremely difficult young people in families, but we need to acknowledge the demand this places on families and recognise their need for breaks and for support. The system needs to work with, and not to be seen at odds with, the needs of the family and child e.g. access to psychiatric facilities, respite facilities etc.

The range of difficulties presented by young people in the care system are summarised in the following table. They give an indication of the challenge the Board faces in delivering a service to meet the diverse and complex needs of those involved.

Table 24: Previous difficulties experienced by young people placed with Carers	
Adoption breakdown	11%
In care in the last two years	17.5%
In care over five years	70%
Confirmed sexual abuse	47%
Known sexual abuser	5.5%
Sibling groups placed	33.5%
Experience of homelessness	36%
Committed to psychiatric hospital	11%

RESIDENTIAL CARE SERVICES

Residential care is a substantial and vital element of the Board's child care services. Over the past two decades residential care has made a major shift from institutional care towards the more integrative approach of community care. Notwithstanding our policy of giving emphasis to family care, residential care serves a valuable purpose in particular circumstances:

1. Where a child cannot cope with the emotional environment of family or substitute family life.
2. When the child's behaviour is such that it requires care and control above what can be reasonably provided in a family setting.
3. Where the child is experiencing acute difficulties, such as severe disturbance or psychiatric illness.

A national trend over the past ten years has been towards a reduction in the number of residential placements available. A contributory factor in this regard may well be the development of more community care and family support services, as well as developments in foster care. In any event, residential care services have tended to become more streamlined and specialist in nature. Increasingly, children tend to spend shorter periods of time in residential care, and the time spent is more focused on objectives than heretofore. Children enter residential care with a plan and leave when it has been implemented.

Description of the Service

The Eastern Health Board avails of a total of 45 residential services, accounting for approximately 400 places. The majority of these are managed by voluntary or religious organisations and are funded by the Board. Some are managed directly by the Board, and others are availed of by the Board and paid for on a capitation basis.

Bartres	Long Term	8	8 - 16	M & F	Sisters of Our Lady's of Charity
The Cottage Home: Main House	Short Term/ Emergency	11	0 - 9	M & F	Cottage Home
St Joseph's	Long Term	5	0 - 18	M	Cottage Home
Myrtle Park	Long Term	6	9 - 16	F	Cottage Home
Miss Carr's Home	Long Term	16	4 - 17	M & F	Miss Carr's Home
Lakelands	Long Term	18	9 - 18	M & F	Irish Sisters of Charity
St Clare's	Long Term	6	3 - 15	M	Sisters of St Clare's
St Vincent's (Goldenbridge)	Long Term	20	3+	M & F	Sisters of Mercy
Blaithin	Long Term	8	5 - 12	F	Sisters of Our Lady of Charity
Royal Oak	Long Term	8	7 - 18	M & F	Daughters of Charity
Los Angeles Society: Conyngham Road	Long Term	7	14 - 16	M	Los Angeles Society
Blackrock	Long Term	10	10 - 18	M	Los Angeles Society
Dalkey	Long Term	10	11 - 13	M	Los Angeles Society
Don Bosco Drumcondra	Long Term	8	14 - 18	M	Salesian Fathers
Don Bosco Clontarf	Long Term	8	11 - 14	M	Salesian Fathers

Table 27: Services availed of by EHB and funded on capitation basis

Home	Type of Care	Places available to H.B.s	Age range on admission	Sex	Service provider
St Michael's Assessment Centre	Short Term (Assessment)	3	Up to 16	M	Department of Education
Sarsfield House	Long Term	Max of 6	16+	M	Department of Justice
St Joseph's Clonmel	Long Term	13	10+	M	Department of Education
St Laurence's School	Long Term	6	13+	M	Department of Education
Lefroy House	Long Term	10	16	F	Salvation Army

The range of services provided by the centres described above can broadly be categorised under four headings:

- (a) Children's Homes
- (b) Adolescent Hostels
- (c) Specialist Centres
- (d) Supported Accommodation

(a) Children's Homes

The majority of children's homes can be described more particularly as group homes, i.e. they provide an intimate and personalised service to a small group of unrelated children who require care. Usually the placement is planned and the objectives of the placement are made explicit in advance. This is in keeping with the principles outlined in the Task Force Report (3).

Traditionally, Madonna House has provided the bulk of placements to children requiring short term or emergency care. It is by far the largest of the children's homes. The Cottage Home will also facilitate short term or crisis admissions where possible. However, in recent years foster care has played a large part in the emergency placement of young children in care.

(c) Specialist Units

Most of the specialist units run directly by the Board are managed by the psychiatric service and provide assessment and treatment facilities. In addition, under the Community Care Programme, Glen House has been established as a safe therapeutic unit for boys and girls with particular emotional or behavioural difficulties. Other specialist services availed of, but not run by the Board, include examples such as St. Michael's Assessment Centre (for short term residential assessment) and St. Laurence's School which combines residential care and educational/vocational training.

(d) Supported Accommodation

In recent years the Board, in conjunction with the voluntary sector, has been developing supported semi-independent accommodation for teenagers. An excellent model of such a service exists in Blessington Street under the management of the Salesian Fathers. In addition Streetline, a new body, has recently opened up a similar new unit for boys, while the Order of Our Lady of Charity is developing a unit for girls.

The demand for such residential services has been enhanced by the requirement of the Child Care Act to provide services to young people up to 18 years as well as suitable accommodation under Section 5. These units, while allowing developing young people the maximum amount of independence, still offer a caring and secure environment.

During 1993 a total of 454 placements were made. Table 4 shows the distribution of these placements across the ten community care areas.

Table 28: Residential Placements in 1993 by Community Care Area			
Area	Number	(1992)	Population (0-19 years)
1	12	(29)	40,562
2	10	(6)	31,976
3	22	(36)	27,376
4	29	(32)	57,338
5	54	(57)	42,923
6	91	(58)	49,142
7	78	(88)	35,209
8	139	(106)	73,649
9	2	(4)	50,283
10	17	(7)	37,092
Total	454	(423)	

(b) Developing New Services

All the indications are that there is a need for a range of further residential placements. The idea of a vacancy in a residential centre is a thing of the past. Most services, including the emergency/short term hostel in Eccles Street, operate waiting lists. In particular, it is difficult to find placements for children over 11 years (7).

For this reason it is planned to develop additional adolescent hostels in identified suburban areas which are known to have particular difficulties with unattached youth.

A need has also been identified by social work managers for group homes which could care for sibling groups, particularly in a crisis. With the co-operation of the voluntary sector it might be possible to provide such a resource through the rationalisation of existing residential services.

Increasingly, there is an expectation by the courts that the Board should be in a position to care for disruptive teenagers who might otherwise be processed through the juvenile justice system. Accordingly a need has emerged for an additional therapeutic centre which can at once manage the behaviour of these youths and at the same time create a nurturing environment where such young people can stabilise and develop.

Given our new responsibilities under the Child Care Act for 16-18 year olds it is envisaged that additional supported accommodation, such as sheltered flats, need to be developed. In the main, it has been the residential services which have spear-headed after care services for young people who have been through the care system. Such services require further development and support.

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HOMELESS PERSONS SERVICE FOR FAMILIES

Families become homeless within the Board's area for many reasons e.g. fire, flood, family disagreement, family violence, eviction, recent arrival in the area etc. In some cases the homelessness can be anticipated and the housing needs can, in many such cases, be met by the housing authorities. In other cases homelessness can arise suddenly and in the majority of such cases the need for immediate shelter cannot be met directly by the housing authorities. Nonetheless the provision of emergency accommodation is the responsibility of those authorities. Because of the Board's expertise and tradition in this area, the Dublin housing authorities have arranged with the Board to provide a placement service for families through the Board's Homeless Persons Unit at Charles Street and the shelters/refuges run directly by the Board. These placements are generally made within the many shelters/hostels/refuges run either directly by the Board or by voluntary bodies. In some cases, particularly where the homelessness is due to family violence, the family may need counselling and other support services in addition to emergency accommodation. These services are available at Haven House and the Women's Refuge, Rathmines both run directly by the Board and at the Women's Refuge, Ballymun, run by Aoibhneas Ltd.

Haven House has accommodation for up to 10 families (30 persons). Occupancy is almost 100% and the average length of stay is just less than 10 nights. The numbers dealt with in a year are approx. 400 adults and 800 children. In addition to shelter the hostel provides on site counselling services. A post of children's worker is needed to enhance the work of the hostel with children of families. Direct access to a specific social work service targetted at homeless families will also be needed.

The Women's Refuge, Rathmines has accommodation for 10 families (40-50 persons). Occupancy is almost 100%. Average length of stay is 50-55 days. The numbers dealt with in 1993 were 65 adults and 190 children. In addition to shelter, here also there is a need for direct access to a social work service with specific responsibility for homeless families.

Homeless Persons Unit - Charles Street: It is estimated that in a year approx: 700 women and 2,000 children seek accommodation through the Homeless Persons Unit in Charles Street. It is highly desirable that the unit be able to call on a social work service with specific responsibility for homeless families.

Neither Haven House nor the Women's Refuge can cope with all the demands for accommodation made upon them. It is estimated that there is a need for three further refuges in the Dublin area to accommodate 25-30 families. Aoibhneas Ltd. have plans for a 10 family refuge in Coolock but this is unlikely to come to fruition in 1994 even though the plans are well advanced.

CHILD PROTECTION

1. Historical Background

Protecting children from harm and abuse is seen as an integral element of a comprehensive child and family care policy. Child abuse - prevention, investigation, management and treatment - is now a major focus of our Board's responsibilities in the area of child care.

Although various statutory and voluntary agencies were involved in the care of children from the 1860's in Ireland, the extent and seriousness of the problem of child abuse has only been acknowledged since the 1970's. A major contribution in the management of physically abused children was the identification of the "battered baby syndrome" in 1962 by the Denver paediatricians, Drs. Roy Heilfer and C. Henry Kempe. The recognition and acknowledgement of child sexual abuse was a slower and more gradual process, and the extent of child abuse is still questioned by some people. However research studies on child sexual abuse have shown that the incidence of child sexual abuse is greater than had previously been thought (1).

In Ireland the Department of Health issued guidelines on the "Identification and Management of Non-Accidental Injury to children" in January 1980. They were amended in 1983, and in 1987 the Department of Health issued "Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse". These are in operation currently.

2. Definition of Child Abuse

The 1987 guidelines define child abuse as follows "Parents, carers (i.e. persons who while not parents have actual responsibility for a child) or others can harm children either by direct acts, or by a failure to provide proper care, or both. Such acts include physical injuries, severe neglect, and sexual or emotional abuse". (2)

Reported cases of child abuse in the Eastern Health Board are categorised under four types - physical abuse, sexual abuse, emotional abuse and neglect. These are not necessarily exclusive. There are no nationally agreed definitions of the four types of child abuse, but there is general acceptance amongst practitioners in the field of the following definitions:

- **Physical Abuse:** Any form of physical abuse where there is definite knowledge or a reasonable suspicion that the injury was inflicted or knowingly not prevented. Such examples would be: hitting, shaking, squeezing, biting, burning, attempted suffocation, use of excessive force when handling a child and deliberate poisoning.

Table 29: Number of Cases of Alleged and Confirmed Child Abuse in Ireland and in the Eastern Health Board (EHB) Region, 1982 - 1989

Category	Year								% increase 1984-1989
	1982	1983	1984	1985	1986	1987	1988	1989	
Ireland									
All child abuse referrals	405	434	479	767	1,015	1,646	2,673	2,352	391.0
CSA referrals	NA	37	88	234	475	929	1,055	1,242	1,311.4
CSA as % of all referrals	NA	8.5	18.4	30.5	46.8	56.4	39.5	52.8	
All confirmed child abuse	112	156	182	304	495	763	1,243	1,658	811.0
CSA confirmed	NA	NA	33	133	274	456	465	568	1,621.2
CSA confirmed as % of all confirmed	NA	NA	18.1	43.8	55.4	59.8	37.4	34.3	
EHB									
All child abuse referrals	189	199	257	353	504	793	1,398	1,699	561.1
CSA referrals	NA	21	29*	81	201	452	568	644	2,120.7
CSA as % of all referrals	NA	10.6	11.2	22.9	39.9	57.0	40.6	37.9	
All confirmed child abuse	52	70	100	137	273	350	722	1,032	932.0
CSA confirmed	NA	NA	11	42	134	211	248	301	2,636.4
CSA confirmed as % of all confirmed	NA	NA	11.0	30.7	49.1	60.3	34.3	29.2	

NA = Not available

*Estimated

Source: Statistics of Child Abuse, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989; Department of Health, Hawkins House, Dublin 2

care teams in the organisation and format of case conferences and further developments are under consideration.

Social workers are involved in the ongoing management and treatment of cases of child abuse. Other agencies involved in treatment include the child guidance clinics and family resource centres. Treatment services for some adult abusers are provided through the forensic service, and a treatment programme is available for adolescent perpetrators in the northside. This group therapy programme is run by staff from Eastern Health Board community care teams and Children's Hospital Temple Street.

Our Board has nominated a number of staff - social workers, public health nurses and child care workers - to attend the Diploma in Child Protection course in Trinity College. Child abuse is a complex area of work and training is essential to ensure good practice.

5. Child Care Act 1991

The Child Care Act 1991 imposes new and extensive responsibilities on health boards in the field of child care and protection. Section 3 places a statutory duty on health boards to identify and promote the welfare of children who are not receiving adequate care and protection. The Act also introduces new powers of intervention by the health boards in cases of child abuse, or where the child is deemed to be at risk. These latter provisions - Sections 12 - 19 - have not been enacted yet.

6. Current and Future Developments

Following discussions between the Department of Health and the Garda Authorities, procedures for the notification of suspected cases of child abuse between health boards and gardai have been agreed. There will be piloted in Community Care Areas 2 and 8.

A review of the child abuse procedures in the Eastern Health Board has just been completed. Meetings have been held with the Director of Community Care/Medical Officer of Health, Superintendent Public Health Nurse, Social Work Managers, and other relevant personnel in each community care area. The review has addressed a wide range of issues in relation to the identification, investigation and management of child abuse cases. These include:

- Referral and notification systems
- Investigation process
- Liaison systems with gardai, general practitioners, schools etc.
- Case conferences
- Long-term management of cases.

BLANCHARDSTOWN HOMESTART

Blanchardstown Homestart is a voluntary scheme in which volunteers offer support, friendship and practical help to families with children under five in their own homes.

Homestart works towards their increased confidence and independence by:

- offering support, friendship and practical assistance to families;
- being available to families who are experiencing frustrations or difficulties;
- visiting families in their own homes where the problems exist respecting the dignity and identity of the individual;
- developing a relationship with the family in which time, flexibility of approach and understanding can be shared;
- encouraging the parents' strengths and emotional well-being for the ultimate benefit of their own children;
- reassuring parents that difficulties in bringing up children are not unusual and emphasising the pleasure of family life;
- encouraging families to widen their network of relationships and to use community support and services effectively.

Homestart is available to any family where there is at least one child under the age of five, but it is at its best where the difficulties are temporary, i.e. due to the birth of another child, post natal depression or a family moving from one area to another. In this situation we can help parents to become more independent and possibly become volunteers themselves.

It is difficult to categorise families but the following groups are included:

1. parents with two or three children very close together in age;
2. parents who are finding it difficult to adapt to being at home with children after having had a fulfilling job;
3. single parents, struggling with loneliness while trying to be mother and father;
4. mothers who have had severe depression or psychiatric disorders and find motherhood frightening.

At present Blanchardstown Homestart is supporting 43 families.

CHILD AND ADOLESCENT PSYCHIATRIC SERVICE

Child and Adolescent Psychiatric Services in the Eastern Health Board are provided by: -

- | | | |
|---|---|---|
| The Eastern Health Board | - | (Part of Areas 3 & 4 - inner city - Areas 5, 6, & 9); |
| The Mater Child and Family Services | - | (Areas 7 & 8 - funded by the Eastern Health Board); |
| Hospitaller Order of St. John of God | - | (Areas 1, 2, 3, 4 - excluding part inner city - and Area 10 - directly funded by the Department of Health). |

Since the adoption by our Board of the "*Report of a Working Group on Child and Adolescent Psychiatric Services in the Eastern Health Board Area*", a Central Co-Ordination Committee, with senior managers from the 3 services, chaired by the Programme Manager, Special Hospital Care, meets on a monthly basis, in the overall review and co-ordination of services.

The Child and Adolescent Services are community based, with Child and Family Centres based in strategic locations in the community.

Eastern Health Board	-	Castleknock Ballyfermot St. James's Hospital
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Mater Hospital	-	Mater Child & Family Centre Ballymun.
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St. John of God	-	Orwell Road, Rathgar Wyattville House, Ballybrack Cluain Mhuire, Blackrock Old Blessington Road, Tallaght Sessa House, Bray
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Mater Hospital - Mater Hospital

St. John of God - St. Peter's, Orwell Road

In addition, these services provide care support to Scoil Caitriona and Benincasa.

Liaison Services:

The Child and Family Services provide a consultative psychiatric service to the children's hospitals, to the group homes operated by our Board, and by private organisations on behalf of our Board, and also to the residential centres, (St. Michael's, Finglas, and Scoil Ard Mhuire/Oberstown House, Lusk).

In-Patient Care:

In keeping with the concept of the community model, assessment and residential treatment programmes are provided in community settings. The Eastern Health Board community treatment model was enhanced in 1988 with the closure of the residential unit in St. Loman's Hospital and the development of facilities in Courthall, James Connolly House, and Dromheath Avenue, Mulhuddart. The three service providers co-operate, as far as possible, in the provision of assessment and residential care in the following settings:-

	<i>Beds</i>
St. Richard's Residential Unit, Orwell Road	10 (<i>St. John of God</i>)
Warrenstown House	14 (<i>Eastern Health Board</i>)
Courthall	8
James Connolly House	8
Dromheath Avenue, Mulhuddart	5
St. Paul's, Beaumont	22 Places <i>Chronic psychotic autistic children.</i>

needs as presented, however, there are major service deficiencies which require addressing. In addition, it is important that the services are established in major population centres, particularly new communities, including the main population centres in Kildare and Wicklow.

The service development requirements are set overleaf:

Area Requirements

Crisis Unit - 6 bed - (Up to 16 years)

There is an urgent need for an assessment unit to cater for the continuous crisis events involving young teenagers up to 16 years of age who present at Child Psychiatric Clinics with psychotically high overtones.

This facility will require a staffing structure and secure physical environment in order to create an ambience whereby adolescents will co-operate voluntarily in the treatment programme.

Following assessment these patients will return to the community with support as necessary from the community care social services and where appropriate from the community psychiatric services.

Staffing ratios would alternate between 2:1 and 3:1 over a 24 hour period in line with client dependency, etc.

It is possible that either Oberstown House or St. Michael's Assessment Unit in Finglas could provide this service with rationalisation of facilities; augmentation of staff, particularly professional staff; refocusing of admission policy and integrated support from health professionals.

Discussions should take place with the Department of Education in this regard.

Chronic Psychotic/Autistic Unit

The need for a long term facility for chronic psychotic/autistic young people has been identified.

St. Paul's, Beaumont has been providing this service for many years on a national basis. The operation of national centres is no longer practical, and with the development of child psychiatric services in each of the other Health Boards, the time is now opportune to review the admission policy of St. Paul's Beaumont.

Catchment Area Requirements

(a) Eastern Health Board Catchment Area Service

1. *Adolescent Day Services*

St. Joseph's Adolescent Unit at Fairview over the years has developed a very effective day service for young adolescents from the north side of Dublin. The success of this Unit in meeting particular service needs requires the provision of similar units in Dublin South as part of the St. John of God service and in Dublin West as part of the Eastern Health Board service.

2. Provision of additional clinical facilities in Child Psychiatric Unit, Kill, Co. Kildare.
3. Provision of satellite Child Psychiatric Unit in Kildare town.
4. Provision of satellite Child Psychiatric Unit in Leixlip.
5. Additional clinical facilities in Child Psychiatric Unit, St. James's Hospital.
6. Provision of satellite Child Psychiatric Unit, Clondalkin.
7. Improvement in clinical facilities in Child Psychiatric Unit Warrenstown House.

(b) Mater/Temple St. Children's Hospital Service

1. Upgrading of clinical facilities in Child Guidance Clinic, Ballymun
2. Provision of satellite clinic, Swords.
3. Provision of satellite clinic, Raheny.

(c) St. John of God Service

1. An Adolescent Day Care Unit (Similar to St. Joseph's Unit, Fairview).
2. Assistance with St. Richard's, Orwell Road Complex.
3. Provision of satellite Child Psychiatric Unit, Wicklow town.

SERVICES FOR MENTALLY HANDICAPPED CHILDREN

Mental handicap services in the Special Hospital Care programme are provided by agencies directly funded by the Department of Health and agencies funded by the Eastern Health Board.

Agencies funded directly by the Department of Health

St. John of Gods:	Provides service for Area 1
Stewarts Hospital:	Provides service for Area 5 & 9
Daughters of Charity:	Provides service for Area 6
St. Michael's House:	Provides service for Area 7
Moore Abbey:	Provides service for Area 9

Health Board Funded Agencies

Cheeverstown House:	Provides service for Area 4
K.A.R.E.:	Provides service for Kildare
Sunbeam House:	Provides service for Wicklow
St. Catherine's Assoc:	Provides service for Wicklow
Peamount:	Provides service for Kildare
Fingal:	Provides service for North County Dublin.

The Board itself is providing services to deal with the remaining two Community Care Areas, 3 and 8.

Policy and Planning

Planning services for the mentally handicapped is a function of the Central Planning Committee which meets on a monthly basis, evaluates submissions from all agencies, makes recommendations as to budgetary allocation and monitors the development of services. Central Planning Committee comprises:-

Disturbed Challenging Behaviour

In each community care area a small nucleus of children will present as having serious challenging behaviour to the degree that they cannot be contained in the specialist educational settings and will require extra intervention. We recommend that as a first step, assessment teams from the services for intellectually disabled persons would carry out a detailed assessment of each person's condition and total circumstances, identify that person's future needs, outline an individual programme and determine the resource requirements in terms of facilities and personnel to implement the plan.

Arrangements should be made for their relocation to existing programmes for intellectually disabled people and for an appropriate transfer of resources to the agency to which the transfer is being made. Where a service does not exist or is not available for receiving such transferred persons, it will be necessary for the health board to provide a service to cater for them.

Disturbed Behaviour

Children with a general learning difficulty who require specialist intervention should obtain this from the generic services. Our consideration of the problem of provision for disturbed persons does not, therefore, embrace this group who will be dealt with mainly under the general psychiatric and psychological services.

It is generally accepted that settings which do not provide a person with meaningful activities and opportunities to develop positive relationships with other people are conducive to a higher incidence of disturbed behaviour. Consequently, as the quality and scope of services develop, the level of disturbance among people with intellectual disability should decrease.

In seeking solutions, therefore, for disturbed behaviour the first option to be examined is the possibility of prevention. Personalised day programmes, combined with family supports or a supportive living environment, will do much to prevent behavioural problems arising. Where disturbed behaviour is a problem, consideration must first be given to effecting a change for the better in the person's daily environment. In practical terms this will involve examining the extent to which the individual's personal needs are being met. Of paramount importance in the prevention and management of disturbed behaviour is the provision of adequate staff. A ratio of 1.5 frontline staff per disturbed person is required overall. The staff concerned should be specially trained and should not be subject to frequent change. Unstable and fluctuating staff routines are particularly inappropriate. The support of a special multi-disciplinary team is a further requirement. This should include as a minimum of a psychiatrist with special expertise in this area, a clinical psychologist with experience in behavioural management and a social worker familiar with the family background.

Early Intervention Programme

Mental handicap brings its own pressures on families and often it is only when serious difficulties begin to arise, at times precipitated by school difficulties, that support agencies are involved. Ideally we should develop early intervention initiatives with a view to identifying those families at risk and developing primary prevention strategies to prevent the crisis arising.

Video Training - Proposal

One strategy proposed to begin preventive interventions is video training. This is a short term intensive form of home support for families - developed in Holland by Maria Aarts and is very much supported by the Dutch Health and Welfare Agency who have a considerable number of people employed using this form of family intervention.

The Aarts training method is a short-term intensive form of home help for families with problems in bringing up their children. Using video film the worker explains what skills parents use in order to come to a successful exchange of communication with their children. Dependent on age and educational level, the worker considers with the parents where a change in parents' behaviour is needed.

Based on video films made within the family, the worker is able to draw the parents' attention to communication initiatives of the child. If these initiatives are correctly responded to, the contact can be restored and the child is supported in its development. The video can show how much communication in the family is still intact and where there is a need for improvement. The principles of the method follow the elements of successful communication.

For the last year this method has been piloted within the Eastern Health Board with 12 social workers. Child care workers have been in training using this as part of their case load. The results of this has been very positive and it is felt that it has excellent potential in working with families in particularly those where the mental handicap of a sibling is the problem. Its primary benefit is at an early intervention stage before serious dysfunctional coping patterns either prevent the normal development of the child or creates inappropriate parenting patterns.

SERVICES FOR PHYSICALLY HANDICAPPED CHILDREN

In addition to the range of service available to all children, there are particular services for physically handicapped children. These include:-

Domiciliary Care Allowance

This allowance is paid in respect of children between the ages of two and sixteen years who are so severely physically or mentally handicapped that they require care and attention which is considerable in excess of that normally required by a child of the same age.

There were 2707 recipients on 31st December, 1993, this includes children with physical, sensory and mental handicap conditions. The rate per month is £92.50

Long Term Illness

There are over 17,000 persons on the 'active register'.

The 15 scheduled conditions include:-

Mental Handicap	Diabetes Melitus
Cystic Fibrosis	Acute Leukaemia
Spina Bifida	Mental Illness (under 16 years)
Hydrocephalus	Haemophilia
Cerebral Palsy	Epilepsy
Phenyketonuria	

and each of these except for (Diabetes and Epilepsy) mainly involve children.

Drugs, medicines and minor appliances are supplied free of charge to individuals with a scheduled condition.

Non Residential Services/Clinics providing medical and Para Medical Services

The Board grant aids organisations providing a range of services:-

Central Remedial Clinic

Cerebral Palsy Ireland - (who also have a residential facility in Bray (Marino Clinic))

Spina Bifida

Educational services in each is provided by Department of Education.

Schools/Homes for the Blind:

Two homes provide residential accommodation/care for 79 children (84 in 1992) attending national and secondary schooling

Table 31: Number of children attending schools/home for the Blind 1992 and 1993		
School/Home	September 1992	September 1993
St Joseph's Drumcondra	52	50 boys
St Mary's, Merrion	32	29 girls

Children are mainly from outside E.H.B. area. Most children from Dublin area attend as day pupils.

Medical, Nursing and Para Medical Services

The service needs of the physically handicapped form a sizeable portion of work load of the field staff and particularly of speech therapists.

Referrals to the occupational therapy service for age group to 19 years is approx 10%.

CHILDREN AND DRUGS/HIV

Drugs

The overwhelming majority of people who attend the HIV/Drugs service are over 18. However, we do get some people under 18 looking for needle exchange or methadone maintenance. Most people under 18 who come looking for these two services have poor relationship with their parents and multiple other problems.

Of necessity over the past year and a half since the setting up of the Satellite Clinics our service has had to prioritise established opiates addicts, with an average age of 27 years and an average duration of injecting drug use of five years. However, in 1994 we are planning to enhance our services to young people in conjunction with other agencies including Trinity Court, Catholic Social Service Conference and the Ballymun Youth Action Project together with other Health Board Agencies such as the Talbot Day Centre. There had been a proposal to set up a residential unit for young people who are addicted which was not followed through.

Amongst families where there are young people engaged in drug misuse there is considerable denial of the problem. Quite often young people will admit to workers that they have a drug problem but do not wish it to be officially acknowledged as that would entail their parents hearing about it. We are in the process of setting up a pilot project in St. Mary's Mansions whereby parents groups will be set up to help them get over this denial phase so that adequate services can be put in place for their children.

AIDS

AIDS related issues as they affect children fall into three categories:

- (a) Young people who are HIV positive because their mothers are drug users.
 - (b) Young people who are HIV negative but who are orphaned or at risk of becoming so because their mother and/or father is HIV positive.
 - (c) Haemophiliacs.
- (a). Most HIV positive children in the city receive their basic medical care from Our Lady's Hospital Crumlin. I am not aware of any major gaps in the provision of services for children. We encourage the use of generic services such as general practitioners and Public Health Nurses to provide back up to the hospital services in the health care of HIV positive children.

CHILD CARE SERVICES PLANNING CONSULTATIVE GROUP

This group was set up by the Chief Executive Officer in late 1993 to meet the challenges arising from issues related to the planning and delivery of expanded services under the Child Care Act 1991. The purpose of the group is to strengthen the existing consultative process between local social work managers and senior management to ensure that as managers a common approach to the new situation is developed.

The group meets at least monthly with the programme manager for community care. Membership consists of two administrators from the programme manager's office, three head social workers and two senior social workers.

Under various headings suggested later, the group will examine policy priorities, participation and communications with the wider social work managers group. Local issues, common to all areas arising from deficiencies, may be overcome.

The policy areas fall into two categories, i.e. those related to family support services and those relating to services for children in care. The group will approach problems by evaluating current services, identifying needs and gaps and setting goals for implementation of plans of action with timescales.

The particular policy areas to be considered by the group are listed below.

1. An equitable way of matching resources to needs using criteria developed such as needs assessment based on numbers of children in care, numbers in population in Social Economic groups 5/6, services already in the area.
2. Defining health board principles and practice in relation to issues such as family support, relationships with residential care, family placements, etc. A document such as this was compiled by the D.H.S.S., U.K. to ground the then new Childrens Act 1989.
3. Consideration might be given to the establishment of development posts in the community care teams to continue the practice of working with local voluntary groups and local residents to identify needs and develop new services needed under the Act. These could be a more focused use of the former community work posts.
4. Consideration should be given to the whole area of training needs for new developments and responsibilities under the Act. A co-ordinated ongoing in-service training programme is required.

COMPUTERISED CHILD HEALTH INFORMATION SYSTEM (R.I.C.H.S.)

The Eastern Health Board has now in place in every community care area a computerised integrated child health information system. Central to the system is a child register, a master index of children, born in, living in, or treated in the region. The register module acts as a central resource of information for the other modules in the system, i.e. appointment-based paediatric developmental examinations and MMR vaccinations. The balance of the immunisation service was devolved to the community care areas in December 1993 and planning for computerisation of it has now commenced. There are resource implications which have yet to be fully quantified.

The R.I.C.H.S. system has proven to be very effective in providing management reports on, inter alia, localised uptake of services, areas of main defect discovered at examination and identification of districts for deployment of additional resources. Operating alongside the computerised system is the piloting of a universal Child Health Card which records all community care-based examination information in respect of a child from the time he/she is born through national school.

Future developments regarding R.I.C.H.S. will be in accordance with the overall corporate I.T. strategy for the Eastern Health Board.

COMPUTERISATION OF SOCIAL WORK RECORDS

In an increasingly complex world the capacity of an organisation to generate, store, process and transmit information is a main determinant of its success in meeting objectives. Without timely relevant information, decision making is likely to be delayed at best and inadequate at worst thus affecting in a major way the service we provide for our clients.

IT (information technology) can greatly enhance the accessibility and flow of information which is a necessity, though not the only one, to competent and appropriate decision making. The current development of community care social work computer system is an important step in making information accessible to social workers and managers alike. A project team came together to design a system which would best meet its users needs. Throughout the design and specification stage, consideration was given to the information needs of social workers, social work managers and management team at local and central level.

Objectives of the Computer System

There are approximately 170 social workers spread over 40 locations in the Eastern Health Board area. Broadly speaking, their workload divides into referral caseload, including all work arising from the referral e.g. child abuse cases, care placements and project assignments.

The main objective of the computer system are data capture, collation and retrieval in relation to: Caseload Data, Project Data, Community Care Management Information Requirements, Inter Area Communication, Word Processing, Reports and Returns.

Benefits of the Computer System

The introduction of IT to the Social Work Service will assist in a variety of ways including: easy access to information, faster decision making, facilitates comprehensive case management, client index, comprehensive management information, improved communication and word processing facility.

Appendix A

Child Care Advisory Committee Eastern Health Board

Board members:

Cllr Ivor Callely TD (Chairperson)
Cllr Roisin Shortall TD (Vice-Chairperson)
Dr James Reilly

Officers:

Dr Sheila Lynch, Director of Community Care & Medical Officer of Health
Ms Stasia Cody, Supt. Public Health Nurse
Ms Brid Clarke, Head Social Worker

Adoption and Foster Care Services:

Mr John Lysaght, Irish Foster Care Association
Ms Mary O'Hagan, Senior Social Worker

Residential Care:

Sister Ann O'Neill, Daughters of Charity of St Vincent de Paul

Services for pre-school children:

Ms Peggy Walker, Irish Pre-School Playgroups Association

Education services:

Mr Sean Hunt, Deputy Chief Inspector, Department of Education

Services for homeless children:

Ms Maureen Lynott, Focus Point
Ms Mary O'Connell, Chairperson, Tabor Society

Child and adolescent psychiatric services:

Dr Paul McCarthy, Clinical Director, Child Psychiatry

Support services for children and their families:

Ms Margaret Dromey, Federation of Services for Unmarried Parents and their Children

Probation and Welfare Service:

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

Garda Siochana:

Inspector Mary Fitzgerald

Co-option

Mr Robbie Gilligan, Social Studies Department, Trinity College

Appendix B

Organisations and persons who responded to the invitation to contribute comments

Barnardos, Christchurch Square, Dublin 8

Miss Carr's Children's Home, Northbrook Road, Dublin 6

The Children's Hospital, Temple Street, Dublin 1

Ms Brid Clarke, Head Social Worker, Community Care Area 7, Eastern Health Board

The Cottage Home for Little Children, Dun Laoghaire, Co Dublin

CSSC Hostel, Eccles Street, Dublin 7

Day Nursery Management Committee, Maryland, Dublin 8

Don Bosco House, Clontarf, Dublin 3

Federation of Services for Unmarried Parents and their Children, Rathmines, Dublin 6

Focus Point, Eustace Street, Dublin 2

Mr Paul Harrison, Head Social Worker, Community Care Area 6, Eastern Health Board

Hospitaller Order of St John of God, Orwell Road, Dublin 6

Irish Pre-School Playgroups Association, Winetavern Street, Dublin 8

Irish Society for the Prevention of Cruelty to Children, Molesworth Street, Dublin 2

Dr Sheila Lynch, Director of Community Care, Area 1, Eastern Health Board

National Maternity Hospital, Holles Street, Dublin 2

Our Lady's Hospital for Sick Children, Crumlin, Dublin 12

Probation and Welfare Service, Department of Justice

Protestant Adoption Society, Rathmines, Dublin 6

St Mary's Residential Home, Sandymount, Dublin 4

St Vincent's Group Homes, Goldenbridge, Dublin 8

Mrs Smyly's Homes and Schools, Blackrock, Co Dublin

Society of St Vincent de Paul, Child Care Centre, Amiens Street, Dublin 1

World Organisation for Early Childhood Education, Dublin 1

Appendix C

GMS cards by age group within Community Care Area.						
Age Group						
C.C.A.	Under 5	5 - 15	16 - 44	45 - 64	65+	Total
1	1,581	3,876	7,299	3,977	6,620	23,353
2	1,528	3,400	9,478	4,562	7,965	26,933
3	1,764	3,785	7,459	3,860	5,481	22,049
4	4,107	11,884	16,684	7,685	7,701	48,061
5	3,905	10,751	14,721	5,431	5,652	40,460
6	3,757	10,060	16,468	7,559	8,651	46,497
7	3,617	7,616	14,040	6,737	9,501	41,511
8	3,973	10,663	17,017	8,793	7,595	48,041
9	2,603	7,814	12,762	5,957	6,853	35,989
10	2,740	7,350	11,852	5,924	6,940	38,806
Total	29,577	77,199	127,780	60,185	72,959	367,700

Very significant sections of the Act remain to be implemented. These include the emergency protection of children, care proceedings, jurisdiction and procedure in the Courts, registration and regulation of child care residential facilities and pre-school services.

It must be mentioned that our Board has, since its establishment in the 1970s, put in place substantial additional services in relation to child care. It has taken a lead role in this area, made significant improvements in family support services, day care services and provision of alternative placements of children outside of their own families. These include:

The deployment at this time of almost 200 social workers and the introduction of the three tier management structure for Social Work/Child Care Services.

The establishment of a special group to structure and develop foster care services - The Fostering Resource Group.

It has undertaken various initiatives to advance the development of foster care services including Day Foster Care, Special Family Carers for older children and adolescents, emergency family carers, a specific project to recruit traveller families as foster parents for travelling children called Shared Rearing and many other initiatives.

We anticipated the statutory increase in ages of children from 16 to 18 by establishing a special group of social workers to attend to the needs of out of home adolescents. We established the first out of normal hours social work service to co-operate with the gardai and other agencies in finding solutions for out of home children and have established since 1988 a network of emergency and other hostel accommodation for older children. Some of this accommodation is provided directly by the Board and some by funding selected outside bodies for the purpose. Over 100 additional places have been provided. All of these initiatives were taken by our Board in close and continuing consultation with the Department of Health, with our own professional managers and with the outside agencies involved.

The Board established in 1992 a special therapeutic residential unit for older children with special problems viz. Glen House.

The Eastern Health Board through its administrative and professional staff keeps in close consultation with all residential care providers in its area and is continually encouraging the best possible working practices and changes needed to respond to the fluctuating needs of families and children requiring our care. The type of services set up in co-operation with the Daughters of Charity in the Claidhe Mor Centre at Santry which works with both children and their families is an example.

- (vi) introduction of arrangements for the inspection and supervision of pre-school services by health boards;
- (vii) revised provisions in relation to the registration and inspection of residential centres for children by health boards;
- (viii) The requirement that health boards provide accommodation for homeless children even those not taken into its care;
- (ix) the provision that courts may require health boards to investigate the situation of children not in the care of health boards who are the subject of custody disputes between parents in some circumstances.

This review will deal with child care services generally under the following heads:

The child at home - family support services, preventive services etc.

The child at risk - child protection services

The child apart from the family - alternative care services.

The review will also allude to demographic, socio-economic and organisational matters. The legislation will be implemented on a phased basis as the provisions of the Act are brought into force and as resources are made available. The Board has received its allocation for the first development of service which began in 1993 and will receive a further allocation in 1994.

Under Section 7 of the Child Care Act 1991, our Board has appointed a Child Care Advisory Committee to advise on the performance of its functions under the legislation. Appointees to this Committee (**Appendix A**) come from a wide base of both statutory and voluntary agencies and represent the principal areas of services for children and young people.

The first meeting was held on 3rd May 1993 and a series of further meetings have taken place to date. Under the terms of the Act, the Committee is required to meet four times a year but it has decided to meet on a more frequent basis.

The Committee has decided that in reviewing existing services, its focus will be on five separate spheres: the child at home; the child in crisis; the child in care; aftercare; preparation for adulthood. Recommendations in each of these areas will then be made to the Board.

In accordance with the provisions of Section 8 of the Act, our Board gave notice of the preparation of a report to the Child Care Advisory Committee and to some 53 organisations and persons involved in aspects of child and family services including the Departments of Education, Justice and the Garda Authorities,

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*Thanks are expressed to all
who assisted in the compilation of this report*

A detailed analysis of teenage births in Community Care Area 8 in 1990 revealed, like other studies, that babies born to teenagers were significantly more likely to be premature and that teenage mothers were less likely to breast feed their babies (9).

Compared with the national average there are more births to single parent families in the Eastern Health Board region. In 1992, 22.4% of all births in the Eastern Health Board were outside marriage compared with 18% for the country. In that year the highest proportion of non-marital births were in Community Care Area 7 of the Eastern Health Board i.e. 37% of all births in Community Care Area 7 were to single parents.

Preliminary statistics for 1993 are available for the 8 community care areas in Dublin show that of the 15,462 births to Dublin mothers, 4,153 (27%) were to single parents and 777 (5.0%) were to teenage mothers (Tables 7 and 8). The highest number of teenage births occurred in Community Care Area 6 (6.9%) and Community Care Area 7 (6.5%). Like 1992, the greatest number of non marital births were in Community Care Area 7. However the proportion increased from 37.2% in 1992 to 40.2% in 1993.

Table 7: Non marital births in Dublin compared with all births (1993) by community care area.			
Community Care Area	Number of births	Number non-marital births	% of all births in C.C.A.
1	1,654	291	17.6
2	1,606	384	23.9
3	1,434	332	23.2
4	1,998	598	30.0
5	1,889	552	29.2
6	2,184	617	28.3
7	1,839	739	40.2
8	2,858	640	22.4
Total	15,462	4,153	26.9

The percentage of children in each age group is given in Table 4.

Table 4: % Childhood population by age group in 1986 and 1991.					
Year	0-4	5-9	10-14	15-17	Total
1986	24.8	26.5	27.0	21.7	100%
1991	23.3	25.7	28.0	23.0	100%

While the proportion under the age of 9 years has dropped by 2.3% since 1986, there has been a similar increase in the proportion over 10 years and under 18 years since 1986. This also reflects national trends in that our population is ageing. The age structure is changing because of the falling birth rate in the area. In 1986 the birth rate in the Eastern Health Board area was 17.3 per 1,000. In 1991 the birth rate was 15.8 per 1,000. Hence there are fewer younger children especially under 5 years and consequently there has been a shift in the population with more children now over 10 years.

Even though there has been a small decrease of 2.7% in the number of children in the Eastern Health Board area since 1986, this drop has been more than offset with regard to the health board's responsibility to children by raising the legal age of childhood from 16 to 18 years. The change in the legal age of childhood has meant that our Board is now responsible for the care of an additional 47,000 children. This fact, together with the bulge in the teenage population, presents the our Board with new challenges in meeting needs of children.

2. Births

The birth rate in Ireland has been dropping since the early 1980's. In 1991 there were 9,835 fewer births in the country when compared to 1986, a reduction of 16%. This trend has also been observed in the Eastern Health Board region although it is less marked than the national figure. Between 1986 and 1991 there was a 10.7% drop in the number of births in the region (Table 5). In 1986, 34.8% of Irish births occurred in the Eastern Health Board region, while in 1992 this figure increased to 36.9%, an indication that the birth rate in the Eastern Health Board is falling out a slower rate than that for all of Ireland. This is shown in Table 5.

- 1: Dun Laoghaire
- 2: Dublin South East
- 3: Dublin South Central
- 4: Dublin South West
- 5: Dublin West
- 6: Dublin North West
- 7: Dublin North Central
- 8: Dublin North
- 9: Co. Kildare
- 10: Co. Wicklow



Not only is demography changing, the social health of children has a major impact on health service provision. In recent years homelessness, drug abuse, HIV and AIDS have become major issues.

Child care and child protection are making increasing demands on our service and *will continue to do so.*

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Table 10: Children (0-15 years) with GMS cards by C.C.A. as a proportion of total childhood population in each age group.

C.C.A.	Age Group (%)	
	Under 5	5 - 14 Years
1	18.6	20.1
2	24.0	25.3
3	27.8	29.1
4	34.9	39.2
5	39.5	35.4
6	33.8	40.8
7	46.3	47.4
8	26.7	29.1
9	23.9	30.0
10	34.1	38%

Back to School Allowance

Analysis of the clothing and footwear scheme gives another indicator of need. This is available by community care area for 1992.

Table 11: Number and % children in each Community Care Area who received clothing and footwear allowance in 1992

Community Care Area	Number	%
1	4,670	11.5
2	3,818	11.9
3	4,717	17.2
4	14,028	24.5
5	13,444	31.2
6	12,106	24.6
7	10,895	30.9
8	12,084	16.4
9	8,202	16.3
10	8,378	22.6
Total	92,342	20.7

68% of the over 25 year group were males and likely to be heads of households, the effect of unemployment on child welfare and need is evident.

There were almost 1,000 more people unemployed in the Eastern Health Board region at the end of 1993 compared with the same time in 1992.

Many factors operate in a community which influence health. Knowledge of the number of children in an area gives little information on their needs. The relationship between income and health/welfare needs of people as measured by indicators is not simple.

Indicators of Health

Factors which influence the health and welfare of children include:

- housing standards
- social inequality and unemployment
- length of time in education
- prevalence of infectious diseases (especially vaccine preventable infections)
- surveillance and early detection of disease
- diet and nutrition
- lifestyle
- maternal health
- prevalence of chronic illness
- emotional and behavioural disorders
- stress
- infant morbidity and mortality

Disparities in health from birth onwards are social class related, (Black Report) (5). Social class distribution appears to be the best predictor of mortality in small areas. There are marked variations in mortality between small areas in Dublin (6) and there are considerable differences in mortality between different socioeconomic groups (7). Less affluent areas appear to suffer higher mortality than more affluent ones (8). District electoral divisions in Dublin with the highest mortality from all causes have been identified (9).

IMMUNISATION

The Eastern Health Board provides a comprehensive immunisation service for children through the area medical officers and general practitioners. At birth, vaccination against Tuberculosis (BCG) is offered; at 2, 4 and 6 months Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza b vaccines are given. Measles, Mumps and Rubella (MMR) vaccine is given at 15 months by general practitioners. On primary school entry, boosters of Tetanus, Diphtheria and Polio are given. A second dose of MMR is now offered to all 11 year old boys and girls. Rubella vaccine which was formerly given to girls only at this age is now no longer routinely administered.

Table 14: Vaccinations in EHB region in 1992			
Vaccinations by EHB Medical Officers	Dublin	Kildare	Wicklow
BCG	17,342	1,287	868
Hib (1.10.92-31.12.92)	10,415	1,797	170
DPT completed	15,008	1,605	1,047
DT (completed)	2,759	326	381
Polio (completed)	17,724	1,777	1,454
Rubella vaccinations (for 11-14years)	6,459	1,090	1,002 (from Sept. '92 to Dec. '92 only)

The following Table gives the uptake of primary vaccination at 2 years of age for Dublin in 1992.

Table 15: Uptake of primary vaccination at 2 years 1992	
Diphtheria	75%
Polio	75%
Pertussis	61%

While the uptakes of primary vaccination are less than satisfactory, they do not take account of vaccinations, except MMR, undertaken privately by general

CHILD HEALTH EXAMINATIONS

(i) Domiciliary Visits:

All babies receive an initial visit by a public health nurse within a few days of receipt of birth notification. This is followed by a second visit at approx. 3 months or earlier if deemed necessary. Further visits are made, including a screening examination at 18 months, up to 3 years of age. Visiting beyond this timescale will continue in cases of vulnerability and handicap.

(ii) Nurse Advisory Clinics:

Clinics are held regularly in health centres and parents may bring their child, without appointment, for advice, screening and monitoring of progress.

(iii) Paediatric Developmental Clinics:

Clinics are held in health centres where children at approx. 9 months of age receive a developmental examination by appointment with the Area Medical Officer. The main objective is to detect and refer for treatment any child who has a remediable defect.

Table 17: Uptake of appointments for Paediatric Developmental Clinics by Community Care Area.					
Year 1992	No. of Clinics	No. of appointments offered	No. attended	% attended	No. needing further attention
Area 1	307	2,687	1,751	65%	265
Area 2	259	2,185	1,625	74%	687
Area 3	243	2,217	1,293	58%	324
Area 4	376	3,092	2,081	67%	337
Area 5	325	2,650	1,581	60%	134
Area 6	299	2,446	1,698	69%	753
Area 7	213	2,234	1,305	58%	308
Area 8	432	3,996	2,874	72%	638
Area 9	702	2,798	2,091	75%	
Area 10	445	3,496	2,972	85%	970

(iv) Area Medical Officer's Referral Clinics:

Clinics are held by appointment in health centres to which infants and children up to 6 years of age are referred by the public health nurse for examination.

DAY NURSERIES

The purpose of day nurseries is to provide an alternative to residential care for young children whose parents are unable to care for them during the day. They also provide day care for children whose development may be gravely at risk due to physical or mental illness in the family or general deprivation.

As such, day nurseries are to the forefront in assisting the Board to achieve its prime child care target of enabling children to stay in their own family home where at all possible.

It is estimated that at any one time, not less than 50% of all children who come to the attention of the Board are maintained in this way, together with other supports.

Our Board grant aids 44 voluntary organisations to provide day nursery places for 1,500 children in our area.

It is our intention to continue to develop preventative child care facilities including day nurseries as new funds permit in order to ensure that an adequate number of home support places are available in each community care area.

The following is a list of the organisations and locations providing Day Nursery Care.

AREA 1

Loughlinstown Day Nursery
Health Centre
Loughlinstown Drive
Co Dublin

Dun Laoghaire Day Nursery
St Mary's Dominican Convent
Convent Road
Dun Laoghaire

Monkstown Day Nursery
Monkstown House
Monkstown Grove
Co Dublin

AREA 2

Day Nursery
c/o Y.M.C.A.
Aungier Street
Dublin 2

Miss Carr's Home Day Nursery
c/o 16 Northbrook Road
Leeson Park
Dublin 6

AREA 6

St Mary's Day Nursery
8 Henrietta Street
Dublin 1

Finglas Day Nursery
Social Service Centre
Wellmount Road
Dublin 11

St Helena's Day Nursery
St Helena's Road
Dublin 11

Roselawn Day Nursery
Roselawn Health Centre
Blanchardstown
Dublin 15

AREA 7

St Louise's Day Nursery
North William Street
Dublin 1

Our Lady's Nursery
Sillogue Avenue
Ballymun
Dublin 11

St Brigid's Day Nursery
Mountjoy Square North
Dublin 1

Ballymun Day Nursery
Holy Spirit Girls N.S.
Sillogue Road
Ballymun
Dublin 11

AREA 8

Bonnybrook Day Nursery
St John Vianney Boys N.S.
Bunratty Drive
Coolock
Dublin 5

Kilmore Nursery
9 Cromcastle Green
Kilbarron Park
Coolock
Dublin 5

Darndale Day Nursery
c/o O.L.I.N.S.
Darndale
Dublin 17

Edenmore Day Nursery
St Monica's School
Edenmore
Dublin 5

Grange/Kildonagh Nursery
49 Swansnest Court
Kilbarrack
Dublin 5

Mead Day Nursery
Donaghmede House
Donaghmede
Dublin 13

Kilbarrack/Foxfield Nursery Day Centre
Coil Iosagain
Greendale Road
Dublin 5

The programme was extended to the other health board regions in September '92. Currently 10 social workers and 11 primary school teachers are seconded to the programme. They have been assigned to the various health board regions and working teams consist of a teacher and a social worker. Teacher training was completed in October 1993 (99.7% uptake) and parent meetings are on going. There is, for various reasons, a time lag between teacher training and a school's decision to hold a parent meeting and to teach the Stay Safe lessons.

Teachers, parents and community groups have used the CAPP teams as an information resource. This is an invaluable role as community awareness is one of the cornerstones of child abuse prevention.

Modifications

As a result of feedback from teachers and parents, the following modifications and additions are being made to the Stay Safe pack:

1. Revised lessons plans have been prepared and are being piloted for 5th and 6th classes and also for junior and senior infants;
2. An Irish version of the pack is at present being prepared for publication;
3. Modifications are being made to the pack to suit the various categories involved in special education;
4. A parent's booklet on child protection is currently being prepared;
5. A pre-service training course is being prepared for teacher training colleges.

Future of Programme

By June '94 the Child Abuse Prevention programme will have completed its primary task of training primary school teachers about child abuse prevention and will have offered all schools an opportunity to hold a parents' information evening. The Child Abuse Prevention Programme will require a degree of maintenance within each health board area which will involve a limited commitment of manpower and expenditure.

We feel that this community based model of child abuse prevention which is based on the education of parents, teachers, community and children, has been very successful to date. It ensures a high level of community vigilance and instils an awareness of children's needs and rights as well as the responsibilities of all adults towards all children. It is supportive of families, children and communities, and takes a competency enhancing approach towards health promotion and child protection.

Adequacy of the Service

Despite the many services described above there remains much work to be done. The additional allocations which have been made to resource the Child Care Act provide an opportunity to bring on stream some of the many plans which have been devised for the residential services. Broadly speaking the task falls into two parts: (a) consolidation of existing resources and (b) development of new services.

(a) Consolidation of Existing Resources

Research undertaken by CSSC showed that 60% of the boys placed in their emergency/short term hostel had a previous history of care (5). Other research conducted by Eastern Health Board/Focus Point found that 38% of young homeless people had a care history, particularly residential care (6).

It is important that residential care centres have adequate staffing levels and training to help them deal with today's children. Too often field workers find that residential centres will not, or cannot, deal with the children presented to them. We have formed, and are developing, partnerships with residential services to work in close harmony to protect and sustain placements.

To this end it is planned to regularise residential services into three sectors. These sectors will be integrated with particular community care areas as follows - Sector 1 will include Areas 1, 2, 3 and Wicklow, Sector 2 will include Areas 4, 5 and Kildare, and Sector 3 will include Areas 6, 7 and 8. Work has already commenced in this regard, particularly in Sector 3.

The policy is to have social work managers and residential managers co-working together towards a common end. The aim is to have each sector self sufficient in relation to residential care requirements. It will also have the advantage of residential managers having to relate to a reduced number of social work managers.

To successfully realise the regionalisation plan it may be necessary for some existing services to relocate. Currently there is a disproportionate number of residential centres in Dublin's southside, particularly Community Care Areas 1 and 2.

A survey recently carried out by the Daughters of Charity at Royal Oak showed that the majority of girls placed with them had, for better or worse, returned to their family after placement. This led staff at Royal Oak to review their policy and they now have a much stronger involvement with the parents of the children while they are in care. In general, a more enhanced role for parents in their child's placement is to be encouraged. In particular, group homes are well placed to change the role of the parent from that of visitor to key participant.

(b) Adolescent Hostels

Hostels cater for older children who require residential care. Most provide long term care and two specialise in short term/emergency care for children who are recently out of home - Sherrard House for girls and Eccles Street for boys. In addition to their regular complement of beds both these hostels provide two places each night to the Out of Hours Social Work Services. This service works through the night to provide a crisis service, and accommodation where necessary, to young people out of home. The service is currently being reviewed.

There is a persistent demand for places in the two short term emergency units. However, this is largely attributable to the fact that placement onward to long term centres tends to be slow, and accordingly, short term placements can become blocked up. There is a need to ensure that there are sufficient long term placements to move children on to when they present in the emergency/short term hostels.

Our Board is conscious that there is an intrinsic danger in concentrating too much on emergency services to the exclusion of other services. If emergency services *only are to be provided then we will only have emergencies*. Emergency services need to fit into a continuum of care between prevention at one end of the spectrum and aftercare at the other end (4).

The long term hostels operate on the basis of planned admissions. There has been a policy development in this area where the concept of localised residential services is favoured, i.e. making the service neighbourhood based. Tried and tested examples of such services exist in Amiens Street and Tabor House (North Inner City) while more recently similar services have been established in Tallaght and Ballymun.

Don Bosco Blessington Street	Aftercare	6	16 - 19	M	Salesian Fathers
Don Bosco Nephin Road	Aftercare	3	17 - 19	M	Salesian Fathers
Ballymun Residential Project	Long Term	6	10 - 18	F	Management Committee
Tabor House	Long Term	6	12 - 16	M	Tabor Society
Eccles Street	Emergency/ Short Term	From 9/93 14 (includes 2 out of hours beds)	12 - 18	M	Crosscare
Lennox Street	Aftercare	4	15+	M	Crosscare
Rathgar Ave	Aftercare	4	16+	M	Crosscare
No. 19, Sherrard House	Long Term	11	13 - 18	F	Homeless Girls Society
No. 20, Sherrard House	Emergency	8 (includes 2 out of hours beds)	13 - 18		
Mrs Smyly's Homes: Racefield Glensilva 2 Flats	Long Term	7 13 2	13 - 18 11 - 18 13 - 18	M M & F M	Mrs Smyly's Homes
St Anne's Kilmacud	Long Term	10	12+	F	Sisters of Our Lady of Charity
An Grianan	Long Term	8	12 - 18	F	Sisters of Our Lady of Charity

As Table 27 demonstrates, the majority of services provide long term care. However the term 'long term' is less likely nowadays to represent an entire period of childhood.

"It seems that residential child care will increasingly be asked to offer packages of care tailored to specific young people to help them during a limited period". (2)

Table 25: Residential Services run directly by the Eastern Health Board

Name	Type of Care	Capacity	Age Range	Sex
Glen House	Long Term	8	12 - 16	M & F
Tallaght Residential Project	Long Term	6	10 - 18	M
Child Psychiatric Services: Warrenstown House	Short Term	14	Up to 16	M & F
Court Hall	Long Term	8	Up to 16	M & F
James Connolly House	Long Term	8	Up to 16	M & F
Drumheath Avenue	Long Term	5	Up to 16	

As is evident from this table, the child psychiatric services operate the majority of placements run directly by the Board. It is becoming increasingly common that children requiring placement are known to both community care and the child psychiatric service. Therefore, co-working and a partnership approach is required more and more when providing residential services to children. Indeed, it is not uncommon that children requiring care for social reasons are also known to the Board's mental handicap services.

Table 26: Voluntary Residential Services Funded by the Board

Name of Centre	Type of Care	Capacity	Age Range	Sex	Service Provider
St Kyran's	Long Term	16	5 - 8	M & F	Sisters of Mercy
Amien St	Long Term	6	6 - 13	M & F	St Vincent de Paul
Trudder House	Long Term	17	9 - 14	M	Dublin Cttee. for Travellers
Derrallossary House	Long Term	12	5 - 18	F	Dublin Cttee. for Travellers
Madonna Hse	Short Term/ Emergency	55	0 - 9	M & F	Irish Sisters of Charity

Developments in foster care

Recruitment:

Recruitment is a continuous process. There is a need to have a major campaign either annually or every two years. There are always children needing long term placements, and the number of requests for short term placements has dramatically risen. We intend to avoid the periodic placement crises which occur from time to time.

Any recruitment plans have to involve the two elements of staff working in foster care: the centralised team and area teams.

Campaigns need to be professionally run. We need the assistance of an advertising agency to this end. The media too may respond to one such event as it is newsworthy. The Irish Foster Care Association have a Focus on Fostering week and it is suggested that such a campaign could be timed for this time. It could be run nationally and the costs divided between the various health boards. This campaign could be supplemented by advertisements on television and/or on radio - again this could be organised nationally and the costs shared between the health boards. Freephone should be available during the campaign. Such initiatives could be continued at local level with articles and advertisement. in the local newspapers/ radios to reflect local needs.

In any recruitment we must define our need - this may seem obvious and simple - where fostering is concerned it involves an assessment of need - who the children are, what their needs are, the issues and the backgrounds they come from. This assessment is vital if we are to recruit families for fostering. Children and their families need to be prepared and involved, as far as possible, and as age permits, in this process.

This work continues as a feature of foster care - especially helping children deal with past experiences and complex issues arising out of their lives. We are looking at the individual work that needs to be done to maintain a child's sense of themselves, and of their identity: who they are, why they are in care. This can be done individually and in groups, and is very much the essence of a developing foster care service.

Conclusion

We have made strides in foster care and we need to build on this. Foster care reflects the ever changing society and child care situation in which we find ourselves. It is a challenge that we must face and continue to develop and evaluate.

There has been a move to involve the 'consumers' in the service and young people need to be involved in planning for their individual needs and certainly it has been our experience that young people in care benefit from groupwork and have also contributed with an input into training of carers and in discussing the outcomes of placements with other young people.

We also need a complaints procedure for foster care.

Foster care has changed dramatically over the past number of years and will continue to do so. Foster carers will require more training if they are to provide an adequate standard of care for disturbed, damaged, and abused children.

Foster carers are being expected to attend court, reviews, case conferences and liaise with various agencies e.g. police, schools, child guidance, hospitals. This will require an input of training/support and increased financial reward.

With the emphasis on rehabilitation and with the expectation that parents will, except for exceptional circumstances, know where their child is, foster parents are expected to share their home and be involved in working with birth parents. Foster carers must be prepared for this.

There has been an increase in the number of allegations against foster carers and foster families need to be made aware of protecting themselves and their family. This is discussed with foster families during assessment. The Eastern Health Board needs a clearly defined policy about what happens if foster carers are accused of abuse.

A number of specialised schemes could be developed e.g. HIV/AIDS, therapeutic and assessment foster care.

Working with groups in foster care

Foster family's own children: A vital group who are often ignored because so much of the concentration is on the foster child. These children often share their parents, their toys, precious time, belongings, clothes, and privacy. There have been requests for groups for foster families' own children and we need to pay attention to this.

Adolescents: We have now a percentage of adolescent young people who have grown up in foster care or who have been placed in foster care as adolescents.

While young children are demanding - it has been our experience that in placing, teenagers are more time consuming. In the Carers Project, one placement can take hours in planning and introductions, e.g. in one case, the time measured was 120 hours of social work time. Young people can be volatile, can be fearful about

Table 22: Numbers of children in care in EHB region 1985 - 1993

Year	Number of children	% increase
1985	976	
1993	1349	38%

Table 23: Numbers of children in foster care in EHB region 1985 - 1993

Year	Number of children	% increase
1985	585	
1993	895	52.9%

All foster parents have an assessment and there are compulsory checks - medicals, garda clearance. Training is also part of the process and this training, presented by foster parents and social workers, looks at the areas involved in fostering. All prospective applicants are required to do a training course - in addition to this there are some post-training courses offered - e.g. fostering a sexually abused child, In Touch with Children etc. Foster care has had to develop and keep abreast of the complex child care issues e.g. HIV/AIDS, sexual abuse etc. and families need to be prepared for this. Foster carers and their families have to deal with a wide range of complex issues and behaviours which has led to demands being placed on foster carers looking after a child. They also have to attend access meetings or have parents to their homes, help the child deal with difficult experiences, attend court and cope with the demands of an agency.

In 1993, the International Foster Care Conference was hosted by the Irish Foster Care Association and held in Dublin. A number of Eastern Health Board foster parents attended and presented workshops. A further number of foster parents and social work staff were involved in the organising of the Conference and presented workshops and papers.

It is perhaps worthy of note that in the foster care budget of 1993, training for foster carers was .08% of the budget. A £10,000 grant was given to fund foster parents to attend the above Conference.

An issue drawn to our attention has been the lack of creche facilities if we expect foster carers to attend conferences and training. This is a point well made and should be considered.

In relation to cost, it is also to be borne in mind, that there are currently inter-country adopters within the Eastern Health Board catchment area who have adopted from countries where the Adoption Orders obtained are not full Adoption Orders as recognised under the adoption legislation of Ireland. This will, in time, no doubt add to the legal expenses for the Eastern Health Board when these couples apply to have the Adoption Order regularised under the Adoption Act 1988. This is likely to have an increased cost implication to the Eastern Health Board. Significant legal and other costs have arisen in the process of facilitating the adoption of children of married parents.

For many people who have expressed an interest in inter-country adoption, they have the hope and expectation that we can help them in finding a child for adoption and some of the disappointment about the service we offer is based on that fact. Our task is limited to the assessment procedure for the adoptive parents.

Inter-country adoption is a very complex and involved task which many people find they are unable to complete. The completion of the assessment and the granting of the declaration, which is done by the Adoption Board on receipt of the assessment from the health boards, is only the first step in that task. The assessment process for inter-country adoption has to be of the same standard as the assessment for national adoption, and in addition to this, has to address the added dimensions of inter-country adoption such as racial and cultural aspects. We have been developing our practice in these areas since the inter-country adoption team has been set up. The assessment, therefore, takes time to explore all these areas. At present the assessment includes group training which addresses these issues. All of these groups are evaluated and consequently are changing all of the time.

Adequacy of the Service

During the past year there have been situations when the numbers of approved adoptive families for national adoption have been very limited and did not allow for choice of placement for the child when this is necessary. An agency needs a pool of couples in order to maintain the possibility of choice so that the matching task, that is, a selection of a family to meet the needs of a particular child, can best be carried out and serve the best interests of the child, bearing in mind the wishes of the natural mother or parent/s.

With regard to inter-country adoption, there have been issues raised about the length of time that couples are waiting, in the Eastern Health Board, for uptake of their assessment. There are four full time social workers allocated to this task and people can expect to wait about 12 months for an assessment to be taken up. This should reduce considerably during the current year as the initial backlog of applications is reduced. There is a steady flow of enquiries for inter-country adoption. There is no reason to think that the demand for inter-country adoption assessments while diminishing, will cease.

All fostering and adoption applications in the Eastern Health Board are examined by a Placement Committee for approval/refusal.

Of the number of inter-country adoption assessments which have been completed, there have been three/four children placed in the past two years. There is also a small number of inter-country applicants who have also applied to the St. Louise Adoption Society and these assessments have been completed.

find parents for children with special needs e.g. children with disabilities. The birth parent/s may also have requests to make about the kind of adoptive parents they are seeking for their child. We try as far as possible to meet their wishes.

It is therefore important that the agency has a range of families to choose from for each child, so that the best match can be made.

c) The Adoptive Parents

The assessment and preparation of parents for adoption involves helping applicants to decide that the task involved in becoming adoptive parents is one that they can take on. It is a long process and takes time. St. Louise Adoption Society re-opened for applications in July 1993 and there are now 79 applicants awaiting assessment. Everyone who enquired was invited to an information meeting - these meetings were held in each Community Care Area. Applications were then invited if people were within the age range. These are currently being processed. All of the adoption applicants will undergo an assessment. It is important that they are processed as quickly as possible so that there are families available to meet the needs of the children to be placed for adoption.

Table 20: Placements made by St. Louise Adoption Society 1991 - 1993	
1991	15 children placed
1992	12 children placed
1993	5 children placed

It is also worthy of note that during 1993 two mothers requested the return of their child whom they had placed for adoption. One of these children was returned. The other request went to Court for a decision.

Assessment Process

The aim of an assessment is to help people realise what is involved in adoption and that it is a life long commitment. We include training, as well as getting to know the particular couple, and this is a process which cannot be rushed. The couple are seen individually and together, and the required medical and Garda checks are completed on all applicants. The areas that are discussed with the couple are - personal history, infertility, marital history, lifestyle etc.

This was subsequently followed in 1985 by the opening of Derrallossary House as a response to the demand for accommodation for female traveller children.

In 1988 a Sub-Committee was set up by the management committee of Trudder House to look at the effectiveness of care within the house. This arose out of concern at the difficulties so many boys were experiencing on leaving Trudder House. Arising out of this Sub-Committee came the following initiatives:-

- 1) Setting up of the after care service to support the children on leaving Residential Care and to prepare the children in residence for moving on.
- 2) Changes in the policy relating to the children in respect of:-
 - (a) Admission:- to create more planning around the admission and to set goals and targets for both the residential unit and the referring agency.
 - (b) To have regular reviews.
 - (c) To increase the outreach work with children and their families.
 - (d) To have better long-term planning towards discharge.
 - (e) A commitment to employing professionally trained staff and on-going staff training.

Shared Rearing Project developed in the early 1990's and has led to the recruitment of travelling families as foster parents to travelling children. To date 5 families have been approved and 16 children have been placed with them.

With the advent of the Shared Rearing Fostering Project and the question of the appropriateness of the residential care, a further policy review was felt to be advantageous and this commenced early this year.

Proposals for Future Development of Traveller Families Care

The current provision of services, Trudder, Derrallossary after care, Shared Rearing should be organised and developed as follows

1. Primary, Emergency/Assessment Unit: mixed sex, family room space, to normally accommodate 6-8 children. Maximum stay to be less than 6 months.
2. Medium Stay Unit: mixed sex, up to eight children, with constructive family involvement. Maximum stay should not normally exceed 2 years.
3. Adolescent Unit: initially for up to 6 adolescent boys. This is to accommodate those who should not go home but are not appropriately placed in Shared Rearing or the medium stay unit. The focus will be on movement to independent living with a large input from the after care team.

From a practical point of view this facility could provide a regional service to the E.H.B. area, with service being accessed by the Board's own service, the services run by the Order of St. John of God, and the Mater Hospital.

The residential facilities in our Board's area - Orwell Road, Warrenstown House, Courthall, James Connolly House and St. Paul's, Beaumont will be used in a flexible manner by the various services in the context of an integrated package of assessment and residential services.

The Child Psychiatric Services are developed on the basis of services to children up to 16 years. It is not yet clear whether the Child Psychiatric Services will be expected to cater for children up to 18 years in line with the Child Care Act; the Mental Treatment Act 1945 recognised the cut off point as 16 years. Should the Child Psychiatric Services be given responsibility for children up to 18 years, all components of existing and planned services will require considerable expansion. For example, we would estimate that approximately 6 in-patient beds would be required in each of the 3 catchment areas.

Unit for Intractable Conduct Disorders

Particular difficulties are being experienced in the management of young persons presenting with challenging and disturbed behaviour who are not psychiatrically ill. These people present from families with very disturbed backgrounds and from residential homes. *They do not require admission to Child Psychiatric Units*, and if admitted to Psychiatric Units, it is very difficult to find a suitable placement due to their history of challenging/disturbed behaviour, and their on-going challenging of the residential programmes in group homes.

Long term accommodation with programmes geared specifically towards management and personal development of these young people is necessary. Fifteen places is considered sufficient and 3 units of 5 places is deemed ideal for these types of programmes. These units could be run by the Community Care Programme with liaison services provided by the Area Child Psychiatric Teams.

Autism:

The assessment and treatment of children with autism is a significant feature of the Child and Family Services. The services are involved with the ongoing development and education of the autistic child. A significant number of patients remain in the service throughout their adolescence and adulthood, and require residential care in adolescence, and later as adults.

Residential care for adolescents is now provided at James Connolly House and thereafter residential and day care is provided by the Autistic Society at their centres in Dunfirth, or by Gheel, a voluntary organisation developed by our Board and the Autistic Society. We are, at present, reviewing the option of a central assessment service for autism. The placement of adolescent autistics into residential care had been problematic in recent years due to the availability of places and funding. At the moment there are sufficient places available due to the developments in Fairview and Dunfirth. There may, however, be a problem with regard to the revenue funding of these places.

Young Chronic Schizophrenics:

A small number of young chronic schizophrenics grow into adulthood in residential care. The integration of these young persons into the normal hostel milieu involves a major challenge as each new case arises. The residents of the standard hostel in adult psychiatry are usually middle aged, and older. It is difficult to integrate young men in their late teens in this type of milieu.

Service Developments:

Over the last decade, the Child and Family Services have had severe curtailment of funding in the context of the usual budget arrangements and value for money programmes. Nevertheless, each of the three services have had ongoing rationalisation programmes in the context of matching resources to needs, as identified, and, more particularly, ensuring that service provision was as pro-active as possible. Within existing resources, services were developed in Kildare and Wicklow, where no service was in place. In this regard, it must be recognised that some new funding was made available for the Kildare service in 1993.

In the last decade, however, there has been a consistent increase in overall morbidity, due to the population increase, and associated demographic changes, (increasing numbers under 14 years in some areas), the development of major new towns (Clondalkin, Tallaght, Swords, Leixlip, Raheny, etc.), changing family structures, (including single parent families), unemployment, substance abuse, etc.. As already stated, services have had ongoing rationalisation to reflect service

Whilst there are 2 centres based in general hospitals, (St. James's Hospital and the Mater Hospital), it is fair to say that these centres operate independently of the main hospital service, and are the most convenient locations available in respect of the communities they serve. Appendix I, II and III gives details of:

- a) Budget.
- b) Staffing.
- c) Profile of Services.

Child Abuse Services:

Two specialised Child Sexual Abuse Assessment Units were established in Crumlin and Temple St. Hospitals respectively. Arrangements were made from the outset to ensure that these services were integrated with existing community Child and Family Services. With the adoption of the "*Report of a Working Group on Child and Adolescent Psychiatric Services in the Eastern Health Board Area*", this arrangement was enhanced with rearranged deployment of existing consultants, and joint appointments of new consultants, whereby consultant psychiatrists now have sessional commitments to the three children's hospitals.

It is now apparent that, following assessment, there are some children who should have specialised treatment in an appropriate therapeutic service within the children's hospitals, rather than the practice of discharge/referral for treatment to the local centres. In this regard, the staffing in the children's hospitals require augmentation; these new staff, however, should be deployed on a joint basis with the local community services, in the interest of rationalisation, integration of the local services and a total care plan.

Education:

The Child and Family Centres provide a day service for children. Programmes include psychiatric services, speech therapy services, psychology services, social work services, playgroups for pre-school and school going children, dealing with problems of inappropriate behaviour, co-ordination, perceptual difficulties, and early learning difficulties.

A range of special schools are operated jointly with the Department of Education, catering for children with mixed emotional conduct disorders, young autistics, and the mildly mentally handicapped.

Eastern Health Board	-	Phoenix Park
		Ballyowen Meadows
		James Connolly House
		Warrenstown House

Volunteers

Homestart volunteers are all parents themselves. They come from a variety of backgrounds. They are selected for their attitudes and care rather than for their previous experience. They must be reliable and able to respect the confidentiality and dignity of the family they are visiting. All volunteers attend a basic preparation course to make them more aware of their own strengths and weaknesses before they begin visiting.

At present there are 24 volunteers attached to Blanchardstown Homestart.

Future Plans

Homestart has been operational in the Blanchardstown areas since the summer of 1988 and caters solely for the community in the Greater Blanchardstown area. Having proved itself to be a very valuable service to the community in Blanchardstown, there is indeed a strong case for expanding and developing the service in other areas.

The report of this review will be available in March. Recommendations from the review will include:

- the standardisation of procedures within the Eastern Health Board
- the preparation of a standardised child abuse protocol for the Eastern Health Board region (some community care areas have already prepared their own protocols)
- procedures to facilitate parental participation in case conferences
- the expansion of treatment services
- the introduction of a systematic training programme for all personnel involved in this area of work
- the organisation of case conferences

"Child abuse is a complex challenging and emotionally charged area of work" (9). The care and protection of children is an extensive and onerous responsibility for health boards. Future developments have been identified and continued investment and review of child protection procedures and services is necessary.

References

1. Finkelhor, Child Sexual Abuse: New Theory and Research. The Free Press, New York 1984.
2. Child Abuse Guidelines, Department of Health 1987 page 7.
3. DHSS Working Together HMSO 1988
4. Schechter MD and Roberge L "Sexual Exploitation" in Child Abuse and Neglect: The Family and the Community. Heilfer RE and Kempe CH (ed) Ballinger, Cambridge University Press 1976
5. McKeown, K and Gilligan, R Child Sexual Abuse in the Eastern Health Board Region of Ireland in 1988 p. (XXII)
6. Ibid p (XXIII)
7. Ibid
8. Ibid p (XXIV)
9. Kilkenny Incest Investigation, Stationery Office, Dublin 1993 p. 113

The Eastern Health Board commissioned a major research study on child sexual abuse in the Eastern Health Board region in 1988 (7). Social workers in the EHB played an indispensable role in this research. The report was published in March 1993 and it provides valuable information on child sexual abuse including (i) the characteristics of the child sexual abuse cases, (ii) assessment and management of the cases, (iii) inter-disciplinary co-operation, (iv) case conferences and (v) civil and criminal proceedings. In 1988, Eastern Health Board community care teams dealt with 990 cases of child sexual abuse. Following professional assessment 512 cases (52%) were found to be cases of confirmed sexual abuse. Other results included:

- 71% of cases were female
- 37% of cases were under 6 years of age
- 63% of cases, the relationship of the child to the alleged abuser was intra familial (8).

For the period 1982 - 1991, 46.2% of all child abuse referrals to the health boards were within the Eastern Health Board region. The child abuse referrals within the Eastern Health Board for 1992 totalled 1,521; of these 639 were referrals relating to child sexual abuse.

4. The Investigation and Management of Cases of Child Abuse in Eastern Health Board.

The guidelines issued by the Department of Health state that all cases of child abuse must be notified to the DCC/MOH. The action to be taken by health board personnel is then outlined.

Medical, public health nursing and social work staff in the community care teams are the key personnel involved in the investigation and management of child abuse cases in Eastern Health Board region. Social workers have a pivotal role in these cases, and child abuse is now the dominant feature in the workloads of the social workers within community care. There is continuous liaison and contact with the children's hospitals in Dublin - Temple Street, Harcourt Street Hospitals and Our Lady's Hospital for Sick Children in Crumlin, particularly during the investigative stage. In 1988, two Child Sexual Abuse Assessment Units were opened in Dublin - in the Children's Hospital, Temple Street and in Our Lady's Hospital for Sick Children, Crumlin - to provide an assessment service for alleged cases of child sexual abuse within the EHB region.

Multi-disciplinary networking and co-operation - a crucial element in the effective management of child abuse cases - is promoted by Eastern Health Board personnel. Case conferences are an essential feature of inter-agency and inter-disciplinary co-operation. Many changes have been introduced by the community

- **Emotional Abuse:** Persistent and/or severe emotional ill treatment or rejection. This includes affection being withheld and being subject to derision and constant criticism.
- **Neglect:** Persistent and/or severe neglect which results in serious impairment of the child's health or development including non-organic failure to thrive. This includes inadequate medical care, being left alone or inadequately supervised, being starved or kept without adequate comfort such as heat.
- **Sexual Abuse:** "The involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles".

3. Incidence of Child Abuse in Eastern Health Board Region:

There has been a major increase in the number of reported cases of child abuse since 1980's. Between 1984 and 1989 all child abuse referrals increased in the Eastern Health Board region by 561%. The comparable figure for Ireland is an increase of 391%. Child sexual abuse referrals in Ireland increased by 1,311% between 1984 and 1989, in the Eastern Health Board region they increased by 2,121% (5).

Table 1 gives a detailed breakdown of reported and confirmed cases of child abuse for the period 1982 - 1989.

Conclusion

It is not always possible to place families requiring emergency accommodation within the hostel/shelter/refuge spaces available. In such cases short-term placements in bed and breakfast accommodation may be made until such time as an appropriate vacancy arises. In particular, the emergency accommodation available for victims of family violence is often unable to meet the demand. The Dublin Housing Forum, which represents the Dublin housing authorities, our Board and the appropriate voluntary bodies, has identified the need for two further 10 family refuges and 15 family units for two parent families. Negotiations are at an advanced stage between Dublin Corporation and the Salvation Army for the provision of two units of two parent family accommodation.

Support to Physically Handicapped in Schools

Apart from the maintenance of children in Homes/Schools for blind and deaf, the Board provides, in the absence of same being done by Department of Education, nursing aids in three 'special' 2nd level schools.

- Ballinteer Community School
- Ballymun Comprehensive School
- Rosmini Comprehensive School

Supply of Medical and Surgical Appliances

Again children's uptake/cost would be high.

Psychological Services and supply of Technical and Educational Aids

The recommendations in the Report of October 1993 on Special Education Review Committee and the implications for Board are being examined at present.

Voluntary Organisations providing services.

Most of the 20 organisations for physically handicapped who are grant aided are providing services for both adults and children - some exclusively for children.

Residential Facilities

The Board grant aids:-

Schools/Homes for the Deaf:

Three homes provide residential accommodation/care for 244 children (252 in 1992) attending national and secondary schooling.

Table 30: Number of children attending Schools/Homes for the Deaf 1992 and 1993		
School/Home	September 1992	September 1993
St Mary's Cabra	134	126 girls
St Joseph's, Cabra	92	94 boys
Mary Immaculate, Stillorgan	26	24 boys

In general the emphasis should be on personnel rather than on special buildings. However, since overcrowding is especially conducive to disturbance, it should be prevented through the provision of ample living space and the availability of quiet rooms.

There is a small number of individuals whose behaviour may be classified as dangerous to themselves, to other intellectually disabled persons or to the staff. While there is some risk that over reliance on special units to cope with this group may make the general body of staff in the services less tolerant of and less able to cope with disturbed behaviour, nevertheless a small number of such units is required. It will be necessary to prevent these units becoming blocked with long-term placements by having an effective admission and discharge policy.

While we do not recommend purpose-built units, we believe that the general movement of clients to community settings should free up some space at a small number of locations throughout the country which would make room for agencies to accommodate, on short-term basis, persons whose current behaviour requires the type of unit mentioned above. Such protected settings should each accommodate only a small number of persons, be adequately staffed and have the regular support of a multi-disciplinary team.

Anti-Social - Criminal Behaviour - Pilot Residential Home - Project

Some children present as major problems to the educational, justice or social work agencies for a variety of reasons:- e.g poor home environment, out of parental control, easily led into deviant peer activities, criminal behaviour.

The tendency is for the educational establishments to exclude this group and they present increasingly with anti-social criminal behaviour before coming to the attention of the justice system and moving into the penal system.

As an initiative to meet the needs of these children and their families, a pilot residential home is proposed using a strict communication model approach that is hoped will not only improve their communication and social skills but also better equip them to function independently in society.

Programme Manager	Eastern Health Board
St. John of Gods	Agency Manager
Daughters of Charity	Agency Manager
St. Michael's House	Agency Manager
Moore Abbey	Agency Manager
Stewarts Hospital	Agency Manager
Sunbeam House (who also represents other Section 65 agencies)	
Cheeverstown	Agency Manager
Representative of Parents Group	

Services for Children

As has been outlined services are provided by identified agencies in selected areas. The new Child Care Act, increasing the responsibility of service provision for two further age cohorts, will further pressurise service needs.

Severely Mentally Handicapped

Specialist hospitals provide both residential, day and respite services for this group. In general this group is well cared for. The emphasis on developing our respite support provision has enabled such children to be maintained at home for longer periods and should be further developed.

This should be further argued by the increased development of home support services enabling parents to have a balanced quality of life.

One of the more urgent needs in this area is in the case of specialist childrens hospital such as Sunshine Home where difficulties have arisen due to the lack of transfer on beds as children reach their mid-teens.

Database

In conjunction with the Department of Health we are currently developing a database on intellectual disability which will provide us with comprehensive information to enable us to identify the amount of needs and to project the further demands on our services. This should ensure that we are in a position to make appropriate projections on need and work better with the agencies providing services for mentally handicapped in developing such responses.

Autism

Services for autistic children have developed in the last few years but focus needs to be placed on the early identification of a suitable intervention process for this group. With this in mind, the mental handicap services need to link with the child psychiatric services and agree a structure best suited to meet this need. This can also become a focus point for the co-ordination of future service development.

Implementation Issues

The system will be implemented in a pilot site in the third quarter of 1994.

The system will be used primarily by social workers.

Data capture documents have been in use since the beginning of 1994 in Areas 9 and 6. The purpose of these documents is to capture all 1994 data in a computer ready format. It is proposed that the use of these documents will spread to all areas in 1995 after the pilot review.

Following a six month run in the pilot site the system will be reviewed, revised and implemented on an area by area basis.

Training and the standardisation of procedures will form a major element of the implementation programme.

It is estimated that one PC will be required per three social workers with one PC for each social work manager and secretary. A printer will be required in each location. In addition there will be a hardware requirement for Community Care management.

Conclusion

Timely and accurate co-ordination of service provision and clear decision making is fundamental to effective service design, delivery and to good practice. Computerisation of the social work service, outlined above, is necessary to meet our Board's information and practice requirements.

This computer system will have sufficient capacity and flexibility to allow for future developments.

Ultimately we see I.T. as an aid to the development of a more effective and open social work practice.

5. Ways of measuring what the social work and child care services are currently doing must be developed. Recommendations could then be made on the most effective ways of working. The computerisation of the service in 1996 will help.
6. The planning and consultative group is a temporary arrangement - further structures need to be in place to facilitate the rapid expansion of this service. Linking these in with the re-organisation of the Eastern Health Board areas must also be explored.
7. Residential care for children has been going through very challenging times: the challenge is to make the service meet the needs of the children not the other way round. The concept of a continuum of care holds true but the continuum needs to be reviewed regularly so that gaps in it can be identified and remedied.
8. Research must be undertaken into what works in residential care from a variety of standpoints, e.g. the consumer, the family, the staff and the referrers. This would be most valuable in making decisions about where to put scarce resources.
9. Fostering recruitment is not as we would like it to be. Research may throw light on this.
10. New systems and partnerships could be forged with outside agencies to both maximise scarce resources and skills and to avoid duplication.

(b) Support Services for children orphaned due to AIDS.

The great majority of orphaned children (whether due to AIDS or otherwise) are looked after by their extended families and do not come into the formal care of the Board. In that situation, the extended family is offered whatever additional supports are appropriate to care for the child or children e.g. home helps, visits by the public health nurse, any necessary extra furnishing such as cots or beds. It is to be noted that the orphans allowances from the Department of Social Welfare are payable.

Statistics on AIDS - related deaths are unreliable due to discretionary death-cause certification. About 40 persons died of AIDS or AIDS related causes in the state in 1992 to date and more than 30 of these relate to the Dublin area. We do not know how many were women or how many children were orphaned as a result. The deaths occurring at present relate to infections which took place in the mid-1980s and perhaps 80% of these infections relate to IV drug abuse. There have been a total of 135 AIDS deaths in the State since these records commenced. To date 85 babies have tested positive for HIV of whom 9 developed AIDS and 6 died. Of the 9 who developed AIDS, 8 related to drug abusing parents. The true transmission rate of AIDS from mother to baby is reckoned at 14%.

Our Child Care Services have placed a total of 10 children in foster care arising out of AIDS/HIV situations. One family left 5 orphans, one of whom also died of AIDS while in foster care, the remaining 4 are still placed in care. Another fostered child, whose mother died of AIDS is HIV+ himself. In two other family situations, each involving 2 children, both sets of parents are alive: in one case both parents have AIDS, in the other both are HIV+. All four children are in foster care.

The boarding out rate paid by the Board in respect of each fostered child is £40.40 per week. Prospective foster parents are made fully aware of all medical circumstances concerning the child to be placed with them and are assured of whatever consultant or other medical access they require in the course of the placement. All fostered children are provided with medical card cover and any other home support necessary. The services of our AIDS counsellors are also available to affected families.

(c) Because of the history of the HIV epidemic in Dublin the Board has little direct contact with any haemophiliac children who are HIV positive. These are usually dealt with by the specialist haemophilia service.