CHILD CARE

AND

FAMILY SUPPORT SERVICES

IN 1995

REVIEW OF ADEQUACY

Eastern Health Board

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Thanks are expressed to all those whose work is incorporated in this review of service adequacy and who have assisted in the compilation of the report.

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INTRODUCTION

Under Section 8 of the Child Care Act 1991 Health Boards are required to prepare an annual report on the adequacy of the Child Care and Family Support Services in its area. We view this as an opportunity, rather than a legal requirement as it provides a framework for us to examine services in terms of their efficiency and their effectiveness.

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:

- Children whose parents are dead or missing
- Children whose parents have deserted abandoned them
- Children who are in the care of the Board
- Children who are out of home
- Children whose parents are unable to care for them due to ill health or for any other reason.

New Legislation

During 1996 significant new sections of the Child Care Act 1991 were introduced. Of key importance are the following sections : -

- Section 12 - deals with the powers of the Gardai to take children to safety.
- Section 13 - provides for Emergency Care Orders.
- Section 15 - requires health power to have emergency accommodation available to deal with the above mentioned situations.
- Section 17 - provides for Interim Care Orders.
- Section 18 - enables the Court to place a child in the care of a Health Board until the age of 18.
- Section 19 - provides for Supervision Orders whereby a Health Board can supervise a child in the home.

- Section 25 and 26 - empowers a Court to appoint a solicitor to represent a child or to appoint a Guardian Ad Litem to give independent representation or behalf of the child.

- Section 37 - requires Health Boards to provide reasonable access by children in care to their families.

In addition to these sections, regulations were also introduced concerning children who are in foster care, residential care or placed with relatives. The main effect of these regulations will be that Health Boards will be required to prepare an explicit care plan for a child before admission. In addition, minimum standards have been introduced for the frequency of visiting children in care and for reviewing these care plans.

Staffing

All of these legal responsibilities have placed a considerable burden of responsibility on staff. For this reason approval was obtained in 1995 for the appointment of two Directors of Child Care and Family Support Services. The two new Directors report directly to the Programme Manager Community Care and have responsibility for policy development; planning and evaluation; quality assurance; the development of protocols, procedures and practices; the co-ordination of services between Programmes with our Board and co-ordination of services provided by our Board and voluntary agencies. The Directors have been assigned responsibility for geographic areas and have been assigned responsibility for a number of specialist areas including child psychiatry; high support and secure units; training and research; services for homeless and out of home children; crisis intervention and for fostering and adoption. The appointment of the Directors does not alter the line management arrangements that obtained heretofore. Social Work Managers and Directors of Community Care continue to be accountable to the Programme Manager, Community Care for the management of services in their areas in accordance with overall policy.

During 1995 approval was also obtained for 10 additional Team Leaders, 19 additional Social Workers, 6 additional Child Care Workers and 11 additional Grade Two Posts.

Service Development

Some of the major development during 1995 included :

- Central Assessment Service - approval has been given to commence this service which will provide quick and comprehensive assessment of certain categories of children with special needs.

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- Family Support Services - additional Family Support Services were established in Wicklow and Area 2.

- Fostering - a total of 118 new foster carers were recruited and approved by the placement committee during 1995.

- Residential Care - three new units were established during the year catering for 15 children. A further three group homes were established by our Board to care for children who were previously placed in Madonna House. In addition, two other units with 6 places were opened on a temporary basis for a number of children in difficult circumstances who required urgent placement.

- High Support Units - in 1995 the High Court ruled that the Eastern Health Board did not have the authority to detain children or young people. However the High Court did make orders in respect of a small number of individual children whom the Court decided were out of control and who should be detained in their own interests under a regime established according to psychiatric or medical advice. Suitable arrangements for the education and therapeutic care of the children were to be provided. Pending the introduction of new legislation which is provided for in the new Juvenile Justice Bill to permit the provision of secure units by health boards, the children will be cared for in special high support units. Two units are being opened at present to care for these children. Their establishment represents a completely new service provision requiring great care and thought in its planning.

- The Social Work Manager assigned by our Board continued to review all residential services provided by or on behalf of, our Board.

Crisis Intervention Service - A Senior Social Worker was assigned to manage the various elements of this service. Approval was given to appoint three Social Work Team Leaders to the Out of Hours Service and these are currently being recruited. Because our new responsibilities under the Child Care Act 1991 it is necessary for the Board to provide a full social worker service to children of all ages during out of hours periods. This will require the appointment of the staff mentioned above and increased placement facilities for younger children. It is hoped to recruit additional foster homes to be accessible at night as well as having further residential placements available to the service.

The Board's allocation in 1995 from the Department of Health included a sum of £1.5m for the development of new services. This allowed for the establishment of new services costing £3.7m in a full year. Further allocations for the development of services will also be made in 1996. Additional funding is required to meet the ever increasing demands on child care and family support services in our region and our Board is in discussion with the Department of Health in this regard.

I would like to take this opportunity to thank all our staff involved in the provision of child care services for their dedication and efforts, often in very difficult circumstances. I would also like to thank all the staff who participated in this review. Special thanks to Ms. Mary O'Connell who had a leading role in researching and presenting the material in this review.

K.J. Hickey
Chief Executive Officer **March 1996**

Chapter 1

METHODOLOGY

The Child Care Act 1991 requires each health board to review the adequacy of its child care and family support services on an annual basis. Since no guidelines exist as to the methodology for undertaking the assessment, or of how "adequacy" should be defined, it is left to each health board to determine its own methods and to establish its own criteria for defining adequacy.

In the Eastern Health Board region, it has been decided to avoid the production of an "annual report" document. At the same time however, it is felt that service outcome measures would be an inappropriate mechanism for undertaking the Review for a number of reasons. The development of valid and reliable outcome measures is still in its infancy in the personal social services and can prove to be a crude instrument when applied to human lives where countless variables exist. Advanced management audit systems such as ISO 9000 call for the involvement of the managers of services in the determination of their own criteria of service quality and in their close involvement in the audit of their own service. For this reason, service managers of the Eastern Health Board were involved in assessing their services for this Review.

The comprehensive nature of the Review of the adequacy of the services in 1994 allowed that the key areas for research were more selective in this Review. The areas chosen were those which have been identified as having an impact upon the effectiveness and quality of the service which is provided. They include: training; access to books and journals; staff induction; recruitment and staffing levels; supervision and support; interdisciplinary liaison and co-operation; service initiatives; secretarial and administrative support. These topics were incorporated into questionnaires which were sent to all service managers in the following disciplines:

- Public Health Nursing
- Community Care Social Work and Child Care
- Child Psychiatry
- Family Refuges
- Fostering

The health strategy places an emphasis upon partnership between statutory and voluntary agencies and in keeping with this, certain voluntary organisations were invited to participate in the review. These include: Focuspoint, the Irish Foster Care Association, Hospitaller Order of St John of God, the Mater Child and Family Centre and Our Lady's Hospital for Sick Children in Crumlin.

Eastern Health Board staff in social work, speech therapy, public health nursing and the AIDS and drugs service also contributed analysis and description of their services. In anticipation of Section 61 of the Child Care Act 1991 which requires the registration and inspection of children's homes, the Eastern Health Board commissioned a review of children's homes in its region by a social work manager. Recommendations of this review are incorporated in this document. Statistics regarding service provision were assembled by administrative staff of the Board.

In recognition of the work of the Child Care Advisory Committee, their reports are incorporated in this Review.

Chapter 2

DEMOGRAPHIC AND SOCIO-ECONOMIC TRENDS

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

Population Trends

The population of the Eastern Health Board at the most recent census (1991) was 1,245,225. This represents 35% of the national figure. The population of every health board region in the country fell between 1986 and 1991 with the exception of the Eastern Health Board where it increased by 12,987 (1%). However this population increase was not evenly spread. Seven of the Community Care Areas had a net increase while three had a net reduction (Table 1).

Table 1: Total population in each Community Care Area of the E.H.B. 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	125,573	2,484	2.0
2	114,558	118,975	4,417	3.9
3	86,593	89,129	2,536	2.9
4	148,781	145,339	-3,442	-2.3
5	103,264	105,755	2,491	2.4
6	137,145	136,378	-767	-0.6
7	120,213	115,549	-4,664	-3.9
8	187,806	188,606	800	0.4
9	116,247	122,656	6,409	5.5
10	94,542	97,265	2,723	2.9
Total	**1,232,238**	**1,245,225**	**12,987**	**1.0**

Kildare had the largest increase in population (5.5%) while Community Care Area 7 had the greatest reduction (3.9%) between 1986 and 1991.

Community Care Area 8 remains the most populated area of the Eastern Health Board with a population of 188,606 while Area 3 has the smallest population of 89,129.

The proportion of the Eastern Health Board population in the 0-18 year age group has been dropping steadily in the past 20 years. In 1991 there were 385,493 children under the age of 18 years i.e. 31% of the total population. In 1986 the corresponding child population was 415,012 i.e. 33.7% of the total population. Nationally, children under 18 years represented 32.5% of the population in 1991.

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

Table 2: Age breakdown of children under 18 years of age in the E.H.B. region by Community Care Area (1991)

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

Table 3 indicates that Kildare has the highest proportion of its population represented by children under 18 years at 36.5%. Community Care Area 5 has the highest proportion of children under 5 years at 9.3%, compared with 7.7% for the Eastern Health Board as a whole. The corresponding national figure is 7.8%. In 1986 children under 5 years represented 9.2% of the national

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

Births

The number of births in Ireland has declined steadily since the early 1980s. The birth rate was stable at 20-22 per 1,000 population through the 1970s and early 1980s but had dropped to 13.4 per 1,000 in 1994 (Figure 1).

Figure 1: Annual birth rate per 1,000 population, Ireland 1970-1994.

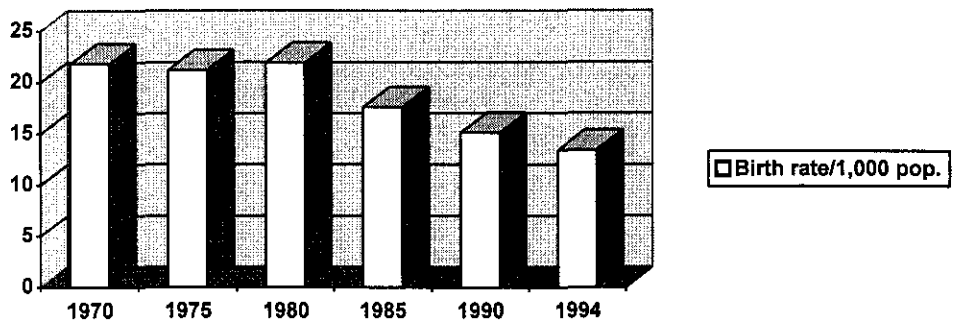


Table 4 demonstrates the number of births and birth rates in the Eastern Health Board region for 1990 to 1995. The birth rate in the region is falling at a slower rate than for the country as a whole. Total births have dropped by 6% for the Eastern Health Board between 1990 and 1995. However, this change has not been evenly spread throughout the region. Birth numbers decreased by 11% in Wicklow during this period, while showing a rise of 1% in Kildare.

Table 4: Number of births and birth rate (per 1,000) in the E.H.B. region, 1990-1995						
County	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**
Dublin	15,696	15,831	14,759	14,428	14,500	14,639
Kildare	2,217	2,188	2,353	2,141	2,130	2,251
Wicklow	1,742	1,653	1,712	1,600	1,551	1,542
Total EHB	**19,655**	**19,672**	**18,824**	**18,169**	**18,181**	**18,432**
Birth rate*	**16.0**	**15.8**	**15.1**	**14.6**	**14.6**	**14.8**

* calculation based on 1986 census for year 1990, and 1991 census for years 1991-1995.

Non-marital and teenage births

The number of non-marital births has increased in all areas between 1992 and 1995. The most rapid increase has been in Kildare where the rate has almost doubled in that period but still remains lower than in most other Community Care Areas. The highest proportion of non-marital births is in Area 7 at 41.8% (Table 5). In 1994, 19.7% of births in Ireland were non-marital. In 1993, 19.5% of births in Ireland were non-marital compared with 21.7% for the 15 European Union countries (1993 is the most recent year for which EU statistics are available).

Table 5: Non-marital births in the EHB region as a % of all births for 1992 and 1995 by Community Care Area				
Community Care Area	**Non-marital births 1992**		**Non-marital births 1995**	
	Number	**% all births***	**Number**	**% all births***
1	273	15.9	314	18.4
2	269	19.4	394	23.9
3	248	18.5	379	27.2
4	539	26.4	642	33.2
5	527	27.0	639	31.4
6	487	22.7	683	30.5
7	599	35.5	761	41.8
8	599	20.3	585	21.2
9	244	9.5	405	18.9
10	289	18.3	327	21.4
Total	**4074**	**21.4**	**5129**	**26.7**

Source: RICHS (EHB computerised child health records) *calculated on basis of births for which marital status recorded

There has been a steady downward trend since 1980 in the number of marriages registered in Ireland. The annual marriage rate per 1,000 of the population which fell from 7.4 in the early 1970s to 6.4 in 1980 has continued to decline to 4.6 in 1992 and 4.4 in 1993.

Non-marital births are a poor indicator of deprivation or social/health need. They are no longer considered to be a risk factor per se as many are in the context of stable two parent families. More emphasis is now being placed on births to teenage mothers, many of whom are not in stable relationship and whose parenting skills are often poor if they are alone and unsupported by their families.

Although teenage pregnancies are declining proportionately, the vulnerability of young mothers means they are cause for continuing concern. Teen mothers, by virtue of their age, have completed a lower level of education and correspondingly are more likely to achieve lower levels of income.

A study of unmarried women who gave birth in the National Maternity Hospital between 1986 and 1990 showed that 91.6% of women under 18 years who were keeping their child planned to live with their parents after delivery, while 59% of those over 18 planned to do so. (Flanagan N and Richardson V, 1992).

Table 6: Births to teenage mothers (<20 years) in the EHB region as a % of all births by Community Care Area for 1995

Community Care Area	Births to teenage mothers (<20 years) 1995	
	Number	% all births*
1	41	2.4
2	42	2.6
3	42	3.0
4	121	6.3
5	123	6.1
6	103	4.6
7	97	5.3
8	96	3.5
9	75	3.6
10	61	4.0
Total	**801**	**4.2**

Source: RICHS (EHB computerised child health records) *calculated on basis of births for which maternal age recorded

Table 6 shows that 4.2% of all births in the Eastern Health Board region in 1995 were to teenagers. There was considerable variation in this rate between Community Care Areas. Area 4 had the highest rate at 6.3% compared with a rate of 2.4% in Area 1.

The number of teenage births in Ireland must be considered alongside the numbers of women travelling outside the country for termination of pregnancy. In 1993, the number of terminations performed in England and Wales on women usually resident in the Irish Republic was 4,402. Of these, 659 (15.0%) were under the age of 20 years (O.P.C.S., 1995). Therefore, the number of teenage births is not necessarily an indicator of the number of women in this age group who become pregnant. This must be borne in mind when using the teenage birth rate as an indicator of success of intervention programmes aimed at reducing the teenage pregnancy rate.

Prematurity and Low Birth Weight

Prematurity and low birth weight constitute risk factors for babies in terms of morbidity and mortality. Birth weight is generally acknowledged as one of the most important indicators of the risk of both mortality and handicap in the neonate, and is a broad indicator of health and socio-economic development in a population. Many studies have shown a linear relationship between birth weight and social class.

An Eastern Health Board study examined the relationship between low birth weight and socio-economic factors (Johnson , Dack and Fogarty, 1994). There was significant positive correlation between the incidence of low birth weight and male unemployment, percentage of population in social classes 5 and 6, and proportion of population covered by medical cards, and a significant negative correlation with percentage of population in social classes 1 and 2 and number of cars per house. The proportion of population covered by medical cards was the best predictor of low birth weight.

Table 7: Premature births (<37 weeks) and low birth weight babies (<2,500 gms) in the EHB region in 1995 by Community Care Area				
Community Care Area	<37 weeks gestation		<2,500 gms birth weight	
	Number	% all births*	Number	% all births*
1	86	5.1	86	5.1
2	128	7.8	110	6.8
3	90	6.5	79	5.7
4	135	7.0	103	5.3
5	158	7.8	137	6.8
6	142	6.3	117	5.2
7	159	8.7	140	7.7
8	173	6.3	144	5.2
9	111	5.3	115	5.3
10	83	5.5	67	4.4
Total	**1265**	**6.6**	**1098**	**5.7**

Source: RICHS (EHB computerised child health records) *calculated on basis of births for which gestation/birth weight recorded

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

In 1991 (the most recent year for which national perinatal statistics have been published) low birth weight babies (<2,500 gms) represented 4.21% of total births. The corresponding Eastern Health Board figure is considerably higher at 5.7%.

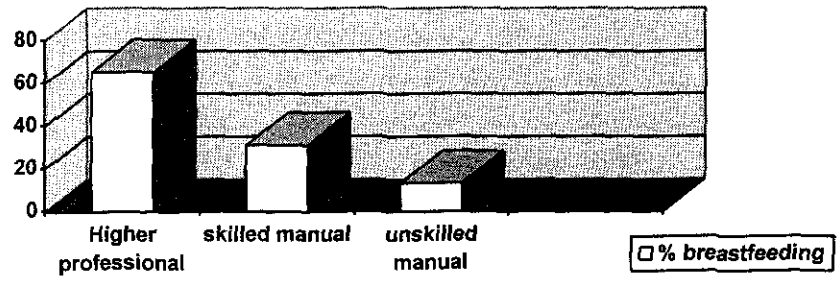
Breastfeeding

The National Health Strategy set targets for increasing the rate of breastfeeding: an initiation rate of 35% by 1996 and 50% by the year 2000, and a rate of 30% at four months of age by the year 2000. These targets were repeated in the document "A National Breastfeeding Policy for Ireland" in which detailed recommendations were made regarding the promotion of breastfeeding in maternity hospitals, at the Community Care level and in the wider community. The prevalence of breastfeeding in Ireland is unsatisfactory (Table 8). There is a big variation with social class, as demonstrated by father's occupation (Figure 2). The age of the mother is also associated with the rate of breastfeeding i.e. mothers at both ends of the age spectrum being less likely to breastfeed.

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

Source: Perinatal Statistics 1991, Department of Health.

Figure 2: Percentage of mothers breastfeeding by selected father's occupation in Ireland 1991 (singleton births).



The prevalence and epidemiology of breastfeeding in the Eastern Health Board is largely unknown. A study carried out in Community Care Area 9 (Kildare) in 1993 revealed a breastfeeding prevalence rate of 38% at birth and 13% at 3 months (Table 9). This Review recommends that a baseline study to establish the epidemiology of breastfeeding in all areas of the Eastern Health Board should now be conducted by the newly established Department of Public Health Medicine.

Table 9: Method of infant feeding in Co. Kildare, May 1993 (n=145).				
Age of baby	Breastfeeding		Bottle-feeding	
	Number	% total	Number	% total
Birth	55	38%	90	62%
Discharge home	47	32%	98	68%
Up to 14 days of age	43	30%	102	70%
4-6 weeks	33	23%	112	77%
12-14 weeks	19	13%	126	87%

Mortality and Morbidity

The last 25 years has seen dramatic changes in child health. The emphasis has moved from the major killing diseases to aspects of ill-health which are influenced by social, educational, economic, environmental and behavioural issues.

Infant mortality

The infant mortality rate (deaths of children under 1 year of age per 1,000 live births) has declined steadily in Ireland since the 1970s (Figure 3).

Figure 3: Infant mortality rate, Ireland 1970-1994.

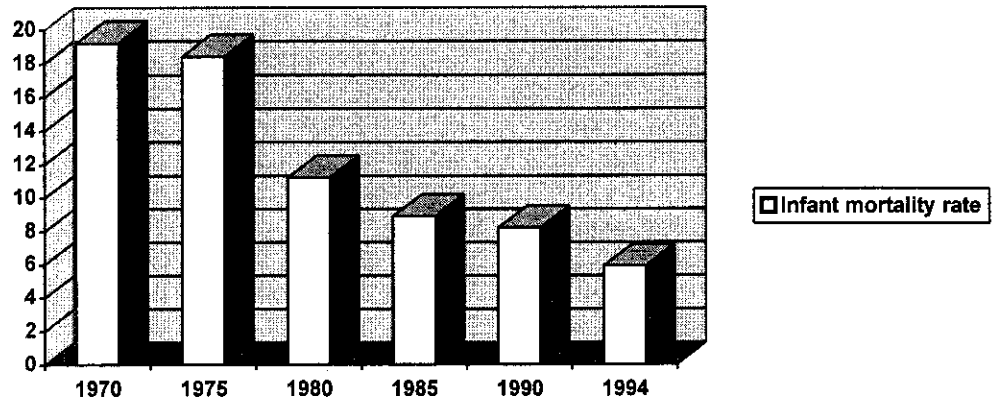


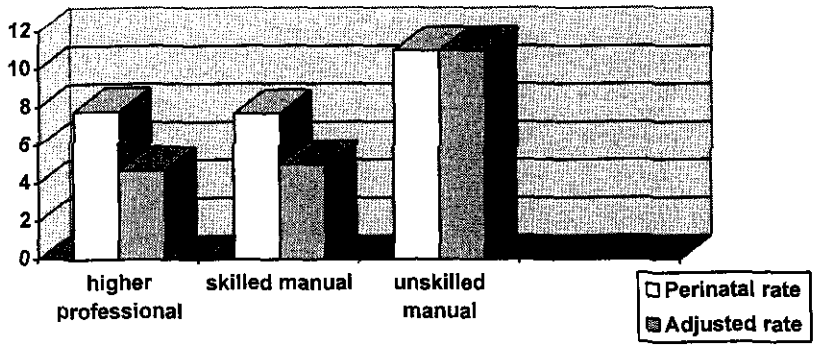
Table 10: Infant mortality rates for EHB region and Ireland 1985-1993									
	1985	1986	1987	1988	1989	1990	1991	1992	1993
EHB region	8.9	7.7	7.3	9.6	7.5	7.2	8.9	7.5	5.9
Ireland	8.9	8.7	7.4	9.2	7.5	8.2	8.2	6.6	5.9

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

The infant mortality rate of 5.9 for Ireland in 1993 compares favourably with that for the European Union as a whole where it was 6.6 in 1993.

Table 11: Principal causes of death of infants (<1 year) for EHB and Ireland 1994				
Cause of death	EHB region		Ireland	
	Number	% all infant deaths	Number	% all infant deaths
Congenital anomalies	54	45.8	117	41.2
Short gestation/low birth weight	18	15.3	54	19.0
Sudden death, cause unknown	13	11.0	37	13.0
Other causes	33	27.9	76	26.8
Total	**118**	**100.0**	**284**	**100.0**

Figure 4: Perinatal mortality rates by selected father's occupation in Eastern Health Board region 1991 (singleton births).



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

Table 12: Perinatal mortality rates and stillbirth rates for EHB region 1988-1991				
	1988	1989	1990	1991
PNMR	11.3	10.2	10.7	9.1
Adjusted PNMR	8.4	7.6	8.2	6.5
Stillbirth rate	7.3	6.1	6.7	5.4

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

The perinatal mortality rate for Ireland in 1991 was similar, at 9.5, to the Eastern Health Board rate of 9.1. The corresponding figure for the European Union was 8.1. Studies from many countries have found perinatal and infant mortality to be closely linked with socio-economic background.

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

Sudden Infant Death Syndrome (SIDS)

SIDS is the leading cause of death in infants aged one month to one year in Ireland, accounting for 4 in every 10 deaths in this age group. The SIDS rate per 1,000 live births in 1980 through to 1990 averaged 2.0. (Table 13) The rate

has fallen considerably since 1990. However, Ireland's current SIDS rate, at the upper end of the European and international scale, has considerable room for improvement.

In the late 1980's, international epidemiological research identified a number of risk factors for SIDS. In March 1992, the Department of Health launched a health education campaign entitled "Reduce the risk of cot death". The recommendations of this campaign were based on study findings which indicated an increased risk of SIDS in infants placed prone to sleep, infants of mothers who smoked and infants who are heavily wrapped. The guidelines also encouraged breastfeeding.

Table 13: SIDS number and rate per 1,000 live births for Ireland 1980-1995 and for EHB 1992-1995

Year	Ireland		EHB region	
	Number of SIDS	Rate per 1,000 live births	Number of SIDS	Rate per 1,000 live births
1980	144	1.9		
1985	139	2.2		
1990	98	1.8		
1991	84	1.6		
1992	59	1.1	27	1.4
1993	37	0.7	15	0.8
1994	40	0.8	15	0.8
1995*	31	0.6	14	0.8

* Provisional figures based on 1993 birth figures and suspected SIDS cases.
Source: CSO, Report on Vital Statistics 1980-1988: CSO, Yearly Summary, 1992 and 1995; National Sudden Infant Register 1992-1995

Suicide

An issue of growing concern in Ireland, as in the rest of Europe, is the increase in the rate of suicides, especially among young men. Table 14 shows the number of deaths in children attributed to suicide in 1991-1994 for the Eastern Health Board and for Ireland. Table 15 details a breakdown by age and sex for 1994.

Table 14: Suicide deaths in children aged 10-19 years in EHB by county and in Ireland, 1991-1994

County	1991	1992	1993	1994
Dublin	5	4	9	6
Kildare	2	0	1	1
Wicklow	0	0	1	0
Total EHB	**7**	**4**	**11**	**7**
Total Ireland	**26**	**26**	**26**	**31**

Source: CSO Vital Statistics

Suicide is a rare event, but because it occurs among young people it is the third most important contributor to life years lost, after coronary heart disease and cancer. Groups recognised to be at increased risk of suicide include current or former psychiatric patients, persons suffering from alcoholism, drug misusers, those with a history of para-suicide, prisoners, those who have HIV or AIDS, Samaritan clients (Gunnell and Frankel, 1994). The Samaritans, Dublin, reported that about a thousand calls received in 1992 were from children of 15 years or younger, and in 1993 the number of calls from those up to 19 years had increased by 50% on the previous year.

Table 15: Suicide deaths by age (10-14 and 15-19 years), sex and county in EHB region, 1994

	Male		Female		
County	**10-14 years**	**15-19 years**	**10-14 years**	**15-19 years**	**Total**
Dublin	1	2	0	3	6
Kildare	0	1	0	0	1
Wicklow	0	0	0	0	0
Total EHB	**1**	**3**	**0**	**3**	**7**
Total Ireland	**6**	**21**	**0**	**4**	**31**

Source: CSO Vital Statistics

In November 1995 the Minister for Health set up a National Task Force on Suicide which has the following terms of reference:

(i) To define numerically and qualitatively the nature of the suicide problem in Ireland.

(ii) To define and to quantify the problems of attempted suicide and para-suicide in Ireland, including the associated costs involved.

(iii) To make recommendations on how service providers can most cost-effectively address the problems of attempted suicide and para-suicide.

(iv) To identify the various authorities with jurisdiction in suicide prevention strategies and their respective responsibilities.

(v) To formulate, following consultation with all interested parties, a national suicide prevention strategy.

Unintentional injury in children (accidents)

In recent years unintentional injury has become the greatest childhood epidemic in all western countries. In Ireland today over 40% of childhood deaths are due to unintentional injury. Furthermore it is estimated that one in six children attends an Accident & Emergency Department for treatment of injuries.

The widely held belief that unintentional injuries are inevitable and "part of growing up" is gradually diminishing as there is substantial evidence to show that injuries have well recognised risk factors and are, therefore, predictable.

The factors associated with unintentional injuries are varied and their control falls within the ambit of many differing authorities, for example, health, local authorities and Garda Siochana, together with many other statutory and voluntary bodies. Effective preventive strategies requires that these authorities adopt a multi-sectoral approach and co-ordinate preventive strategies.

In 1995 the Office For Health Gain took an important step in facilitating the development of a unified approach to injury prevention by establishing a representative, multi-sectoral Forum at national level. The aims of the Forum are to:

- obtain and publish on a regular basis information on injuries including details relevant to prevention
- co-ordinate preventive strategies
- advise on national and regional targets and monitor progress towards achieving these targets
- liaise with multi-sectoral fora at regional level
- keep abreast of advances in injury prevention and make this information available.

It is essential that prevention strategies are targeted to specific risk groups. Specific measures to reduce the toll of injuries among children in the Eastern Health Board Region are:

Pre-school Children

- Education programmes highlighting dangers in the home, specifically targeting first time mothers and low social class groups
- Reduction of accidental poisoning by recommending the mandatory use of child resistant containers on medicines and by providing advice on safe storage of medicines/agents associated with poisoning
- Development and monitoring of safety standards for crèches and pre-schools
- In association with the Garda Siochana to encourage the greater use of child restraints in cars for young children and to encourage greater seat-belt use for all age groups
- Greater availability of competitively priced child safety devices in the home

- Consideration of the provision of safety devices on a loan/rental basis for certain risk groups
- Consideration of the development of Accident Prevention Centres to provide advice on home safety, to demonstrate measures known to prevent injury and to make these devices available.

School Children

- Education on safety on the road particularly regarding young pedestrians and regarding the use of bicycles
- Greater availability of cycle lanes
- Promote the need for legislation on compulsory use of bicycle helmets
- Promote the need for legislation on compulsory training prior to motorcycle use.

General

The success of accident prevention strategies is measured by comparing the rates of injury from one year to the next. Comprehensive information systems are available for injury deaths and hospital admission rates for injuries. However, less than one in ten people who sustain injuries are admitted to hospital and a very small proportion die. Measurement of success against death rates or hospitalisation rates is, therefore, not ideal. It is recommended that a comprehensive information system capable of capturing most injuries which require treatment be developed. Such an information system should be available in our Accident and Emergency departments.

Table 16 Number of Casualties in Ireland (1994)

Category	0 - 17	All Ages	% Children	% change in casualties in Ireland 1992
Pedestrians	470	1491	31.5	- 19.8%
Pedal Cycle	223	695	32.1	- 31.4%
Motor Cycle	46	1004	4.6	- 2.1%
Car User	737	6443	11.4	+ 9%
Other	84	1002	8.4	- 17.6%
Total	**1561**	**10633**	**14.7%**	**- 10.1%**

Table 16 shows national trends in road traffic accident casualties by type of road use. At a national level greatest change in casualties between 1992 and 1994 relates to pedal cycle injuries, a drop of 31%. Whether this drop in cycling injuries represents the start of a downward trend will be determined

over the coming years as will the possible effect of bicycle helmet use on such injuries.

Congenital abnormalities

Table 17: Commonly occurring congenital abnormalities: comparison between 1980 and 1994, EHB region				
	1980		1994	
	Number	Rate per 10,000	Number	Rate per 10,000
Neural tube defects	124	46.9	21	11.6
Congenital heart disease	113	42.7	106	58.4
Cleft lip/palate	45	17.0	33	18.2
Chromosomal disorders	68	25.7	50	27.5
Down Syndrome	57	21.5	40	22.0
Limb defects	165	62.4	98	53.9
Congenital dislocation of hip	49	18.5	41	22.6

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

Neural Tube Defects

Since 1980 there has been a considerable reduction in the rate of occurrence of neural tube defects (spina bifida, anencephaly and encephalocoele) from 46.9 per 10,000 births to a rate of 11.6 in 1994. Extensive research has highlighted the importance of **folic acid** in the prevention of neural tube defects. Since 1993, the Department of Health has recommended peri-conceptional folic acid supplements.

A cross-sectional community survey was carried out by the Eastern Health Board in Dublin in 1995 to document the knowledge and behaviour of women in child-bearing years to peri-conceptional folic acid (Sayers et al). Of 335 women who took part in the study, 63.6% had heard of folic acid, knowledge being significantly associated with higher social class and higher education. Few (5.4%) had been advised to take folic acid before pregnancy and only 2.7% were currently taking folic acid supplements. Three quarters of the group said they would be willing to take peri-conceptional folic acid supplements if they knew it would reduce the risk of malformations. This study clearly showed that few women in childbearing years have been advised on folic acid. However, if advised appropriately the majority would be willing to take peri-conceptional folic acid in tablet form.

Eurocat

Eurocat is a programme supported by the E.C. for the epidemiological surveillance of congenital anomalies. In 1992 (the most recent Eurocat report) the prevalence rate (per 10,000 births) of all congenital anomalies recorded by the Eurocat Registry in the Eastern Health Board region was 226.3 compared with a rate of 212.1 for the 28 Eurocat Registries. In 1992 the prevalence rate for neural tube defects was 17.8 per 10,000 births in the Eastern Health Board compared with 9.9 for the 28 Eurocat Registries.

Down Syndrome

The prevalence rate (per 10,000 live births and fetal deaths from 20 weeks gestation) of Down Syndrome, 1980-1992, was 18.3 for the Eastern Health Board compared with 11.9 for the total 28 Eurocat registries. This figure of 11.9 rises to 15.1 when the figure for induced abortions following prenatal diagnosis is added. 53% of cases of Down Syndrome are to mothers aged 35 years or more. A study of the epidemiology of Down Syndrome in Dublin, Kildare, Wicklow and Galway 1981-1990 showed that the risk of having a Down Syndrome child increased seventy fold from 1 in 1,841 at age 15-19 years to 1 in 26 at age 45 years or older (Johnson et al, 1995).

The percentage of births to mothers 35 years of age or more in the Eastern Health Board has increased from 14.0 in 1980 to 15.8 in 1992. The mean age of women at childbearing in 1993 was 30.3 years for Ireland compared with 28.6 years for the European Union. The Irish figure has changed little in the past 2 decades - it was 29.6 years in 1975.

Communicable diseases notifications

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

Table 18: Notifications of communicable diseases received by EHB in 1994 and 1995 - listing of most frequently notified diseases.		
Disease notified	Number of notifications	
	1994	1995
Gastroenteritis <2 years	1470	1621
Salmonellosis	82	148
Measles	244	134
Meningococcal infection/meningitis	75	153
Pertussis	104	86
Infectious mononucleosis	67	71
Hepatitis A/viral hepatitis unspecified	35	61
Meningitis - pneumococcal, Hib, and bacterial unspecified	17	54
Rubella	42	50
Mumps	16	18

Source: EHB Communicable Diseases Surveillance System

Under the Infectious Disease Regulations 1981 there is an obligation on the attending physician to notify to the health board cases of specified communicable diseases. It is well recognised in Ireland and in many other countries that there is considerable under-notification of these diseases. However the figures compiled are still important in indicating trends from year to year and in detecting excess cases and outbreaks.

Table 18 lists the most frequently notified diseases for 1994 and 1995. It is important to note that measles, pertussis, rubella and mumps are all diseases which are preventable by vaccines which are delivered as part of the childhood immunisation programme in Ireland.

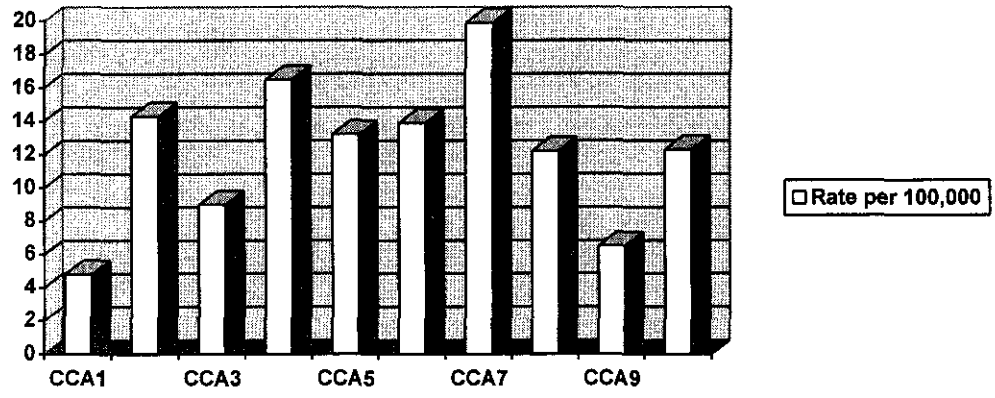
Meningococcal infection

There were 153 cases of suspected systemic meningococcal disease notified to the Eastern Health Board in 1995, with 11 deaths attributed to the disease in this period. This gives a notification rate of 12.3/100,000. The majority of cases occurred in children, 72% occurring in children under 10 years of age.

The number of notifications has doubled in 1995 from those reported in 1994 (75 cases). However, 72 of these in 1994 were laboratory confirmed cases which would suggest that not all cases were notified in that year. While some of the increase in 1995 is undoubtedly due to better notification it is likely that there was a true increase in the level of cases in 1995. This would be in keeping

with trends seen in 1995 in some other developed countries e.g. the United Kingdom.

Figure 5: Meningococcal infections in EHB - notification rate per 100,000 total population by Community Care Area 1995.



Gastroenteritis in travellers

Gastroenteritis is notifiable when it occurs in those under 2 years of age. It is by far the most frequently notified infectious disease (Table 18). Traveller children appear to be at increased risk for gastroenteritis and other enteric infections. It is difficult to verify this as records e.g. notifications of infectious disease, are not flagged for traveller status. In an attempt to clarify this issue, a search was made on the EHB Communicable Diseases Surveillance System (the computerised system recording all cases notified under the Infectious Disease Regulations) for all records having the following in the address: "campsite", "caravan", "halting", "c/s" (indicating campsite), "nfa" (no fixed abode). Such cases were then defined as travellers. Table 19 compares the notifications of cases of enteric infections in travellers with the total number of such cases notified in the Eastern Health Board. It is clear from this table that travellers represent a much higher proportion of these notifications than would be expected on the basis of their numbers in the population. Unsatisfactory living conditions such as overcrowding, lack of clean drinking water, and poor sanitary conditions predispose to enteric infections.

Table 19: Notifications of enteric infections Dublin City and County 1995 - comparison between total notifications and those in travellers.

Disease notified	Total notifications	Notifications in travellers*
Gastroenteritis <2 years	1481	115
Shigella	21	11
Salmonellosis	124	6

Source: EHB Communicable Diseases Surveillance System * traveller defined by having the following in the address: "campsite", "caravan", "halting", "c/s", "nfa".

Traveller children's health in Community Care Area 5

A study was carried out on the travelling community within Community Care Area 5 during the summer of 1995. Part of the study was concerned with a review of traveller children's health. It was undertaken to provide a baseline of information about aspects of traveller's health and their uptake of the health services offered by the Eastern Health Board. The results showed that:

- uptake of services deteriorated as the child got older
- immunisation rates were low at 57% and the majority were given in the Mobile Clinic
- there was a very high prevalence of hearing problems found in the pre-school children, comprising 70% of all medical problems found
- incidence of infectious diseases and the number of hospital admissions were high and those travellers who were more mobile utilised the hospital services to a greater extent
- there is a need for a culturally appropriate health education programme for travellers

Smoking in pregnancy

The harmful effects of smoking in pregnancy have been well documented. These include: an increased risk of low birth weight, perinatal mortality, spontaneous abortion, placenta praevia, abruptio placentae, bleeding during pregnancy, premature rupture of membranes and premature delivery. Maternal smoking has been shown to have long term consequences for children in terms of physical growth, intellectual ability, emotional development and behaviour. Recent studies have also shown an increased risk of SIDS for the babies of smoking mothers.

In the past 2 decades there has been increasing concern about the effects on children of exposure to cigarette smoke in the home. Cough, phlegm and wheezing, chronic infections of the lower respiratory tract (pneumonia, bronchitis and bronchiolitis), middle ear effusion (glue ear), and childhood asthma occur more frequently in children exposed to passive smoking.

In Ireland 28% of women smoke (Joint National Media Research Survey, 1993/4). Many studies in Ireland and internationally have shown that smoking is more common among the younger age groups, those in manual jobs, having a lower level of education, and living in urban rather than rural areas. Preliminary analysis of smoking rates among women attending the public antenatal clinic at

the Rotunda Hospital in Dublin in 1995 has shown a smoking rate in these pregnant women in excess of 50%. The Eastern Health Board, in conjunction with the hospital, and with the support of Europe Against Cancer and the Health Promotion Unit of the Department of Health, is now piloting a smoking cessation programme for pregnant women in the Rotunda Hospital.

Disability

Mental Handicap

A national database has been set up for planning services for people with intellectual disabilities or mental handicap. This system has been in use in the Eastern Health Board since August 1994. The table below gives a breakdown of cases entered on this database by age and degree of handicap.

Table 20: Degree of mental handicap by age group in EHB (February 1996)

Degree of handicap	0-4 years	5-14 years	15-18 years
Unknown	243	137	33
Borderline	2	81	59
Mild	36	801	453
Moderate	68	575	311
Severe	28	201	102
Profound	4	52	17
Total	**381**	**1847**	**975**

Source: Department of Health Intellectual Disability System, EHB.

There is no formal register for physical and sensory disability at present but one is being proposed at national level. Consequently, comprehensive figures for physical and sensory disability are not available.

Domiciliary Care Allowance

Domiciliary Care Allowance is paid in respect of a severely physically or mentally handicapped child between the ages of 2 and 16 years. It applies to children normally resident at home. It is not means tested.

Table 21: Number of Domiciliary Care Allowance recipients in each Community Care Area (March 1996)		
Community Care Area	Number of recipients	Total number children <18 years in the Area
1	219	34,415
2	181	24,699
3	156	23,373
4	345	50,760
5	311	38,266
6	349	43,055
7	235	29,375
8	459	63,673
9	320	44,734
10	269	33,143
Total	**2844**	**385,493**

Table 22: Selected conditions in respect of which Domiciliary Care Allowance paid. EHB March 1996	
s	Number of recipients
Malignancy	100
Endocrine and metabolic	197
Psychiatric	93
Epilepsy	63
Blindness and low vision	50
Deafness	135
Congenital anomalies	146
Cerebral palsy, with or without mental handicap	328
Down Syndrome	340
Spina Bifida, with or without mental handicap	101
Other mental handicap	595

Asthma and Wheeze in Schoolchildren

Asthma is a common condition in children and it is generally accepted that the prevalence of asthma is increasing. A questionnaire survey of schoolchildren aged 4-19 years in counties Dublin, Kildare and Wicklow was carried out in 1992-93 (Taylor MRH, Holland CV and O'Lorcain P). The reported prevalence of asthma was 11.9%, compared to 4.4% in 1983-4 - a rise of 170% over 9 years. The asthma prevalence was 8.35% in girls and 14.8% in boys. The prevalence of asthma and wheeze were slightly higher in urban than in rural children but this difference was not statistically significant.

The apparent rise in the prevalence of asthma is likely a combination of a true increase in the number of cases and also an under-reporting of cases in the past. The increased prevalence of asthma in children is probably multi-factorial in origin e.g. increased exposure to allergens in the environment, urban pollution and others. The implications of this frequent illness are considerable in terms of costs of treatment and in morbidity and mortality for children.

Socio-economic status of children

Social deprivation and poverty and their impact on the health of children have been well documented. In areas of social disadvantage and high unemployment there is a very poor uptake of breastfeeding, a higher rate of gastroenteritis, a higher rate of childhood accidents, both in the home and as a result of road traffic accidents, a lower uptake of childhood immunisation programmes, a higher incidence of smoking, serious substance/drug use, and related HIV problems, and suicide. In these areas the higher incidence of teenage pregnancies may perpetuate the poverty trap.

The Black Report "Inequalities in Health" in 1980 stated that "class differences in mortality are a constant feature of the entire human life time. They are found at birth, during the first year of life, in childhood, adolescence, and in adult life. In general they are more marked at the start of life." The report stressed the social vulnerability of children. There are class differences in the incidence of low birth weight, mortality in infancy, physical growth, educational performance, accidents, illness (especially respiratory) and the provision and use of services. The report stated that early childhood is the period of life at which intervention could most hopefully break the continued association between health and social class.

The proportion of the population in each D.E.D. of the Eastern Health Board having a medical card is a good indicator of material deprivation. It can be used as a health need indicator as it is means tested and takes account of the elderly and children in the population. 28.8% of the Eastern Health Board population have a medical card (June 1995). The D.E.D.s where over 50% of the population had a medical card at the end of 1995 were calculated. This highlights the areas of greatest material deprivation. They are:

	D.E.D.	%with GMS card
Community Care Area 2	Royal Exchange A	69.6
	Royal Exchange B	58.2
	Wood Quay A	56.6
	Mansion House A	51.6

	D.E.D.	%with GMS card
Community Care Area 3	Merchant's Quay A	72.5
	Ushers E	54.8
	Ushers C	54.5
	Ushers B	52.7
Community Care Area 4	Tallaght Jobstown	73.8
	Tallaght Killinardan	60.0
Community Care Area 5	Cherry Orchard C	60.6
	Kylemore	55.6
	Clondalkin Rowlagh	52.7
Community Care Area 6	Blanch.-Tyrrelstown	69.7
	Arran Quay C	62.0
	Blanch.-Mulhuddart	55.3
	Rotunda B	53.1
	Inns Quay C	51.6
Community Care Area 7	Ballymun D	69.1
	Mountjoy A	65.6
	Ballybough A	60.8
	Rotunda A	59.8
	Mountjoy B	59.5
	Ballymun B	55.6
	Ballymun C	53.8
Community Care Area 8	Priorswood C	76.2
	Priorswood B	62.1
Community Care Area 9	Rathangan	61.1
	Nurney	50.6
Community Care Area 10	Rathmichael (Bray)	60.9
	Bray No. 1	59.0
	Ballyarthur	56.3

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

Table 23: Children (0-15 years) covered by medical cards (GMS) by Community Care Area as a proportion of total child population in each age group (May, 1995)		
Community Care Area	Age Group (%)	
	Under 5	5-14 years
1	17.6	17.0
2	23.3	22.7
3	29.7	26.5
4	33.7	33.4
5	40.3	43.7
6	32.4	34.9
7	45.8	41.4
8	27.4	26.1
9	25.0	25.1
10	34.5	33.3

Table 23 shows that over 40% of children living in Community Care Area 5 and 7 are covered by a medical card, more than double the rate in Area 1.

Unemployment

Research by the Economic and Social Research Institute (ESRI 1991) 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 (Nolan, Farrell, 1990). 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.

Measures of unemployment

The Live Register is a register of those claiming a social welfare payment. An individual may not be put on the Live Register unless he/she is entitled to such a payment. It is possible to be on the Live Register and still be working up to 3 days a week. The Live Register figures tend to underestimate rates of unemployment among women. The explanation for this is as follows: The means test for social welfare payments covers the whole household. Thus, if a woman is married or cohabiting and her husband or partner is earning, in most cases she would not be entitled to a social welfare payment and so would not be entered on the Live Register. Similarly, if her husband or partner is unemployed

and is claiming Assistance, including an allowance for an adult dependant, the woman would not be entitled to go on the Live Register. There is no financial incentive for the woman to demand a split payment thereby gaining access to the Live Register.

Labour Force survey figures for unemployment may be more reliable than the Live Register. Labour Force Survey figures show a much lower rate of unemployment than the Live Register. The Labour Force Survey uses two different measures of unemployment: (1) Principal economic status, which is based on the individual respondent's own assessment of his/her usual situation with regard to employment, and (2) ILO measurement, based on the individual's employment in the week before the survey.

In summary, there is no one measure of unemployment. Each measure has its own problems and shortcomings. All measures are likely to underestimate the rates of unemployment among women to some extent. The table below details figures for unemployment based on the Live Register.

Table 24: Number of persons on the live register in EHB region by county, October 1994

	Male			Female			Total
	<25 years	>25 years	Total male	<25 years	>25 years	Total female	
Dublin	16,143	43,383	59,526	11,041	20,203	31,254	90,780
Kildare	1,273	3,718	4,991	1,042	2,099	3,141	8,132
Wicklow	1,159	3,761	4,920	921	1,708	2,629	7,549
Total EHB	**18,575**	**50,862**	**69,437**	**13,004**	**24,010**	**37,024**	**106,461**

Table 25: Number of people in EHB region in receipt of selected social welfare payments by county, December 1994 and December 1995

County	Family income supplement		Illness benefit*		Live register	
	1994	1995	1994	1995	1994	1995
Dublin	1,936	2,041	28,358	28,999	91,473	91,569
Kildare	401	418	2,528	2,690	8,562	8,387
Wicklow	371	379	2,145	2,161	7,613	7,729

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

Child Support Entitlements

The most widespread form of child income support in Ireland is Child Benefit which is paid by the state for all children. It is directed at all families whether the parents are in paid employment or not.

In addition to this, parents on social welfare payments are eligible for additional child dependant allowances. Since child dependant allowances form the mainstay of child support payments provided by the state and are available only to parents out of work, families where the parents are in paid employment receive only a fraction of the cost of child-rearing. This system of child support can create disincentives for parents to take up employment, particularly amongst larger families (Carney, Fitzgerald et al, 1994). Increasing child dependant allowances further exacerbates existing unemployment and poverty traps.

The Budget of January 1995 brought about a major rise of 35% in Child Benefit - this increase came into effect in September 1995. The objective of substantially increasing Child Benefit was to reduce deprivation and poverty in families with children without having a knock-on effect of creating or exacerbating disincentives to work.

Table 26: Children assisted in each Community Care Area in 1995 by the Back to School Clothing and Footwear Scheme

Community Care Area	Number of children assisted*	% children <18 years
1	4,778	13.9
2	4,081	16.5
3	4,705	20.1
4	14,844	29.2
5	13,388	35.0
6	12,753	29.6
7	11,343	38.6
8	12,349	19.4
9	8,629	19.3
10	8,470	25.6
Total	**95,340**	**24.7**

*The figures for "children" include some individuals up to 22 years of age. However, approximately 98% are under 18 years of age.

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Chapter 3

CHILD HEALTH SERVICES

During 1995, the Eastern Health Board established a group to review the child health services within the region. The group has concluded its work and their recommendations have been incorporated into this chapter. The Department of Health is conducting a national review of these services and these recommendations are made as a contribution to that work.

Birth Notifications

Last year, this Review highlighted the difficulties which are being experienced in attempting to reach the target in relation to home visiting which was established by the Health Strategy. According to the Strategy, each baby should receive a visit from a Public Health Nurse within 48 hours of discharge from maternity hospital. The review group undertook a two day pilot study to determine the length of time between births in maternity hospitals and the receipt of the birth notifications by Public Health Nurses. As a result, the group made the following recommendations:

All mothers attending maternity hospitals, general practitioners or private midwives antenatally should be advised to contact their public health nurse. A process should be put in place to enable the referring agency, with consent, to forward a mother's name, address and telephone number to Community Care headquarters for onward transmission to the nurse.

Public health nurses should have an input at antenatal classes. Information on their service should be displayed on notice boards at antenatal clinics and classes, and information packs detailing contact telephone numbers should be given to mothers at the first antenatal visit and on discharge from hospital.

Since computers are the most efficient means of transfer of information, the computer systems of the Board and of maternity hospitals should be made compatible.

Births should be notified daily via computer link between all three maternity hospitals and the baby's home Community Care Area.

Modern technology, such as computer terminals and fax machines, should be installed in health centres to facilitate the efficient transmission of information to public health nurses.

Information transmission procedures within all Community Care Areas of the Eastern Health Board should be streamlined.

A more detailed one-month study to determine the lengths of time between births in maternity hospitals and receipt of birth notifications by Public Health Nurses, scheduled for May 1996, should proceed.

Immunisations

Immunisations are considered a key tool in the prevention of childhood morbidity and mortality. During 1995, the Department of Health agreed a new strategy for the delivery of childhood immunisations from general practice. The strategy includes incentives for reaching desired uptake rates and it is hoped that this new approach will increase the uptake rates for the primary childhood immunisations. The percentage uptake rate for the Measles, Mumps, Rubella immunisation is shown in the Table below. There was some slippage in MMR uptake rates in 1995 when compared to those in the previous year. It is hoped that the factors which contributed to this will be addressed by the new system of delivery.

Table 27: Percentage MMR uptake at 3 years in Community Care Areas 1994-1995

Community Care Area	1994	1995
1	85	76
2	88	79
3	75	72
4	67	70
5	69	70
6	64	67
7	66	67
8	85	81
9	80	79
10	82	79

During 1995, a catch-up campaign was conducted in the schools which was aimed at children aged five to nine years old who had not previously been immunised against measles and rubella. In total, 23,713 children were immunised with MR vaccine which provided an uptake rate of 90% of those identified as not having previously received the MMR vaccine.

The BCG vaccine against tuberculosis was delivered to 15,311 infants, mostly in the maternity hospitals. In addition, 952 BCG vaccines were given in

Kildare and 475 in Wicklow. The number of births in the region in 1995 was 18,721, giving a crude uptake rate of 89%.

In health board clinics in Dublin, 11,231 infants completed a course of three-in-one immunisations against diphtheria, pertussis and tetanus which equates to a crude uptake rate of 75% of infants in Dublin. In addition, 827 children finished a course of diphtheria and tetanus which accounts for a further 5% of children. Approximately 81% of infants received polio immunisation in the Dublin clinics. The status of the remaining 20% of infants is unclear as many of them would have been immunised privately by their own general practitioner. The uptake of the Hib vaccine in the clinics was lower than that of polio or DPT/PT at approximately 70%. This may be due to the timing of the Hib vaccine at 2, 4 and 6 months compatred with DPT and polio at 2, 3, and four months.

In the new system, all infants will be immunised by their general practitioner for DPT, polio and Hib at 2, 4 and 6 months and for MMR at fifteen months. This entails one less visit for parents or guardians than in the old scheme. Returns will be made to the health board on each named child and will be entered on the board's computerised child health system. It is hoped that the new system will enable easier tracking of children who have not been immunised and the identification of black spot areas and will lead to a noticeable improvement in uptake rates. The new arrangements will give easier access for parents and for opportunistic vaccinations.

Developmental Examinations

The review group has pointed out that the aim of the nine month developmental examination is to detect early those children who have developmental delay or other health related problems and that there are many disorders where early detection and treatment improves outcome. The review group concludes that the nine-month developmental examination is very reassuring for parents and should be maintained in its present form. The group also points out that "changes in health and health services will change the purpose of the nine-month developmental examination. Measures of the effectiveneess of the examination must include not only objective outcome measures but also subjective measures, including views of consumers, the role of the examination in the new morbidities, social changes and health promotion. Although specific recommendations were not made regarding these issues, other recommendations are as follows:

- Each community care area should nominate one area medical officer to follow-up those who do not attend clinic services.

- Health centres in which examinations take place need attention to decoration, furniture, facilities for mothers and babies, storage areas for buggies, and changing facilities.

- Hospitals to which children are referred following developmental examinations should be requested to send feedback letters, detailing findings, investigations and treatments, to referring area medical officers.

- The specialist in child health in the Department of Public Health should, in consultation with appropriate specialists, develop guidelines and criteria for follow-up and referrals of children attending developmental examinations.

- Computer forms, similar to those issued for the nine-month developmental examinations, should also be issued for special clinics, and details of children attending these clinics should be entered in the RICHS system.

- The offer by the three major paediatric hospitals to facilitate access to records of children referred by area medical officers should be followed up, and a study established to examine how these records can be accessible to referring doctors in the future.

School Medical Examinations

The introduction of school medical examinations predated the provision of general medical services and were put in place to provide children, who would not otherwise have access to a doctor, a medical examination at least twice during their primary school years. When they commenced, all children in designated classes were screened. As the health status of children has improved, and because of entitlement by children of low income to the services of a general practitioner, the focus of these examinations has changed. School medical examinations are now more selective and few Areas provide screening to all children in designated classes. Children are more usually seen only if they have been brought to the attention of the Area Medical Officer by the teacher or parent. In the light of better health among children generally, the review group recommended that it would be timely to review Section 66 of the Health Act 1970 which requires health boards to make available a health examination and treatment service for all pupils in national schools. Other recommendations regarding school medical examinations were made by the review group as follows:

The specialist responsible for the child health services in the Department of Public Health should standardise consent forms, screening examinations and systems of referral and feedback throughout the Eastern Health Board. An advisory group comprising one senior area or area medical officer and one superintendent or public health nurse in each community care area should be appointed to advise and assist the specialist in this task.

The consent form, which parents receive before the first school examination, should be modified and standardised throughout the Board's area. The form should be sent to parents of all children to be screened. Emphasis should be placed on questions about vision and hearing and there should be a short third section on the form for other health concerns.

The specialist in child health services should clarify with the relevant agencies the pathways by which referrals of schoolchildren with social and behavioural problems should be made.

The booster immunisation service should be extended to all schools.

Screening for vision and hearing

Public Health Nurses carry out screening for vision and hearing in schools in the region. The numbers of these are shown in the following Table:

Table 28: Number of hearing and vision tests carried out in EHB region: 1995

Community Care Area	No. of hearing tests	No. of vision tests
1	2,422	4,123
2	1,408	2,897
3	441	667
4	2,938	3,638
5	2,400	2,491
6	4,171	4,271
7	1,856	3,051
8	10,193	10,201
9	2,865	4,230
10	3,504	3,942
Total	**32198**	**39,511**

The review group made the following recommendations in relation to screening for vision and hearing:

- School screening for vision and hearing should be carried out in first and fifth classes only, except where a specific request is made.

- Public health nurses should undertake all screening of vision and hearing.

- Apart from screening of vision and hearing, other screening tests should be discontinued in all areas.

- A lighted Snellen box should be used for all vision screening. Stycar tests and Keystone boxes should be abandoned.

- The problem of inadequate room space in small schools preventing the use of the lighted Snellen box can be solved by using diagonal room dimensions (i.e. from one corner diagonally across a room to the other) instead of the width and breadth dimensions.

- In vision screening, criteria for referral should be standardised. The sub-group suggests that 6/12 vision or worse should be the minimum criteria for referral irrespective of demands from outside agencies.

Public Health Nursing Service

Public Health Nurses are assigned to Community Care Areas where Senior Public Health Nurses are first line managers; overall management in each Area is the responsibility of Superintendent Public Health Nurses. All children in the region receive visits from a Public Health Nurse soon after discharge from maternity hospital. These visits continue until the child is three. After that, children may be brought to the clinic until they reach the age of six. In the case of children with special needs, home visits continue until the child is six years of age. Public Health Nurses also assist at Developmental Clinics and they carry out screening for hearing and vision defects in primary schools. A variety of other initiatives are also undertaken by Public Health Nurses such as breast feeding support groups; health education in schools and in the community; parenting skills training and pregnancy prevention with teenagers.

Because of their access to all small children in the region and the responsibility for their health and welfare which this places upon nurses, the Public Health Nursing Service is included in this Review. Superintendents were asked to evaluate the aspects of their services which impact upon their effectiveness and efficiency. One of the principal elements identified was that of staffing and included in this was recruitment, induction, supervision and support and the development of skills though training and access to professional literature. Effective interdisciplinary liaison and co-operation has been identified by the *Report of the Kilkenny Incest Investigation* as crucial in the protection of

children, and an evaluation of this too was included. Adequate secretarial and administrative support increases efficiency and this was also examined.

Recruitment, induction and retention of staff

Superintendents report that recruitment of staff is extremely difficult. Many vacancies exist which are hard to fill; this is most acute in the Areas which experience high levels of deprivation. In addition, it is felt that the numbers of Public Health Nurses graduating each year from the relevant university course may not be adequate to meet national requirements. The apparent shortage of nurses is compounded by the numbers on career breaks for domestic and other reasons. Expanding responsibilities of the service, such as undertaking Guthrie (heel) tests are also notable. In the region, 3,296 of these tests were performed by Public Health Nurses during 1995 as shown in the following Table:

Table 29 : Number of Guthrie Tests carried out by Public Health Nurses in each Community Care Area - 1995

A. 1	A. 2	A. 3	A. 4	A. 5	A. 6	A.7	A.8	A. 9	A. 10
108	113	70	813	455	385	252	417	542	141

This Review last year pointed out that the impact of early discharge of babies from maternity hospitals, often after 48 hours, has transferred far greater responsibilities to the Public Health Nursing service. Early discharge can mean that the mother is less rested than in the past, episiotomies will not have healed, breastfeeding will not be established and, as is shown above, Guthrie Tests will not have been performed, or their results may not be available.

It is recommended that a review of Public Health Nursing personnel requirements be undertaken.

A number of Areas are developing comprehensive induction procedures; others rely on the attachment of new staff to more experienced nurses. A standardised induction procedure which includes all child welfare and child protection procedures should be developed for all Areas.

Staff's sense of personal safety in some areas may be heightened by the provision of small personal alarms and this is recommended. One Superintendent ensures that professional success and new initiatives among her staff are formally recognised. Retention of staff can be improved by the provision of enhanced support and this is addressed below.

Supervision and support

Public Health Nurses who carry responsibility for very vulnerable children may experience uncertainty and anxiety about the child's welfare. To lessen this, and to ensure professional accountability, strong systems of support and supervision are important. Some Areas have developed strategies such as peer review of difficult cases while others assign Seniors to meet with the nurses in very deprived areas to evaluate their care of vulnerable children. In many Areas, monthly inter-disciplinary meetings are held to review cases of children at risk. This Review recommends that a combination of these strategies be employed in each Area. In addition, consideration might be given to ensuring that a Senior Public Health Nurse who has attended the Advanced Diploma in Child Protection and Welfare is employed in each Area. Such Seniors would be invaluable in providing the necessary supervision in cases where children are vulnerable, particularly in Areas of high deprivation.

Staff training

This Review recommended last year that the expertise gained by the Board's staff who had attended the Advanced Diploma in Child Protection and Welfare should be harnessed for the benefit of larger numbers of staff. In response to this, a multi-disciplinary child care conference was held in 1995; this was attended by Public Health Nurses from each Area and the response has been very positive. It has been suggested that this conference "tour" each Community Care Area in order that even greater numbers of staff might benefit. In one Area, a Public Health Nurse who has attended the Diploma has, in conjunction with her colleagues, developed risk indicators for use in working with very deprived families.

Training has taken place in many Areas in relation to breastfeeding in order to help reach the targets which have been set by the Health Strategy *Shaping a Healthier Future* (1994). Other training undertaken in 1995 includes parenting, enuresis and smoking prevention among school children. Many Superintendents have requested that attention be paid to the need for multidisciplinary training in relation to child protection at Area level.

Access to current professional books and journals is important in the maintenance of skill levels; such access could be improved in many Areas. The availability of a small inter-disciplinary library in each Area headquarters has been suggested and should be supplied as resources permit.

Interdisciplinary liaison

Interdisciplinary liaison and co-operation in protecting children has been emphasised by the *Report of the Kilkenny Investigation* as one of the principles which should inform policy and practice in protecting children (p94). While recommending that written protocols on inter-professional collaboration be developed, the report points out that:

> *"Procedures in themselves.....are not a substitute for good practice and services must be responsive to local circumstances....to ensure that intervention is effective. The investigation team supports the view that standards of good practice be developed and be updated through ongoing appraisal."* (p97)

This Review recommends that inter-professional collaboration in this regard be appraised.

Administrative support

Fax machines have been installed in many Areas, particularly in health centres which are remote from Area headquarters and by mid 1996 these will be installed in all Areas.. In addition by the end of the year, electronic mail facilities will be available in all health centres. Manual systems of record keeping are proving cumbersome; initial meetings have been held to explore the possibility of computerising Public Health Nursing records. The experience gained in computerising social work records (SWIS), which is discussed elsewhere in this document, should be valuable in this regard. Access to word processors in some Areas could be improved. The secretarial support for Superintendents in some Areas has been enhanced.

Visiting children

This Review last year highlighted the number of "ineffective" calls made by Public Health Nurses. In 1995, almost 35% of calls were in this category i.e. no one was home when the Public Health Nurse called. In response to this, a pilot scheme has been undertaken in Community Care Area 8 where prior appointments were made with parents. Although the evaluation of this pilot will not be completed until April, initial findings show that the initiative is successful with a very large reduction in ineffective calls being experienced and a consequent more effective use of the nurses' time.

The recommendations which were made by the child health review group in relation to public health nursing are as follows:

Public health nurses should have an input at antenatal classes in maternity hospitals. At the first antenatal visit, an information pack on the relevant community services should be given to the mother. Information on the public health nursing service should be displayed at antenatal clinics and classes. An information leaflet should be given to the mother on discharge from hospital and this should include health centre telephone numbers.

Home visits should be concentrated in the first three months of a baby's life to facilitate rapport between nurse and mother, and to enable nurses to provide better support for first time and breast feeding mothers. The frequency of visits should be based on an assessment of need by the nurse.

To facilitate working mothers and to encourage greater participation by fathers in the care of their children, the possibility of flexibility in the working hours of public health nurses, within an agreed time frame, should be explored. Community Care Area 8 is piloting a flexible working week based on a working day of 8.30 a.m. to 6 p.m. and this has increased the effectiveness of home visiting.

An appointment system for child health home visiting was identified by Superintendent Public Health Nurses as being very worthwhile in addressing the problem of ineffective calls. A protocol for this system should be agreed following assessment of the pilot which is currently in operation in Community Care Area 8.

Chapter 4

SPEECH AND LANGUAGE THERAPY SERVICES

Overview of services

Speech and language therapy involves the assessment, diagnosis, management and treatment of a range of communication difficulties including problems in the areas of language, speech, voice and fluency. Therapists also have a role in the assessment and treatment of clients with swallowing problems. They are involved in the prevention and early detection of communication problems. Provision of training to other staff and involvement in the training of undergraduate speech and language therapists is an important aspect of the therapist's role.

In the Eastern Health Board each Community Care Area has a Principal and a minimum of three basic grade therapists. In areas where staff numbers are higher there is a Senior post in the community, with some administrative responsibility. In addition there is a specialist senior post in Trinity College and a specialist senior post in Mental Handicap in Area 8. The majority of therapists in the region are involved in provision of service to children (less than 5% of therapy time is currently devoted to adults).

Clients are seen in many settings including health centres, special schools, child psychiatry clinics, pre-schools, special classes in normal schools, and child and family clinics. Numbers of children referred, assessed, discharged and waiting for assessment are given below.

Table 30: Numbers of children referred, assessed and waiting for assessment in speech and language therapy service in each Community Care Area 1995

Area	Total no of referrals	No of assessments	No waiting for assessment at year end
1	338	221	211
2	231	202	70
3	282	171	221
4	333	249	359
5	349	307	330
6	432	430	140
7	305	304	307
8	529	507	191
9	472	461	173
10	367	262	228

Referrals

While the number of referrals continues to increase, they still fall short of the number expected in the population. For example, based on extensive U.K. studies, 691 children under 4, and 400 children of school age (in a general population of 100,000) have speech and language difficulties, which require intervention.

Referrals come mainly from public health nurses, area medical officers, parents, psychologists, school medicals and general practitioners.

The continued increase in referrals is due to a number of factors, including an increase in the general level of awareness of speech and language problems and their long term implications.

While there is continued emphasis on prevention and early intervention, the number of referrals of children aged over 4 years has increased in some areas. The numbers of children who were referred to the service over the age of four are shown in the following Table:

Table 31: Numbers and ages of children referred for speech and language therapy in each Community Care Area 1995

Area	No of children aged 0-4	No of children aged 5-18	Total no of referrals
1	150	188	338
2	175	56	231
3	169	113	282
4	141	200	333
5	183	166	349
6	279	153	432
7	128	177	305
8	356	173	529
9	270	202	472
10	197	170	367

It can be seen that of the total of 3,646 referrals, 56.17% were aged four and under. Referrals of those aged over four amounted to 1,598 and represented almost 44% of total referrals. It is hoped that greater public and professional awareness of speech and language problems would encourage earlier referral and that numbers being referred over the age of four will decline.

Extra demands have been placed on the service because of increased referrals from agencies such as Barnardos, the Department of Education psychologists,

and schools. Children referred at 4 plus, are children whose speech and language problems are not detected until they are in school. More recently there has also been a significant increase in the number of adolescents referred. Facilitation of parental referrals is considered important as an additional way of ensuring early referrals.

Language Unit and Classes

In the Language Unit and Classes a special service is provided to children with severe receptive and expressive language problems and severe speech problems, including dyspraxia. Referrals are mainly from speech and language therapists and psychologists. The Language Unit in Ballinteer caters for 30 children up to the age of 6 years, while Language Classes in Tallaght, Drumcondra and Churchtown cater for 56 children of primary school age. In September '95, a service for children with language problems at post primary level was opened in Ballinteer Community School.

The Language Unit also provides an assessment and advice service. In Tallaght an intensive service is provided to children from the community, who are awaiting placement in the Language Class, or who failed to secure a place because of the demand for places.

Adequacy of service

With regard to the adequacy of the speech and language therapy service there is a great variation within the region. In some areas where staff numbers have increased and where there is a Senior therapist in addition to the Principal post, a lot of positive changes are noted. Increase in staffing, as well as resulting in a direct improvement in service to clients, has led to improved opportunities for support from colleagues, more case discussion, opportunities for joint approaches to intervention and less isolation of staff.

All areas have difficulty in providing the optimum level of service to children - for example intensive therapy, or even twice weekly therapy is not available in most areas. In some cases this is due to staffing levels as is shown in the following Table:

Table 32 : Speech & Language Therapy posts in each Community Care Area showing percentage child population		
Area	% distribution of child population in EHB region	Speech & language therapy (whole time equivalent) posts
1	9	4.0
2	6	5.5
3	6	4.0
4	13	4.0
5	10	5.0
6	11	6.3
7	8	4.0
8	17	8.8
9	12	5.5
10	9	6.0

This table indicates the number of whole time equivalent posts, including sessional posts, and includes posts which are currently vacant. In addition, the service for children with specific speech and language impairment has total of 9.2 whole time equivalent therapists, including a Principal. This Table does not include those employed in hospitals.

In the case of children with severe speech and language impairments, therapy at least twice weekly would be considered essential, yet most areas can only offer once weekly appointments. In some areas pressure of caseload indicates that most clients are seen on a contract system. Children are offered blocks of therapy - for example one session a week for a set number of weeks, often with a considerable time gap before the next block can be offered. While this system is appropriate for some children - particularly those with less severe problems,- it is often used because of caseload management issues, not because it is seen as the appropriate service for the child.

Access to the service for disadvantaged groups, such as travellers, socially deprived children etc. remains inadequate. In order to provide an appropriate, equitable and easily accessible service, the needs of these groups should be examined by therapists in conjunction with the relevant community and other service providers. Given current level of resources, provision of an appropriate service to such groups is very difficult. In the case of disadvantaged children, therapists who have experience and a special skill mix are required. The links between early language difficulties, poor language stimulation, social deprivation and school failure are well documented. Provision of well resourced services within the community, and in designated pre-schools, would enable therapists to provide a more equitable service to children from disadvantaged backgrounds, linking in to Health Board and Department of Education pre-school schemes.

There is a need for further development of Language Classes and a Pre-school Language Unit on the northside. Proposals regarding the development of this service have been submitted. Children with specific speech and language impairments require specialised intensive input, which cannot be provided in the general clinics. The fact that the service to children with specific language impairments is limited means that many of these children attend long term in local clinics, where their needs cannot be adequately met.

While there has been a reduction in the length of waiting time for therapy in some areas, the waiting time for some children for initial assessment is too lengthy. Even within some community care areas there is a variation in the length of waiting time between clinics. In some cases this inequity is due to accommodation problems. For example in certain clinics speech and language therapists may be restricted to holding clinics three days a week, because the room used is only available for that time, and no other accommodation is available in the clinic. While parents may be offered the option of travelling to another clinic, this is not often feasible.

In areas where there is a lot of disadvantage and social deprivation, therapists are often in the position of dealing with children from families with multiple problems. If such families have psychiatric problems they may be referred to the Child Psychiatric service. If not, there may be no social work involvement and a therapist may be the sole professional involved. Due to the multiplicity of problems, and limited backup from home, these children may need to attend therapy for a considerable length of time. In Areas where there is a large proportion of children and families with such special needs, throughput will be very slow.

In some community care areas there are several special schools, which receive a speech and language therapy service. For example in Area 4, two Special Schools each have a service five sessions per week - therefore the equivalent of one full time post is devoted to this service. In Area 6 , five sessions are devoted to a special school and five sessions to the School for the Deaf, again the equivalent of one full time post. In Area 7, with a compliment of 4 therapists, five sessions are given to the School for the Blind. These factors need to be taken into account in staff allocation.

The document The Way Forward (October 94) reviewed the Speech and Language Therapy services and made recommendations regarding the future development. Some area of the service for which recommendations were made are reviewed here.

Uniformity

Uniformity regarding criteria for assessment, admission to waiting lists, monitoring progress, termination of therapy and optimum patterns of therapy was recommended.

This area is currently being examined in detail by the Principals. Practice in all areas has been documented and results of a detailed questionnaire are being analysed, with a view to establishing uniformity where appropriate, and outlining optimum practice procedures. However, it is recognised that, because of differences in staffing levels, demography and needs, a degree of flexibility is important.

Clerical Support

Only one area has full time clerical support, including duties other than typing. In all other areas clerical support is shared with other disciplines and typing only is available- often with long delays. A lot of therapists' time is spent on non-clinical duties - photocopying, issuing of appointments, filing, maintaining waiting lists etc.

Computerisation

A system is currently in preparation and will be piloted in two areas in the near future. This should result in easy access to statistical information. Provision of clerical support, to input some of the information involved, is considered essential.

Psychological Service

Many children with speech and language problems will require psychological assessment to ascertain their overall level of intellectual functioning, and in order to consider placement needs.

The provision of psychological services varies greatly across community care areas, varying from 2 to 6 sessions per week. Long waiting exist in several areas. In some areas a prioritisation system exits and children with severe speech and language problems, who are being referred for special placements, are seen within 3 - 6 months. Children must have a psychological assessment before they can be admitted to a Language Unit or Class. In some cases lack of such assessment results in long delays in admission.

In some areas service is provided by other agencies and therapists have no input into the level of provision or prioritisation.

The Department of Education provides a psychological service via schools in Areas 4, 5, 6 and 8. While therapists do not have direct access to this service, they may refer school children via the school Principal. Referral onward to the psychological service is dependent on the school Principal's agreement and the relative needs of other children in the school.

Due to these factors, only children with severe problems are referred for psychological evaluation and the service provided is generally restricted to assessment. This role needs to be broadened.

Audiology Service

All children with speech and language problems will require an audiological assessment, either screening or detailed evaluation. Many children with severe speech problems will need repeated testing.

Within the region, screening is available in all Areas. Referral for further evaluation varies. In some cases therapists can refer directly, in other areas referral is via the area medical officer. The N.R.B. and Cabra provide the service. In general the system for audiological evaluation has improved and in most areas waiting lists are not unduly long.

Equipment Budget

Therapists require a comprehensive range of assessment and therapy materials, if they are to meet the requirements of clients of different ages with various disorders. In many areas budget is considered to be inadequate and in most cases, Principals do not have a specific budget. Most Areas have no set budget for equipment. Several Principals were concerned about the equipment provision in their clinics. Where there have been increases in staff, or in the number of clinics, this has not been reflected in increased budgetary allocation. This Review notes that the decentralisation of budgets to service heads has commenced.

Specialist Posts

In *The Way Forward*, creation of specialist posts in the areas of Learning Disability (mental handicap), Specific Speech and Language Impairment, Geriatrics and Child Psychiatry was recommended. Currently all areas are providing services to some of these groups. Within the Board, services are currently provided for children with learning disability, visual impairment, cochlear implants and specific speech and language impairment. One specialist

post exists in the area of learning disability and two further specialist posts have been advertised - one in Child Psychiatry and one in a Stroke Unit.

Currently, many therapists are working in specialised areas but posts are at basic grade level. As the services develops the need to look at other areas of specialisation arises.

Liaison

In all areas this is considered to be important, both in terms of liaison with colleagues within community care, and with voluntary bodies.

In Community Care, while informal contacts with other disciplines are ongoing, it is felt that Community Care Team meetings play an important role. Where meetings are held regularly they serve to increase awareness of other services, to foster liaison and to provide a forum for exchange of information. This leads to improved delivery of service, better planning for the future and increased staff morale. In some areas, meeting are held regularly, while in other areas meetings are very infrequent.

Liaison with voluntary bodies is on-going in most areas, where therapists meet regularly with colleagues from a variety of other agencies. On the northside, therapists from the Board and voluntary bodies meet formally twice a year. In some areas therapists have established formal links with voluntary bodies - e.g. St. John of God Services, Barnardos. A number of areas have run joint therapy or public awareness projects with colleagues in voluntary agencies.

Strong links also exists with the Department of Education and with individual schools, both special schools and normal schools. In some cases there is a need for more formal links, with clearer definition of roles.

Aspects of intervention

In addition to individual therapy, many areas run groups for children with certain disorders, for example fluency problems, language difficulties, speech problems.

An increasing number of areas are also involved in running groups for parents of children with specific disorders. As well as providing information on communication problems and specific ways of facilitating progress, such groups provide support for parents, who often feel very isolated.

Across the region a variety of internationally recognised programmes and courses are also used. Several areas have run Rustin courses, for children who

stammer and their parents. Hanen courses for parents of children with marked language and / or learning difficulties are also run. Such groups are often run outside normal clinic hours, to facilitate attendance by both parents. In some cases these courses are run jointly by two Community Care Areas, or by the Board in conjunction with a voluntary agency.

Two Areas are in the process of introducing Wilstar, an assessment and remediation process which targets very young children. In view of the emphasis on early intervention this is an important development. The impact of this system will be monitored, with a view to recommending more widespread implementation of the system, if appropriate.

Research

Many areas are undertaking research projects as part of their work. Some examples of recent research include - evaluating effectiveness of parental groups, and screening inner city pre-schools and primary schools to document the level of speech and language problems.

A number of staff are also involved in formal research as part of post graduate education.

At a Conference entitled "Working with Speech and Language Disorders in Children" in Trinity College in 1995, the following papers were presented by the Board's speech and language therapists:

- Integration : Experience and issues. This presentation looked at the experience of integrating children from a language class into mainstream classes in a primary school.
- Case study of a child with a severe speech problems in a Language Unit
- Semantic-pragmatic difficulties: clinical findings and social issues
- Treating language disorders: pitfalls of practice in the community.
- Working with groups - one approach to communication disorders
- Analysis of the data collected in the Drumcondra Language Classes over an eight year period.
- Follow up study of children who attended a pre-school Language Unit

- Considerations in the intensive treatment of childhood language disorders
- Report on a four day course on communication disorders for remedial teachers, resource teachers and psychologists.

Conclusion

Continued emphasis on early intervention is important. However as referrals and waiting lists continue to increase additional staff will be required to address the level of need. While early intervention is effective in reducing the number of children who will require very long term input, a significant number of children will still require therapy for long periods of time.

The services for children with special needs - learning difficulty, specific speech and language impairment, sensory handicaps, deprivation - require special resource allocation. The needs of these children are long term and are not being adequately catered for at present.

A small sub-group was formed following publication of The Way Forward, to look at implementation of the recommendations. The re-establishing of such a group, involving Principal therapists and management may provide an effective forum to look at the future development of services.

Chapter 5

DENTAL SERVICES

According to a study carried out in 1993 (EHB/UCC 1994), the dental health of children in the Eastern Health Board region has improved considerably during the past twenty years as is shown in the following table:

Table 33 : Average number of decayed, missing or filled teeth in 12 year olds in the EHB region: 1964-1984-1993

	1964	1984	1993
Dublin region		2.2	1.2
Co Wicklow & Co Kildare		3.4	2.1
Average for EHB region	5.5	2.8	1.4

The report showed that children in deprived areas did not enjoy quite the same level of improvement in dental health as their more advantaged peers. The Eastern Health Board has implemented a number of measures to raise the standard of these children's dental health.

A fundamental re-orientation of the Board's dental services commenced in 1995 to meet the objectives of the Dental Health Action Plan and to ensure that people with special needs, including disadvantaged children have access to an adequate dental service. Eight senior clinical dental surgeons were assigned to identify specific target groups in each dental area, to research the numbers involved and the facilities required. A multi-disciplinary approach is required in order to achieve these objectives, involving close working relationships with Public Health Nurses, social workers etc. A strategyis being identified to target special needs groups and to identify training needs of staff who will deliver the service.

At the moment, children in second, fourth and sixth classes of primary schools are systematically screened. Where it is noticed that oral health in certain schools is particularly bad, this schedule is extended. The extension of eligibility to age fourteen has resulted in an increase of 20,000 children being treated by the dental service in 1995. These children are now being treated and a systematic screening programme for them is being instituted.

Eight dental hygienists were appointed during 1995 and they will play a vital role in planning and implementing preventative programmes such as fissure sealants and dental health education. The dental hygienists will be concentrated particularly in areas where children's oral health is poor and will also be involved in the treatment of mentally and physically handicapped children and other groups with special needs. Mouth rinsing programmes were extended in the Kildare areas to all schools where the water supply is not optimally fluoridated. Fluoridation plants in Kildare and Wicklow are being upgraded and refurbished.

By the end of 1995, the Eastern Health Board had advertised for two consultants in orthodontics. When they are appointed additional appropriate support staff will be provided. Recruitment of eight community based orthodontists has been approved. During 1995 the number of orthodontists was increased from two to five whole-time equivalents. Seven private orthodontists were employed on a sessional basis and the number of sessions worked by them equated to two whole-time equivalent posts.

The management of the orthodontic service, which has been centralised until now, will be devolved to the Principal Dental Surgeon in each area. This will facilitate the review and management of waiting lists. This devolution of responsibility will be accompanied by the agreement of targets with the providers of the service on an individual basis.

Chapter 6

DRUG MISUSE

Altered patterns of drug misuse in the region became evident recently; in particular an increase in the smoking of heroin by young people was noted along with an increase in the supply and consumption of ecstasy. The use of each drug is inter-related: ecstasy is endemic in the rave scene in Dublin, and young people are then smoking heroin to come down from ecstasy before going home at night. Ecstasy can therefore be seen as a major gateway drug. This calls for new approaches.

The first objective of the drugs service is to re-engage drug users with health professionals. This is being achieved through a number of important initiatives, the first of which is the expansion of the methadone programme, or a methadone-alternative programme which may be more suitable for adolescents. The opening of a ten-bed assessment and detoxification unit at Cherry Orchard Hospital in July 1995 represents a major increase in the level of service provision for young drug users. In 1996 this will increase to fifteen beds. In addition, the provision of a number of downstream detoxification beds will ensure maximum use of acute detoxification facilities.

For young people, treatment by their own general practitioner may prove to be the most effective medical intervention as general practitioners will have detailed knowledge of each young person's history and family background. A number of general practitioners in the region are participating in a pilot project which commenced in March which will pilot a methadone prescribing protocol. The doctors' participation in the programme will heighten their skills in the detection of the signs of early drug misuse among their young patients, and will place them in a particularly advantaged position to begin intervention. An anticipated result of the pilot, is that a significant increase in the number of participating general practitioners will take place.

The importance of education and prevention programmes cannot be over-emphasised. The Board's drugs counsellors and outreach staff work in schools, often making presentations to classes in conjunction with the Gardai Juvenile Liaison Officers and Community Gardai. Education and support for teachers and parents is also provided. In June 1996 a pilot prevention programme will begin in the north and south inner city. Health education workers will work in settings where young people are found, such as schools, youth clubs, residential centres etc to ensure that preventive work is more focused on young people.

Drug misuse among females presents many child care issues. Accordingly, a rehabilitation programme has been established which is specifically targeted at female drug users who have stabilised through the Board's clinic in Amiens Street. Seventeen women are participating in the first round of the programme which is jointly funded by the Eastern Health Board and FAS. This programme will have a positive impact on child care in the north inner city of Dublin.

In the past, communities reacted to drug users in a way which further marginalised them. A welcome change is noticeable during the past year. Programmes of early intervention have been established to address the issue of heroin smoking and early heroin injecting in a number of communities. This is in response to changing trends in drug misuse in young people which was noted above. The Eastern Health Board, through grant-aid and staffing, will support initiatives where local communities are empowered to develop responses which best suit their own area. It is expected that these initiatives should lead to substantial improvements in quality of life.

The Board experienced extreme difficulties in 1995 in recruiting qualified staff of a suitable calibre. Because of this, planned initiatives in relation to a programme for drug using parents in the north inner city did not commence during the year. The underlying issues which have led to addiction are now becoming more apparent among women drug misusers and issues of an emotional and psychological nature have arisen among them which need to be addressed in a comprehensive way. Issues such as these require to be addressed by the parents' programme which is planned to commence in July 1996 and by the recruitment of suitably skilled staff.

In addition, two programmes will also commence for adolescent drug misusers, one each in the north and south inner city. These programmes are aimed at adolescents who are either dependent or at high risk of dependency on opiates. While the programme will engage each young person for six months, participants must commit themselves to involvement in follow-up, further training or education when their participation in the programme is completed. The programme's mix of occupational, recreational, educational therapeutic and medical input will be of sufficient variety, challenge and interest to engage the young people. Clear expectations of participants and rules will be elaborated. The programmes will be evaluated to assess their effectiveness.

The Eastern Health Board has engaged the services of a team of international consultants who are experienced in the field of the management and delivery of drugs services abroad. The team is assessing the quality of service provision in the region. Their recommendations are awaited.

Chapter 7

CHILD AND ADOLESCENT PSYCHIATRIC SERVICE

The provision of the child and adolescent psychiatric service in the Eastern Health Board region differs in some important respects from the provision of other services for children such as social work and child health provisions. Although responsibility for the provision of the service rests with the Board, the service is provided both directly by the Board and through the Mater Child and Family Services and the Hospitaller Order of St John of God.

Also in contrast to other provisions for children, the responsibility for which rests with the Community Care Programme of the Eastern Health Board, child psychiatry services in the region are the remit of the Special Hospital Care Programme. It can be seen also that a third variation exists in that the Hospitaller Order of St John of God, although a service provider to the Eastern Health Board, is funded directly by the Department of Health with the exception of their service in Area 1 and Wicklow which are funded by the Eastern Health Board. In order to provide cohesion to these arrangements, the senior managers from the three services have joined in a Central Co-Ordination Committee which meets on a monthly basis to review and co-ordinate the services. These meetings are chaired by the Programme Manager of the Special Hospital Care Programme of the Eastern Health Board.

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

Table 34: Provision of Child & Adolescent Psychiatry Services in EHB region showing service providers and their catchment areas

Service Provider	Catchment Area	Funding Body
Eastern Health Board	Part of CC Areas 3 & 4 (inner city) CC Areas 5,6 & 9	Eastern Health Board
Mater Child and Family Services	CC Areas 7 & 8	Eastern Health Board
Hospitaller Order of St John of God	CC Areas 2, 3 & 4 (excluding part inner city) CC Areas 1 & 10	Department of Health Eastern Health Board

Service Locations

Although many professionals working with children would wish for a child psychiatric service which was neighbourhood-based, within available resources the services are based at the most strategically possible locations which are as follows:

Table 35: Locations of Child & Adolescent Psychiatric Services in EHB region		
Eastern Health Board	**Mater Child & Family Services**	**Hospitaller Order of St John of God**
Castleknock Ballyfermot St James's Hospital Kill, Co Kildare	Mater Hospital Ballymun St Frances Clinic, Temple Street St Joseph's Adolescent Unit, Fairview	Orwell Rd., Rathgar Ballybrack Blackrock Tallaght Bray Wicklow

Service provision

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

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

Table 36: Provision of special education within EHB region (day service)		
Eastern Health Board	**Mater Child & Family Services**	**Hospitaller Order of St John of God**
Phoenix Park Ballyowen Meadows James Connolly House Warrenstown House Courthall	Mater Hospital	St Peter's, Rathgar

These schools cater for children with mixed emotional and conduct disorders, young autistic children and mildly mentally handicapped children. The Board also provides support to the special school Benincasa by the provision of care staff. It should be noted that the Ballyowen Meadows and James Connolly House Schools have transferred from their original locations to a new modern complex at Beech Park, Stillorgan, Co Dublin. The development of an intensive "assessment and statementing" service in this complex is gradually evolving. Interviews for some of the key personnel necessary for this planned "centre of excellence", which will include staff training and research, are in progress.

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

Table 37: In-patient child and adolscent psychiatric provision in EHB region

Eastern Health Board	Mater Child & Family Services	Hospitaller Order of St John of God
Warrenstown House Courthall Farmleigh Park Dromheath Avenue, Mulhuddart	St Paul's, Beaumont	St Richard's, Orwell Road Rathgar

Both Warrenstown House and St Richard's are acute units which also provide assessment facilities. The remainder of the units, with a combined complement of 40 beds, provide residential care for chronic psychotic and autistic children.

Service developments

Throughout 1995, a number of improvements were made to the provision of the service in the region. The appointment of three consultant child psychiatrists to Kill Child and Family Centre, St James's Child and Family Centre and to the residential units with established links to Harcourt Street and Temple Street Children's Hospitals and Our Lady's Hospital in Crumlin, consolidated the service during the year. At Warrenstown House, the nature of the service means that the demands on the fabric of the building are great; developments are therefore in hand to improve facilites there.

The St John of God residential facility at Orwell Road (Lucena Clinic) was rebuilt during the year and further developments are in hand to develop the service in Wicklow in order to provide greater equity of access to the service for that sector of the region. Additional places were made available at Gheel Training Centre in Fairview for autistic adolescents.

Liaison and co-operation

Last year's Review pointed out the need for a shared vision of work with children to develop between social workers within Commmunity Care Programme and the child psychiatry services in the region. The responsibility of one of the new Directors of Child Care and Family Support Services in the Board includes liaison and co-operation between the Community Care Programme and child psychiatry services. Greater co-operation with the Mater Child and Family Services, the Board's own child psychiatric services and Community Care has been experienced. Our Lady's Hospital in Crumlin has pointed out that liaison with Community Care social workers is good, in spite of mutual frustration when care placements are difficult to find for particular children. Discussions are on-going with the St John of God service to facilitate greater supportive interaction between their service and the Community Care teams in the south eastern parts of the region.

Court requirements

Both child psychiatry services and Community Care are facing increasing demands from the courts in relation to the provision of assessments and social reports for children and families. These demands have significant staffing implications.

Adolescents

The need for an adolescent treatment service for west Dublin was pointed out in the Review last year. It will be remembered that the facility will be modelled on St Joseph's Unit in Fairview which caters for adolescents on an outpatient basis who present with significant emotional, behavioural, educational and family problems. Since then, preparatory work for the unit in west Dublin has taken place and the service should commence in the Summer of 1996 pending availability of premises and staffing. The impact of new legislation on service provision for adolescents is discussed below. Our Lady's Hospital points out that it strives to provide greater privacy for adolescents along with special areas where adolescents can be together and provide mutual support which is important at this developmental stage. When children and adolescents are admitted to the hospital with medical conditions and associated psychiatric disorders, they are managed on general medical wards by nursing staff without

any psychiatric training. Because of the difficulties which this presents, the hospital intends to develop a Psychosomatic Unit to cater for such patients and discussions are in progress regarding this development.

White Paper: A New Mental Health Act

The recent publication of the White Paper comes just three years after the launch of the Green Paper on Mental Health Services. Over one hundred submissions were received in response to the Green Paper, following which the Minister and his senior officials pursued a consultative process in meeting service users and professionals in the service. This was facilitated through study days, conferences and seminars.

In line with the Child Care Act, the White Paper extends the definition of a child from 16 to 18 years. Under the new Act, children will have the opportunity for admission without parental consent, if they meet certain criteria; admission may then be effected by means of a court order. Our Lady's Hospital points out that where a child does not consent to admission, it appears to be unnecessarily undermining for parents to have to resort to a court hearing where inpatient treatment is deemed necessary for the child.

Provision is also made in the Act for health boards to apply to the court for treatment orders and emergency orders. The new Act also allows for children to be detained without parental consent. The procedures which are detailed, as they apply to child treatment orders, should be expanded upon to specify designated centres specialising in the care of children with mental illness or metal handicap as appropriate, so as to fully reflect the distinction between adult and child services. The proposal, where an application is made to the District Court for the admission of a child without the consent of parents or guardians, that the applicant should not be employed in the mental health services, should also apply to staff of the mentally handicapped services of a health board or voluntary body, depending on the case involved. The position with regard to the requirement for a treatment order under the new mental health legislation in respect of a child, who is already the subject of a care order or supervision order under the Child Care Act 1991, needs further clarification, particularly in respect of the rights and duties of a health board to provide health services.

This increase in the age of childhood will have resource implications for the health service in providing suitable day and residential care facilities for the 16-18 year old group. Unlike adults, these children will require educational rather than rehabilitation programmes; it will also be necessary to establish acute units specifically for disturbed adolescents as the acute psychiatric units presently available are not suitable to cater for the needs of this group.

McQuaid (1995) points out that the new Mental Health Act will provide special consideration to children and will provide the opportunity for admission for treatment for children suffering from severe depression, schizophrenia, psychosis, or significant mental handicap who may be a danger to themselves or others. The new Act is seen by McQuaid as a "significant improvement" on existing arrangements. Statutory duties are now placed on health boards to promote mental health and to provide services either directly or in partnership with voluntary agencies. He points out however that "much remains to be done by way of additional facilities and resources to provide additional facilities and resources for adolescents and that these resources have yet to be identified, quantified and provided". This Review recommends that the Eastern Health Board establish a planning group to commence this task.

Chapter 8

EARLY CHILDHOOD SUPPORT & INTERVENTION

Service managers today are under increasing pressure to evaluate their effectiveness and to direct their resources towards those services whose effectiveness is proven. The case for early childhood support and intervention has been well proven, both here and internationally. This Review last year cited studies in which demonstrable postitive outcomes were shown by early intervention programmes; so important are these studies that they are repeated again this year. Gibbons (1990) details research which has taken place in this area beginning with the Head Start Programme in the United States:

> *"The Head Start approach assumed firstly, that environment was the key determinant of intellectual and social development; secondly that poor children were deprived of experiences enjoyed by their middle-class counterparts; and thirdly, that "enrichment" of their environment at a critical point in early development would compensate for environmental deficits".* (p19)

The long-term outcome of children who had participated in Head Start showed that:

> *"For example, more children who had experienced pre-school programmes were kept in their original grades (i.e. kept up with more fortunately circumstances classmates) and significantly fewer were referred for special education. Longer term gains appeared to depend on the involvement of parents, as well as children, in the programme, and on pre-school enrichment being followed through in the ordinary school programme."* (p20)

In Britain, similar favourable outcomes were demonstrated in children who had attended nursery school or playgroups. Gibbons writes of a longitudinal study of all children born in one week in 1970:

> *"Children who had attended nursery schools or playgroups showed significantly greater achievement on a variety of measures at five and ten years of age. Socially disadvantaged children gained even more than others from their participation".* (p20)

Involvement of parents is shown to be important to the success of early intervention programmes. In one programme, disadvantaged black children

were involved in a two year attendance at nursery school which also involved regular home visits from a teacher:

> *"In subsequent evaluations at age 14. 15 and 19 the experimental group....outscored the controls on some measures of attainment and were more likely to have been retained within the mainstream school course. By age 19 they were less involved in crime; made less use of welfare services; and had a lower incidence of teenage pregnancy. they more often graduated from high school and obtained work."* (p20)

Similarly, in a small study undertaken by Yale Child Welfare Research Programme, inner-city, poor parents who were expecting their first child were selected to receive an individualised package of services which lasted from pregnancy to when the child was two and a half. Services offered included paediatric care, day care, social work and psychological services and access to an informal children's centre. Because the service began in pregnancy, it was seen as a service which was directed at meeting the adult's needs. Results of this study were encouraging:

> *The programme was shown to have a long-term influence on family functioning: more experimental mothers continued with their education after the birth of their first child; they had smaller families; more of them were self-supporting and fewer were living with extended families. There were no differences in parenting style or in the children's IQ; but experimental children had less absenteeism from school and better school performance."* (p21)

It can be seen that a common indicator of success of such early intervention programmes is that of school success. Retention in school and a positive experience of education is perhaps one of the best predictors of improved life-chances for a child. Reports from the Board's professionals highlight the current high levels of school refusal and school exclusion of young people who come to the attention of staff of the Board. School, then, can be an excellent barometer of a child's social health and programmes which enhance a child's performance in school should be fostered. The later such programmes are initiated with a child the more problematic is its outcome and evaluated programmes such as those cited above clearly state that early intervention is successful.

Research points out that certain criteria must be applied to the provision of early intervention programmes. O'Flaherty (1995) highlights that:

> *"An analysis of the research indicates that programmes most likely to succeed in preparing children for school are those which emphasise both*

cognitive and social skills; where staff support and encourage and are flexible in their approach, where parents are involved and integral to the curriculum; programmes that are rooted in local culture and traditions, which understand the central role of women and support them in their many tasks; and those which recognise the need for a holistic approach - in other words 'good quality curricula'."

In addition, when resources are limited, the relatively low level of the cost of early intervention should be carefully considered against far more expensive, later intervention.

Two main forms of early intervention programmes are employed by the Eastern Health Board and these are detailed below.

Community Mothers Programme

This programme, which has been closely evaluated, supports young mothers by providing a "mentoring" relationship with a more experienced mother who visits in order to foster the inherent skills of the young mother and to encourage the mother's own problem solving skills. In the Eastern Health Board region in 1995, 960 first and second time parents were visited by 160 Community Mothers. After initial training of four weeks, the Community Mothers work under the guidance of a Public Health Nurse on special assignment who is known as a family development nurse. During 1995, the Programme was expanded in Community Care Areas 4 and 10; it is intended in 1996 to re-start the Programme in Area 3.

Evaluation

When the Programme was evaluated in 1989, "items for which the intervention group scored significantly better than the controls:

* Immunisation of the child
* Child's diet
* Time of introduction of cow's milk
* Cognitive stimulation of the child
* Maternal self esteem
* Maternal diet
* Maternal positive feelings" (Johnson and Molloy 1995)

In the U.K. publication *What Works in the Early Years?,* MacDonald and Roberts (1995) for Barnardo's have undertaken a detailed literature review in search of early intervention programmes which have demonstrable

effectiveness. Having discussed the Community Mothers Programme in the Eastern Health Board and other initiatives, the authors conclude:

> *"among the perinatal and early childhood intervention programs, according to the outcomes assessed in this overview, long-term visitation has been shown effective...among families with one or more of single parenthood, poverty and teenage parent status. The evidence regarding the effectiveness of intervention of short-term home visitation, early and extended postpartum contact, intensive paediatric contact, use of a drop-in centre, classroom education and parent training remains inconclusive."* (p32)

In short, the report concludes that the success of Community Mothers has come about "because parents have been supported...to become better parents" (p32)

As discussed above, early intervention programmes show very clear benefits for children which are retained throughout childhood and into young adulthood. These benefits can be seen most clearly in the school careers of participating children. This Review recommends a follow-up the 1989 group of Programme children, concentrating on their school performance and to thus begin a longitudinal study of the impact of the Programme upon them.

Other Programme benefits

In addition to the above, the Community Mothers Programme has shown clear advantages to the mothers who deliver the Programme. In addition to their own sense of self-worth being enhanced, Johnson and Molloy (1995) point out:

> *Many of the Community Mothers have become involved in adult education programmes, for example, literacy, counselling and personal development as a result of their contact with the Community Mothers Programme. Once the process of empowerment has begun, it then appears to develop a momentum in other directions".* (p80)

Many spin-off initiatives have also taken place within the Community Mothers Programme. These include parent and child groups (14); breastfeeding support groups (7); a toy library; an additional health information visit to families on a pilot basis; and a Programme for travellers in which 70 traveller parents received visits from the Programme during the year.

Programme targets for 1996

- To restart the Programme In Community Care Area 3

- To evaluate and extend the Health Information Visit to all Areas
- To increase the number of ante-natal visits by 5-10%
- To further develop the home support visits by Community Mothers to breastfeeding mothers
- To continue the development of Irish-based materials for the Programme, using a participatory process, involving users in the development and production of materials

Nurseries

The second important early childhood intervention which is fostered by the Eastern Health Board is that of nursery provision. In the region, nurseries can frequently be the location also for additional initiatives such as after-school intervention, afternoon programmes, mother and toddler groups, toy libraries and individual work with particular parents and their children. It should be noted that staff in Eastern Health Board funded nurseries have early childhood qualifications in child care, Montessori education or in nursery nursing. The following Table shows their distribution across Community Care Areas:

Table 38: Number of Nursery School places funded by Eastern Health Board in each Community Care Area in 1995

Area	No of nursery places	No of full-time* places	No of part-time places
1	97		97
2	16	16	
3	244	88	156
4	30	30	
5	240	100	140
6	133	133	
7	220	105	115
8	267	119	148
9	85		85
10	35		35

*Places are designated as full time if children remain until 3.30 p.m. or later

It can be seen that provision of nursery services is unequal throughout the region and that provision is inadequate in Community Care Area 4. This Area has an almost identical number of children in the 0-4 group as Area 6, yet access to nursery care in Area 4 is a fraction of that in Area 6. Area 3, with almost half the number of children in that age group has a comparatively

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

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

Some confusion has arisen in relation to the pre-school provision by the Department of Education in deprived areas. One element contributing to this is that such pre-school places are totally free, unlike the nurseries. This may be a very important factor in such poor areas. In addition, since nursery places are usually reserved for children who are seen by professionals to be at risk, an element of stigma may attach to their use, unlike the Department of Education's Early Start pre-schools which are open to all children. All services provision which is targeted and which is not universally available can become stigmatising and their acceptability to consumers consequently unattractive. A fundamental examination of the role of the nurseries may have to be undertaken as a result of these developments. An Early Start Monitoring Committee has been established by the Department of Education and a submission was made by the Eastern Health Board which highlighted many of these issues.

Conclusion

Since the effectiveness of early childhood intervention programmes has been clearly demonstrated, the Eastern Health Board should develop a clear and comprehensive strategy for its development in the region. Particular attention should be paid to the fostering of such services in areas of acute need so that equitable service provision exists in the region. In addition, it is important to ensure that these services are delivered in a manner which has high acceptability to consumers. This Review notes that the proposal of the Child Care Advisory Committee to establish an early intervention pilot project has been approved by the Board and the project will commence in 1996.

Chapter 9

CHILD AND FAMILY SUPPORT & INTERVENTION SERVICES

In writing on families under stress, Gibbons (1990) remarks that:

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

The stress which many families are experiencing from a variety of causes - most notably deprivation - can be seen throughout this document. A range of family support services, which are targeted at families undergoing stress or otherwise in need of support in raising children, exists in the region which are either directly managed by the Eastern Health Board or managed by voluntary agencies which are funded by the Board. These include the following services:

Family Resource Centres

Family Resource Centres are a community resource which are readily accessible to all families in the district in which they are located. They provide a wide range of activities including mother and toddler groups; parenting courses; personal development programmes; after-schools groups and teenage groups. Accessibility and community involvement are the key features of Family Resource Centres. Three such centres are located in the region: Ballymun, Finglas and Tallaght. Each has developed in a unique way, reflecting the needs of the communities in which they are based.

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 toward increasing confidence and independence by offering support, friendship and practical assistance to

families and by being available to families who are experiencing frustrations or difficulties. Families are visited in their own homes and at all times the identity and dignity of the individual is respected. A relationship is developed with the family in which the parents' own strengths and emotional well-being is fostered for the ultimate benefit of the children in the family. Families are encouraged to widen their network of relationships and to use community support and services effectively.

Families helped by Homestart include parents who have children who are very close in age or those who are finding it difficult to adapt to their role as parents. Single parents are also supported as are parents who have had severe depression or psychiatric illness. All Homestart volunteers are parents themselves who come from a variety of backgrounds and they attend a basic preparation course before they begin visiting.

Neighbourhood Youth Projects

Neighbourhood Youth Projects enable young people to remain in their own communities while receiving skilled help directed towards resolving personal or family problems. They provide a resource to mobilise the potential of the neighbourhood in which they are located to define and meet the needs of its younger people. There are Neighbourhood Youth Projects in the north inner city of Dublin, Blanchardstown, while Dochas opened in Clondalkin in 1994.

Children and families are referred to Dochas if there is concern about a child's social, behavioural or emotional development and its effect on the child's family, social and school life. Dochas works in close partnership with parents and a commitment is made by parents to support the aims of the programme. Families are visited by the child's key worker and parents participate in twice-yearly reviews. In the first year of service, over half of the families who were referred already had at least one child in care. The support offered to families extends beyond specific child care issues; for example there is close liaison between Dochas, the parents and the locally based money and debt advisory service.

In working with the children, emphasis is placed on maintaining and supporting them in their school. The child's keyworker draws up an individual programme which identifies specific needs and goals; this may include the need for "regressive" play, language development, temper control or school attendance . In 1995, as a result of concerns expressed by schools and information received in working with families, a breakfast club was established for a specific group of children. A hot nutritious breakfast is provided and the children's hygiene receives attention before they leave for school - towels and personal toiletries are provided. Participating children appear to benefit significantly by this

intervention in terms of school attendance and behaviour. It appears that attention to hygiene and dress improves the child's sense of well-being and their school attendance through the reduction of the bullying or teasing they may receive from other children. Although Dochas staff try to ensure that the child's home circumstances improve so that the need for the breakfast club will not be long term, sadly it appears that there is a need to extended the service to include other children.

Family Support Services

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

Family Centres

Family Centres provide professional support to families which are experiencing difficulties in child raising, personal relationships or parenting. One Centre is located at Claidhe Mor in Santry, while another has recently opened in Phibsborough. The Centres provide comprehensive, specialist support for referred families: family therapists, counsellors, social workers and psychologists are included in the staff group. A family therapy approach is employed; rather than focus upon a "problem" child, there is an emphasis on supporting parents to fulfil and develop their own potential at a personal and parental level.

Child Care Workers in the Community

The number of community based child care workers in the region was increased during 1995. Although direct work with individual children is an important part of their work, work with families in a preventive role also features to a great extent. With individual families, work can include the development of a programme to manage a child's behaviour difficulties; helping a parent intellectually stimulate a child; preparing a family for the return of their child

from care. Group work also takes place either for parents or in the form of women's groups, facilitated by a child care worker and social worker.

It can be seen that services such as the above help the Eastern Health Board towards meeting the objectives of family intervention services as stated by Gibbons:

- *"Relieving family poverty*
- *compensating for material or other disadvantage in individual families*
- *preventing serious childrearing problems and removal of children from home*
- *strengthening resources for families in local areas with many social needs".* (p15)

This Review recommends that Community Care Areas in deprived districts should have a full range of family intervention services so that it may fully bring about health and social gain for all families in the region. Although the demand for other services may be pressing, it is important that such interventions always remain a priority and are targeted towards the Areas which experience the most deprivation.

Chapter 10

Child Abuse

Rate of Referrals

Only two Community Care Area report a decrease in the number of cases reported to them of child abuse. In all other Areas, the increase in the rate of referrals continues. Comparisons between referrals in 1993 and 1994 show that there has been a 23% increase in referrals. Since 1992, there has been an increase of almost 63% in the number of referrals. This can be seen in the following Table:

Table 39: Reported cases of suspected child abuse in each Community Care Area of Eastern Health Board region 1992-1996

Area	1992	1993	1994	1995
1	35	43	183	56
2	114	113	115	111
3	57	62	113	137
4	214	124	250	360
5	109	214	168	329
6	111	118	155	185
7	185	183	273	329
8	108	144	163	147
9	279	240	204	276
10	115	135	130	228
Total	**1327**	**1376**	**1754**	**2158**

The implications of this increase in referrals must be discussed. The effects of staffing shortages highlighted elsewhere in this document are compounded by the increased rate of referrals. Whether or not a case is ultimately confirmed or unconfirmed, each referral represents a considerable time investment, principally on the part of social workers. The ripple effect since 1992 of this considerable increase which is taking place throughout the service must also be examined in terms of increased staffing requirements and the need for augmented administrative services and infrastructure. At the same time, while the increased volume of referrals demands attention, the time cost of the increased volume of referrals must be recognised along with the concurrent and urgent need for preventive services.

Categories of Abuse reported

The Report of the Kilkenny Incest Investigation points out that children may experience four different types of abuse:

- ***"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.*

- ***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." (pp36-37)*

The following Table shows the categories of abuse which were reported in the region in 1995:

Table 40 : Categories of suspected abuse reported in EHB region in 1995

Area	Physical Abuse	Sexual Abuse	Neglect	Emotional Abuse
1	20	30	5	1
2	34	42	27	8
3	39	42	56	-
4	95	99	147	19
5	83	102	144	-
6	45	111	27	2
7	109	131	76	13
8	28	86	30	3

9	36	90	144	6
10	71	128	19	10
Total	**560**	**861**	**675**	**62**

This review draws attention to the high rate of referrals of cases of suspected neglect. Heretofore, cases of child sexual abuse have attracted great attention. It should also be recognised however, that the effects of neglect are silent and pernicious. Some professionals speak of the "neglect of neglect" (Wolock and Horowitz, 1984) in both public and professional attention. The attention paid to the role of mothers is also notable in the literature; the "neglect of fathers" is very apparent. Savage (1994) has reviewed the literature on child neglect and has shown that early studies of neglectful parents tended to be judgemental. She cites Oliver and Buchanan's (1979) study which concluded that *"almost without exception, the mothers were at all times prepared to put even slight interests of themselves or their co-habitee before the children's interests. The maternal drive failed to compete with the mother's own need to be loved by anyone".* (p30)

More recent theories cite factors such as limited intelligence and a tendency to cope with problems by ignoring them. Savage reports on Polansky's 1992 study which highlighted that the lack of support available to these mothers, whether real or perceived, is also crucial; and where Thompson (1992) has highlighted the role played by alcohol abuse by the mother in cases of child neglect. Savage quotes Thompson's conclusion that:

> *"policies in child protection agencies should reflect an understanding of the harm caused to children who live in alcoholic families and should encourage intervention in order to identify and obtain treatment for the alcoholic family. Seventy per cent of the neglecting sample had difficulty in budgeting for essential items such as food, fuel or children's clothing. ...Repeated requests for this type of financial help should arouse suspicions and may provide an opportunity to discuss the problem and find out if the financial problem is alcohol related."* (p28)

Iwaniec (1985) studied failure-to-thrive infants who presented as *"they looked starved; all of them were withdrawn, lethargic in movements, apathetic, depressed-looking, detached and irritable."* (p255) They were developmentally delayed in motor, language and social skills. The study showed that no specific psychpathology was demonstrated in the mothers of these infants, although there was some predisposition among them to react to stress with anxiety. Their self-esteem was low. The social backgrounds of the infants studied was one of deprivation and there was a tendency for their families to be large. Living conditions were inadequate; there were more financial problems in their homes compared to the control group and "more of their parents tend to

mismanage what income they do receive". (p250) For their part, the infants displayed acute feeding problems and were tempramentally 'difficult'. As Iwaniec remarks, we must not forget their unwitting role in their "sad fate as seriously malnourished beings". (p254)

Preventive services have an important role to play in interrupting the onset of child neglect. Iwaniec (1985) showed that the parents in her study "cannot call on as much extended family support as can the contrast groups. This isolation and lack of support is widely based and relates to friends and neighbours." (p250) Antenatal and early post-natal support, particularly for mothers of infants perceived as "difficult" and access to programmes such as Community Mothers, Family Resource Centres and nurseries is vital. As Savage remarks when examining one intervention study:

> *"The mothers reported that having a person to talk to who reallly cared about one was the most important element in the helping process".* (p28)

Supervision

The importance of adequate supervision of social workers engaged in child protection is often emphasised. The Kilkenny Incest Investigation Report pointed out that:

> *"Child abuse is a complex, challenging and emotionally charged area of work. The work can evoke feelings of anger, distress and revulsion. Workers may be faced with conflicting evidence, retraction of statements, disbelief and denial. Many workers will be subjected to intimidation, violence, threatening behaviour and language....Regular professional consultation and supervision are essential for those working in child abuse. Supervision facilitates learning, provides and opportunity to plan and evaluate and supports workers. Supervision also promotes good standards of practice to the benefit of the public." (p113)*

In order to enhance the supervisory ratio in the Eastern Health Board, ten additional Team Leaders were recruited to social work teams during 1995. Supervision, and the impact of these appointments is discussed further in the section on the social work service in this document.

Training

In 1994, this review recommended that the expertise gained by staff who had completed the Diploma in Child Protection be shared with other staff in the Board. As a result, a number of training seminars were held which had a multi-

disciplinary attendance. Staff also continue to avail of other training in the area such as joint conferences in St Louise's and St Clare's Units. In addition, a number of staff continue to attend T.C.D.'s Diploma in Child Protection. The appointment of a Training Officer to Child Care and Family Support Services is discussed elsewhere in this document; this Officer will also undertake responsibility for training in this area.

Protocol

Following the publication of the Kilkenny Incest Investigation Report in May 1993, the Eastern Health Board undertook a review of child abuse procedures within its region. This review recommended that a standardised protocol for practice and procedures in cases of child abuse be introduced in each Community Care Area. In 1995, a working group was established, comprising representatives from social work, Directors of Community Care and Public Health Nurses, to oversee the development of this protocol.

In addition, procedures in relation to the notification of suspected child abuse will be circulated in the very near future. This will ensure that all staff in the Board, regardless of area or location of work are fully informed about child abuse notification systems in the region.

Assessment of allegations of sexual abuse and treatment of victims

Two units in Dublin, each located in children's hospitals, are responsible for the validation of allegations of sexual abuse. Children from Dublin's northside attend Temple Street Hospital, while those on the southside and in Wicklow and Kildare attend St Louise's Unit at Crumlin Hospital.

In addition to confirmation of abuse, the development of a treatment service for children who have been sexually abused is important so that a seamless service is available for victims. Until recently there was a paucity of such treatment services available in the region. and in order to rectify this, a new treatment service at St Louise's Clinic in Crumlin Children's Hospital was proposed. Staff have now been recruited to this service and a range of treatment services have commenced. It is intended that this staff group will be augmented by the secondment or rotation of staff from Community Care and child psychiatry teams. In this way, it is hoped that the expertise gained in working in the Units will be dispersed through both of these services. The possibility of outreach treatment service from St Louise's will be considered in the future as an extension of this work. In the north side of the region, discussions are taking place between St Clare's Unit in Temple Street Hospital and Eastern Health Board staff regarding the most appropriate way to develop treatment services for victims of child sexual abuse there.

Liaison with Garda Siochana

In order to ensure that both health boards and Gardai are kept fully informed of suspected cases of child abuse known to each agency, a national system of joint notification of suspected cases of child abuse commenced in 1995.

Joint training for social workers and Gardai is seen as a priority in order to ensure the effective operation of the new system and therefore the Dublin Metropolitan Area of the Garda Siochana invited Eastern Health Board social workers to provide training at a series of one day seminars for over 600 of their officers.

Meetings have been held in all Community Care Areas between the social work team and local Gardai in order to enhance communication between both agencies. It is intended that these meetings between each agency will continue and it is envisaged that joint training and joint working will develop. A number of proposals in this regard are under active consideration. It is understood that the joint notification procedures are to be evaluated in June 1996. This Review considers that the requirement to report all underage sexual activity to the Gardai will require close consideration during that evaluation.

The Department of Health has issued *Putting Children First,* a discussion document on manatory reporting in cases of child abuse. The Eastern Health Board is consulting with professionals in the organisation regarding the document and a response will be sent to the Department.

Adolescent Abusers

The Northside Inter Agency Project provides a treatment programme for adolescent sexual offenders. The project is an excellent example of inter-agency collaboration as personnel from the Department of Child and Family Psychiatry in the Mater Hospital, the Eastern Health Board and St Clare's Unit are involved. Following a detailed assessment and acknowledgement by the young person of the abusing behaviour, he may be selected for group therapy while professionals also work with his parents. The effectiveness of this programme is being evaluated and a similar programme for the southside of the region is being examined. The proposal for this project makes the following points:

Both in the UK and US, research studies have established that young people commit a significant proportion of sexual offences. UK studies have found that between 36% and 52% of all reported sex offences committed in one particular

year were perpetrated by adolescent males. (Lurney et al 1989, Horne et al 1991). Equally, one fifth of those cautioned or prosecuted for sexual offences were juveniles over the age of ten and under the age of seventeen years, and this age group is also responsible for up to one third of indecent assaults against females in any one year in England and Wales (HMSQ 1990).

Furthermore, there is sound evidence from other countries that there is a strong association between sexual offending behaviour in young males and sexual offending in adulthood. (Becket 1986, Groth 1982, Abel 1985, Beckeer 1986). In this country, clinical experience by agencies and professionals suggests that the Irish situation is no different.

It is argued that a juvenile justice response to the issue of adolescent abusers may be inadequate as research suggests that the offenders' behaviour patterns and thought processes are significantly different from other offenders. It appears therefore that a response is required which :

- focuses on the offending behaviour and demands accountability from the young person.

- provides specialised assessment, evaluation and treatment of these offenders and their families with a view to interrupting the behaviour and preventing its re-occurrence and escalation.

- selects the appropriate placement for the young person from a range of treatment settings including community based, non-residential through to secure residential accommodation followed by post-treatment services.

This Review recommends that the establishment of the project on the southside be established.

Prevention

The Child Abuse Prevention Programme began in the region in 1991. It is funded by the Board and by the Departments of Health and Education. Its purpose is to equip teachers and parents with the knowledge and skills necessary to protect children in their care. Children are also taught personal safety skills to help them in potentially dangerous or threatening situations. The Board assists the Programme through administrative help and through the secondment of a social worker.

There are a number of elements to the Programme. These include information meetings for principals and chairpersons, meetings for parents, training for teachers and classroom programmes for the pupils. Linkages between home

and school are further formed through worksheets which children complete at home with the help of their parents.

There has been high acceptability of the Programme in schools in the region as is demonstrated in the following Table:

Table 41: Numbers of schools in Eastern Health Board region operating Child Abuse Prevention Programme in 1995

County	No of schools in county	Uptake of teacher training	Uptake of parent education	No of schools teaching programme
Dublin	445	444 (99.8%)	417 (93.7%)	405 (91%)
Kildare	98	98 (100%)	92 (93.9%)	88 (89.8%)
Wicklow	81	81 (100%)	78 (96.3%)	73 (90.1%)
Total	**624**	**623 (99.8%0**	**587 (94.1%)**	**566 (90.7%)**

The acceptability of the Programme is confirmed by a national survey which has been undertaken by the Department of Education (1995) to determine the extent of the Programme and to obtain the opinions of all those involved on its suitability and effectiveness. Support for the Programme was expressed by 98% of parents and 87% of them felt that the Programme was having a beneficial effect on their child. 73% of chairpersons and 84% of teachers believed the Programme was achieving its purpose in giving children personal safety skills.

Respondents to the survey proposed some alterations to the Programme, in particular the need to include ways of increasing children's self esteem and confidence, especially as a response to peer-pressure and bullying. The need to develop broad life-skills and sexuality education elements to the programme was also highlighted. The survey concludes:

> *"The programme is effective in educating school personnel, parents and children regarding prevention of child abuse and in heightening their awareness of the subject. Only time will tell whether it is effective in the long term in preventing child abuse. On the evidence of the survey there is reason to be optimistic that the Stay Safe programme will be effective in achieving its long term as well as its short term objectives."* (p16)

Chapter 11

SOCIAL WORK SERVICE

The legislative back-drop to social work continues to change. Parts Three, Four, Five and Six of the Child Care Act 1991 were enacted on 31st October 1995. These new sections of the Act extend the powers and obligations of health boards in a number of areas.New sections of the Child Care Act, enacted on 31st October 1995, give obligations and powers to health boards to take children into care. The Out of Hours Service and Community Care Area social work teams can use these new sections as follows:

- Section 4 allows voluntary care agreements to be reached with parents. If at all possible, social workers attempt to obtain the consent of parents to voluntary care agreement, rather than to have recourse to the courts.

- Section 12 gives powers to Gardai to intervene where there are suspicions that children are at serious risk of neglect; the child is then handed over to health board social workers as soon as possible.

- Section 13 allows for Emergency Care Orders: if it is brought to a social workers' attention that a child's health and welfare is immediately and seriously at risk, the health board can apply to the court for an Emergency Care Order. This order allows the health board to care for the child for a period of eight days or shorter.

- Section 19 allows for supervision orders under certain circumstances. If the court grants a supervision order, the health board has to visit the child and/or require the child to attend assessments etc. This is a significant development, placing new powers and responsibilities on health board personnel.

- Section 37 places an obligation on the health board to facilitate reasonable access to the child by parents or significant others. It is the policy of the Eastern Health Board to promote access between the child and parents where this is in the child's best interests. However, the provision of regular access for children in care raises questions regarding staff time involved, costs of transporting children and the provision of access facilities. A number of Community Care Areas are reviewing their access arrangements and have proposed alternative models of service provision. The implications of this should be examined.

Sections of the Act enacted on 31st October 1995 also introduced new regulations in relation to children in residential care and foster care and those placed with relatives. These are discussed elsewhere in this document.

As was pointed out in this Review last year, the primary responsibility for investigating reported cases of suspected child abuse and of protecting the children concerned rests with social workers. It follows therefore that increases in the rate of notifications of suspected cases of child abuse will impact most directly on the social work service. Since 1992, there has been an increase of almost 63% in the number of referrals received in the region. This can be seen in the following Table:

Table 42: Reported cases of suspected child abuse in the Eastern Health Board region: 1992-1996			
1992	1993	1994	1995
1327	1376	1754	2159

The implications of this increase are considerable and should be discussed in relation to the effects of staffing shortages which compound these difficulties and which are discussed below. Whether or not a suspicion of abuse or neglect is ultimately confirmed or unconfirmed, each referral represents a considerable time investment, principally on the part of social workers. The ripple effect since 1992 of this huge increase in referrals must also be considered in terms of increased staffing requirements, support and training; resource allocation and the need for enhanced administrative services and infrastructure. At the same time, while the increased volume of referrals demands attention, there is a concurrent and urgent need for preventive services.

In the U.K., the Audit Commission (1994) undertook an investigation of community child health and social services. Referring to the rate of notifications of suspected child abuse, their report notes that social work practitioners in that country were "overwhelmed" and "over-burdened" and that "little time appears to be available for what is regarded as less crisis-driven work...". (p57) While the Audit Commission recommended that certain measures should receive attention in helping social work teams meet these demands, there can be no doubt that fundamental staffing levels must be addressed. In addition, the following are recommended by the Commission:

- Workload management and social work supervision
- The spread of resources between teams
- The duty system for receiving child care referrals
- The level and range of clerical and administrative tasks

It is recommended that resource allocation between Areas should be carefully examined in the light of agreed need criteria, as was highlighted in this Review last year. During 1995, the allocation of social work and child care staff was decided upon the basis of the known levels of deprivation in each Area. The appointment of the new Directors of Child Care and Family Support Services should continue to facilitate this process.

Review

This Review asked social work managers to evaluate their services in relation to a number of key issues which impact upon the quality of the service which they provide. A key element of this Review was staffing including recruitment, retention, induction, training and supervision. Clerical and administrative support was also evaluated as was interdisciplinary and interagency liaison and co-operation.

Recruitment

The availability of an adequate number of professionally trained social workers has proved to be extremely difficult in the Region in 1995 and vacancies exist in almost all Areas. It appears that the needs of the Board are not being met by the numbers of social workers being trained in the universities. In response to this, interviews were held in Britain during the year to recruit social workers for the most hard-pressed Areas and some Areas hold interviews in the universities. A small number of social work students are being sponsored and contracted to work in the region upon obtaining their qualifications. In spite of measures such as these, acute difficulties still exist. The Eastern Health Board has established a review group of personnel from Community Care, Personnel and Training Departments to explore resolutions to the problem. This Review urges that their recommendations are implemented as a matter of urgency. In addition, since retention of staff is as important as recruitment, it is recommended that a process of exit-interviews of all social work staff who resign from the Board should be undertaken. Should the rate of referrals of suspected cases of child abuse continue to rise, careful attention will have to be paid to the numbers of social work posts in the Region, even after the increased allocation of posts which came as a result of the Child Care Act.

Training

Training which was undertaken by Area teams during the year includes legal training; brief therapy; In Touch with Children; child abuse; the Child Care Act. A comprehensive training programme for all Team Leaders was commissioned by the Eastern Health Board and was implemented in conjunction with Trinity Colleges. Some Areas are resourceful in ensuring that

training takes place at least once a month at team meetings, with experienced social workers and child care workers being responsible for the provision of training inputs. Access to professional books and journals, which help to raise the levels of skill and knowlege, could be improved in some Areas. The allocation of places on training courses across Community Care Areas should be equitable and should take account of the varying numbers of social workers in each Area. The proposal to appoint a Training Officer for Child Care and Family Support Services is widely welcomed. A comprehensive, well designed and planned training programme is vital to maintain standards of practice. Its role in the maintenance of morale is also noted. The training programme should also ensure that the training needs of social work managers are met so that expertise in management is further developed. Management development programmes, which aim to develop the future cadre of managers of the service, should also be in place.

Support and Supervision

The appointment of additional Team Leaders in the Areas has been extremely valuable and has raised the quality and frequency of the support received by social workers. Social work managers report that it is now possible to provide more adequate supervision, particularly for inexperienced workers. They note that the appointments have also served to raise expectations of supervision. At least one Area intends to carry out an evaluation of the improved supervision ratio in the team. In the light of the increased number of referrals of suspected cases of child abuse, the level of supervision received by social workers in the region should receive constant attention.

The personal safety of staff should also receive attention, particularly in more dangerous areas.

Induction

Many Areas have devised comprehensive induction procedures for new staff. It is recommended that this is standardised across the region, with some of the induction taking place centrally. Some Areas are able to ensure that newly qualified social workers are given limited caseloads initially along with increased supervision and, in some Areas, group supervision. It is recommended that these mechanisms of support for new social workers be employed wherever possible.

Interdisciplinary Liaison and Co-operation

There is a recognition in some Areas that this could be improved, particularly in relation to the Public Health Nursing service. The increased number of

referrals to the social work service has made this difficult. Many Areas are hoping to hold joint meetings and workshops during 1996 to increase liaison.

Relationships with local Garda Siochana are reported by most Areas to be positive. Mutual expectations between some child psychiatric services and social work teams need clarification, as do expectations between residential care centres and social workers.

Administrative Support

Many Areas report improvements with regard to clerical support and the provision of fax machines and word processors. The active support of the Area Administrator is vital in this regard.

Service Initiatives

A varied range of service initiatives began in 1995. These include: the development of an After-Schools Project; Supported Lodgings; expansion of Family Support Workers; establishment of residential units to care for family groups of siblings taken into care; establishment of intake and assessment unit; group work with children; support group for parents of children who were sexually abused; extension of MOVE; expansion of Carers Scheme in many Areas.

In addition to the above a number of Areas report that considerable work has taken place in the development of improved intake sytems for social work cases.

Management Information System

Modern child care organisations have more complex management information requirements than heretofore, when manual systems of storage and retrieval of data sufficed. Now, managers require:

- instant access to current caseloads and client list
- instant access to data on foster families and residential units
- standardisation of recording methods
- elimination of time-consuming searches for records
- statistics and data for reports

In order to meet these needs, a Social Work Information System for Social Work Teams (SWIS) was designed by Eastern Health Board staff from social work, Community Care and Management Services. The design of the system reflects the needs of community based social workers, their managers and the

information needs of Community Care management and the Department of Health.

SWIS has been piloted in Community Care Area 9, and staff training there commenced in May 1995. To date, twenty staff members have been trained by the user liaison social worker who has been seconded for the project. A further social worker will be recruited to ensure final completion of the project by the end of 1997. Since July 1995, all new referrals to Community Care Area 9 have been put on the system. At the same time, social workers are transferring previous cases to the system. This has proved to be extremely time-consuming and the task has not yet been completed. Training has also proved to be complex: at the outset of training, participants have very different levels of existing computer skills. Training is modular, and initially takes place in groups, followed by individual sessions. It has been found that emergencies, duty and court appearances etc., can disrupt the training schedule. To date, evaluation has centred on participants' levels of confidence, their understanding of each module and the benefits of the system as perceived by them.

This Review recommends that when fully developed in Area 9 that a full evaluation of its benefits take place. The Audit Commission (1994), when reviewing services in the U.K., pointed out that collection and analysis of information should be used a a management tool to review and adjust service activity accordingly. Having gathered information on currenty activity, the Commission recommends that this can then be used to review activity and to develop strategies. In addition, in order to ensure that services become responsive to need, the Commission recommends that the path of individual children should be capable of "analysis and aggregation". (p60) The Commission also recommends that financial information should become sophisticated. This Review recommends that management information needs and systems within the Eastern Health Board be comprehensively reviewed.

Extension of SWIS

During 1996, SWIS will be extended to Community Care Areas 6 and 7. Staffing numbers are higher in these Areas and it is expected that training and full implementation in each Area will take approximately six months. In addition, new modules are being added to the current training programme in order to reflect the provisions of the Child Care Act.

Chapter 12

THE FOSTERING SERVICE

The Minister for Health introduced regulations in relation to foster care in October 1995. Of key importance in the regulations is the requirement to produce a care plan prior to the placement of a child. This care plan must then set out aims and objectives of the placement and arrangements for reviewing the plan. The regulations also lay down standards for reviews of placement. Emphasis is placed on including the views of foster parents, the child and parents. In addition, minimum standards have been set for the holding of reviews. A review must be held at least every six months in the first two years and at least every year thereafter. Minimum standards have also been set for visiting. A child in foster care is required to be visited at least every three months in the first two years and every six months thereafter. Similar regulations have been set for the placement of children with relatives. Under the regulations a relative can be any person who has acted in loco parentis.

The following table shows the number of children in foster care in the region on 31st December 1995 compared to those in foster care in previous years:

Table 43 : Numbers of children in foster care in EHB region 1993-1995 showing type of placement

Placement type	1993	1994	1995
Long term	542	547	557
Short term	215	271	270
Day foster care	75	73	45
Holiday/weekend	26	30	25
Sections 61/36 (with relatives)	37	52	111
Total	**895**	**973**	**1008**

While numbers in most types of fostering are either static or falling, the number of fostering applications by relatives, either under Section 61 of the 1970 Health Act, or more recently under Section 36 of the Child Care Act, has more than doubled in the past year. This is discussed further below when recruitment to fostering is examined.

Recruitment and retention of foster carers

There are 628 families involved as foster carers in the region at the moment. Serious difficulties exist in the recruitment of further numbers, particularly in some areas of Dublin and social work managers who were contacted in the course of this Review remarked on the recruitment problems which are experienced in a number of Areas. Steps which have been taken there to recruit additional families have not met with much success. Disincentives to fostering which are noted by managers include the level of payment, the level of challenging behaviour which many children now present, the changing role of women in society and the expectation among applicants of quasi adoption.

The Eastern Health Board region is not alone in experiencing a scarcity of foster families. Triseliotis (1995) points out that the recruitment of more foster carers has been the preoccupation of very many countries for a long time. Studies are cited by him which demonstrate that suitable placements for many children may be difficult, if not impossible to find. Other studies which he quotes also highlight a scarcity of foster carers with the necessary skills, especially for teenagers and children with special needs. This experience is borne out in the Eastern Health Board region where managers remark on the difficulty in recruiting families who were both suitable and prepared to endure at the task.

Historically, the provision of a financial incentive was not seen as important in recruitment; altruism was viewed as the primary motivation in the decision to embark upon fostering. A "reward" element in fostering allowances attracted suspicion, as did those foster carers who questioned the levels of those allowances. In Britain, as in other countries, falling numbers of foster carers forced policy makers to re-think these firmly held views. Recently, increased fostering allowances for children aged twelve and over were announced. This decision is in line with the recommendations made in the report by the Commission on Social Welfare which states in relation to child benefit:

> *"There is universally accepted evidence that the costs of adolescent children are significantly greater than the costs of younger children and infants. We therefore recommend the introduction of an age supplement in respect of all children aged 12 years or over or, alternatively, aged 13 years and over....We regard this supplement as a useful device for targetting expenditure on the basis of need....."* (p299)

Triseliotis concludes:

> *"It would .... be a very unusual foster carer who did not consider the question of rewards in a society whose emphasis is on allowing market forces to determine the value of goods and services."* (p39)

Social work managers in the region agree with this viewpoint. They repeatedly remarked on the unattractiveness of the payment for fostering and feel this contributes to the difficulty in recruitment. At the same time however, Triseliotis notes that on present evidence, the relationship between recruitment of foster carers and levels of rewards is still tenuous. A report of the U.K. National Foster Care Association quoted by him points out that it is resignations from fostering which should cause concern rather than recruitment and that four main reasons apply:

- the low level of allowances paid by some authorities
- the expectation of much more contact between children and their families
- the fear of being accused of abusing a child
- the pressure on social services budgets, and increased workloads from new legislation leading to some authorities cutting back on support for foster carers

Social work managers here make additional points regarding the ways in which the changing lives of women contribute to recruitment difficulties and that women's increased participation in the labour force is the principal factor in this. Fostering has often been seen by women as a chance to rear a "second" family when their own children were reaching a level of independence. Delayed childbirth, a trend which is noticeable in many Western societies, means that women do not have those years available to fostering when their children are "off their hands" while they still remain comparatively young. Private childminding, for which they may be paid £10-£12 per day, also presents a more attractive option, with fewer responsibilities and stresses. Such economic considerations are particularly acute in deprived areas.

The views of the Irish Foster Carers Association in relation to these issues are given below. It is clear that the Association is unhappy with the levels of fostering allowance and other related matters. This Review is aware that discussions are taking place at national level in this regard. In the meantime, it is recommended that the Association's suggestion regarding bringing greater clarity to the issue of entitlements to additional payments, perhaps through the issue of a booklet to both social workers and foster carers, be implemented.

The Association's recommendations regarding other supports should also be noted. Greater recourse to additional help such as training in behaviour management, respite care, laundry service and access to care workers for particularly difficult children should be available. In this way, the need to retain foster carers, as highlighted by Triseliotis, might be met.

Table 44: Fostering Applications in EHB region 1990-1995

Year	Number received
1990	129
1992	170
1994	177
1995	255

It can be seen that the rate of increase of fostering applications is growing very slowly. This is in contrast to the growth in the number of children who are placed with relatives as was shown above. It was pointed out to this Review that applications from relatives are as demanding on social work time as any other, since the same level of assessment etc must be undergone as with any other fostering application. The resulting fostering "capacity" of that family is extremely limited however, as their application relates only to a particular child. Fostering applications from the general public on the other hand, represent a potential capacity to foster very many children.

The low number of fostering applications is in contrast with high numbers of applications for both foreign and home adoptions. It is clear from this contrast that the temporary nature of fostering and the high levels of contact which children maintain with their birth families are even further disincentives to fostering.

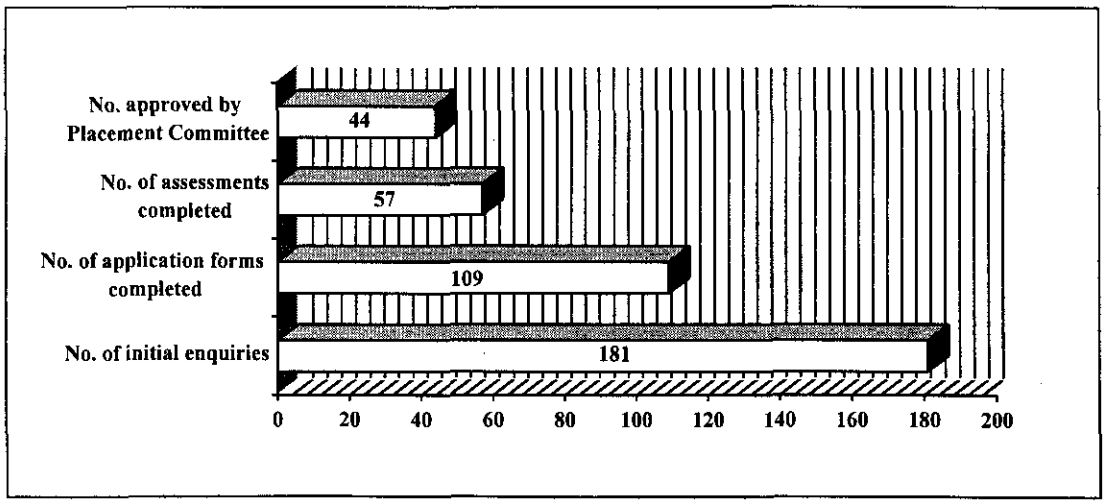
Recruitment to fostering in the region now takes place on a local Community Care Area basis. During the year, many Areas ran fostering recruitment campaigns and the disheartening experience of one Area is described by the manager:

> *"A local campaign was held in February/March 1995 and this included producing a video. 46 enquiries came as a result of this campaign, four of whom were from this Area. A public meeting was attended by eleven people, five of whom were from this Area. From these, we got three applications. Two subsequently withdrew, and the third is in the final stages of assessment. It appears that this application will be a resource for two children in long-term care."*

Another Area manager reports:

> *"Nine thousand leaflets on fostering were delivered to the homes in the Area through primary schools and An Post. Local newspapers were also asked to print articles on fostering. Four public meetings were held, two at night and two coffee mornings during the week at different venues. The meetings had a very poor attendance. Sixteen enquiries for follow-up visits resulted from this campaign. All of these follow-up visits have been done. At this time, there has been no applications made."*

A major national fostering campaign is planned to take place shortly. It should be noted that speed is of the essence in following up applications from such campaigns. As Triseliotis warns: *"In order not to lose these potential recruits, social workers need to respond quickly. They need to be at the end of a telephone."* (p43) He also quotes two studies which each point to the importance of increased fostering allowances in retaining applicants. The first, from the U.K., claims to have found that higher allowances resulted in a greater proportion of approved families who proceeded to take children. The difficulty experienced in retaining applicants and in processing these to the final stage of approval by the Placement Committee is shown in the following figure which gives data for 1995 from the six Community Care Areas which provided detailed information to this Review:



Supporting foster carers

An American study showed that the drop-out rate of foster carers is significantly reduced when they are better paid, better trained and better supported by the agency. Triseliotis concludes that social service agencies should concentrate on supporting existing carers in order to retain them, rather than continued new recruitment.

The need to support and retain existing foster carers is recognised by social work managers. However, Areas differ in the range of support options which they list as being available. These include the provision of home helps; family support worker; child care worker; counselling; help with the cost of child minding and some limited recourse to respite care. Of the Areas which provided detailed information, it is notable that those which experienced least fostering breakdowns during 1995 were those which listed the most comprehensive range of support services which they offer to foster carers.

Breakdown of placement was seen by social work managers as being attributable to three main causes: recruitment of foster carers; recruitment of social workers and lack of support services. Foster parents appear to experience difficulties in coping with the behaviour of a number of teenagers; in these cases, greatly increased social work support may be needed which may not be possible for hard-pressed teams to provide. Difficulties in filling social work posts, discussed elsewhere in this document was mentioned also in this regard. This also contributes to the difficulty in achieving the number of reviews of children in foster care which is required by the Child Care Act. Children being retained in short-term placements beyond agreed time scales is another factor contributing to breakdown and one which can only be addressed by improved recruitment and retention of foster carers.

Carers

A Carers scheme is in operation in the region to meet the special needs which some children in care present. Carers are foster families who are specially trained and who are paid an enhanced fostering allowance to care for children whose placements in other foster families or group homes have not been successful. Recruitment to the Carers scheme in 1995 is shown in the following Table:

Table 45 : Applications to Carers and Emergency Carers Scheme: 1994-1995

Number of applications 1995	38
Approved : Carers	2
Approved: Emergency Carers	17
Shared Rearing	5
Carers for specific children	7
Total approved 1995	31
Total approved 1994	7

Irish Foster Care Association

As part of the process of conducting this Review, the views of the Irish Foster Care Association were obtained regarding the adequacy of the fostering service. These are given below. (It should be noted that this submission was received in advance of the announcement of the increase in fostering allowance for children aged twelve and over, the impact of which has yet to be analysed.)

Fostering Regulations

The Association welcomes the new regulations which have been issued regarding fostering. As participants in drawing up the regulations, the Association welcomes their clarity with regard to the respective duties of health boards and foster parents alike.

The most important change which the regulations bring and which are welcomed by the Association, is that relating to the formulation of care plans for each child. This will state the reason for the child being in care, the type of care required, the supports which the carers will require and details regarding access arrangements etc. As this document will form the basis of all future reviews of the child, the Association feels it will ensure that the aims of the placement are not forgotten. In this way, the continued suitability of the placement can be monitored so that the child is assured of the best possible placement to meet his or her needs. It is hoped that the new regulations will be adhered to by all to improve the overview and management of every placement, especially of those children who are taken into care on a regular basis.

Fostering allowance and methods of payment

Great dissatisfaction with the level of the Fostering Allowance was expressed by the Association. The "anger and frustration" of foster parents with the current allowance is voiced at their meetings. A research document has been circulated to all health boards pointing out the need for an improved allowance and the possibility of paying this without including a "payment" or "reward" element. The Association points out that many families are hard pressed economically; many women are going back to work in response to this and families find that in these circumstances fostering allowances do not represent an attractive alternative. While difficulties have been experienced in recruitment of fostering families, the Association remarks that happy, supported foster families are the best advertisement for fostering. Otherwise, they fear that recruitment to fostering will become even more difficult.

The Association is unhappy with the way in which foster parents are re-embursed for items which they purchase for children in their care. They find the system of receipts cumbersome, time consuming and embarrassing. It is felt that a more adequate system of allowances would negate the need for the current system of repayment for out-of-pocket expenses. In addition, they recommend that all social workers and foster parents are issued with a booklet which lists all the entitlements of foster parents.

Foster children

Foster parents are noting that children are presenting with much more challenging behaviour than previously, more are showing signs of psychological damage and more are disclosing previous abuse which they have experienced. In order to cope with these children, the Association highlights the need for foster parents to be resourceful, patient and above all to be well

trained, both before and after placement of a child. Such training is vital to help foster parents stay in touch with new methods and techniques for coping with difficult behaviour.

In addition to training, practical support would be welcomed, such as a laundry service when an individual child has a bedwetting or soiling problem. Other supports such as respite care and the provision of child care workers in the home for extremely difficult children would be welcome.

Full information regarding the child is also essential. A pre-placement assessment of the child, with a full report being given to the foster parents is also seen by the Association as vital for a successful placement. Other details, such as fears, illness, dietary requirements, history of abuse etc are also essential. In the words of the Association: *"It is vitally important to a successful placement that the foster parents have as clear a picture as possible of the child they are to care for if they are to do well."*

Access

Access by children to their parents is seen by the Association as vital, even if it is not expected that the child will eventually return home. Such access visits should be as natural and fulfilling as possible. Currently, many visits take place in a health centre: unnatural settings like these make the child's parents nervous and this in turn is sensed by the child. Alternatively, children may meet their parents in a cafe; a "party" atmosphere ensues which may give the child unrealistic or fantasy ideas about their parents. In addition, this arrangement may be expensive for all concerned. Instead of these arrangements, the

Association recommends that where possible, visits should happen in the natural parent's own home. In this way, the parents are comfortable in their own setting; a meal can be cooked for the child and the child then retains realistic ideas of their own family. The Association points out that every effort should be made to ensure that contact with natural parents is a positive, happy and realistic experience for all concerned, but especially for the child.

Liaison and co-operation

The Association recognises that while social workers have professional qualifications, foster parents in turn have a wealth of information about each child in their care. In this way, the potential for partnership between social workers and foster parents is very great and this operates in practice in most situations. Some cases have been reported, however of foster parents feeling undervalued.

Placement breakdown

The Association is about to undertake research into the cause of placement breakdown in fostering and would welcome the assistance of the Eastern Health Board in this regard. Ideally, they feel that health boards should have three families from which to choose in selecting a foster placement in order to enhance the chance of a placement's success. Information which the Association has gathered to date suggests that when foster parents sense that a placement is in difficulty, problems become compounded and frustration mounts as the foster parent is not empowered to call a review. It is recognised that the new regulations may help in this regard. In addition, the level of the fostering allowance is again noted by the Association; families fostering children over the age of ten may be under financial strain which they are reluctant to discuss with their social worker. Training and assessment are again mentioned in this regard, especially in the case of very difficult children.

Conclusion

The Irish Foster Care Association points out that foster parents are providing an exceptional service on a voluntary basis and must be valued and treated with respect. The Association is willing to join with others to promote foster care and to support members.

Summary

The Eastern Health Board plans a major, professional recruitment campaign in 1996. Should this fail, and if the support and retention difficulties discussed above are not addressed, it is clear that the needs of children cannot be met.

The major difficulty, such as recruitment, appear so far to be outside the control of the Eastern Health Board and would require cultural and societal change and commitment in order to provide children with safe, suitable alternative families. Retention of existing foster families through enhanced support must become a priority. Failing this, it is clear that other options will be required such as increased residential care provision and greater levels of support to keep children at home must be relied upon. Experience abroad, such as Strathclyde's use of very short term respite care should also be explored. Throughout the discussion, the importance of early intervention for children at risk must not be forgotten.

Chapter 13

RESIDENTIAL CARE

The Minister for Health introduced regulations in relation to residential care in October 1995. Of key importance in the regulations is the requirement to produce a care plan prior to the placement of a child. This care plan must then set out aims and objectives of the placement and arrangements for reviewing the plan. The regulations also lay down standards for reviews of placement. Emphasis is placed on including the views of the child and parents. In addition, minimum standards have been set for the holding of reviews. A review must be held at least every six months in the first two years and at least every year thereafter. Minimum standards have also been set for visiting. A child in care is required to be visited at least every three months in the first two years and every six months thereafter.

The regulations also set out standards in relation to care practices and operational policies, staffing, accommodation, access arrangements and record keeping. The regulations only apply to residential centres operated by, or on behalf of, a health board. They do not apply to institutions run by, or on behalf of the Minister such as a residential school for the hearing or visually impaired. Neither do they apply to institutions covered by the Mental Treatment Act.

Health Boards are obliged to inspect the standards of the residential centres which they fund. To this end, the Eastern Health Board will be establishing an inspectorate service during 1996. Likewise, the Department of Health will inspect the standards within centres run directly by health boards.

Placements

During 1995, the Eastern Health Board experienced difficulties in securing placements for all children. This was due to a number of factors. The closing of Madonna House which had catered for large numbers of children, impacted heavily upon the service, particularly in finding placements for smaller children. The recruitment difficulties which were experienced in foster care and delays in processing applications to fostering because of staffing shortages also contributed. In addition, the challenging behaviour displayed by some children made their acceptance by residential units difficult to obtain. This Review last year recommended that a Task Force be established to determine long term care needs for the region and to develop a strategic plan to meet these

needs. It is understood a review group has been newly established to undertake this task. Their recommendations are urgently awaited.

Notwithstanding the findings of the review group, significant service developments have taken place in the meantime. In the past year six long-term units were opened, four of which provide care for children who had been in Madonna House when it closed. Most of these new units care for sibling groups. This is a major service initiative by the Board in which it will directly manage the units in order to enable family groups to remain together while in care. A number of individual residential arrangements were also made during the year. These reflect the trend towards children in care requiring specialised, intensive care and support because of their level of disturbance and difficult behaviour.

A small crisis centre for 0-12 year olds is planned. This will provide short-term care for children while their situation is being assessed and while more long-term plans for their futures are being put in place. Posts for this unit have been advertised and properties are being identified.

High Support Units

In 1995 the High Court ruled that the Eastern Health Board did not have the authority to detain children or young people. However the High Court did issue orders in relation to individual children who were declared to be out of control and who should be detained in their own interests under a regime established according to psychiatric or medical advice. Suitable arrangements for the education and therapeutic care of the children were to be provided. Pending the introduction of new legislation to permit the provision of secure units by health boards, the legislation under which the children were to be detained was Section 58(4) of the Children's Act 1908 which established industrial schools.

Two units will be opened to comply with these orders, one in Dublin and the other in Co Wicklow. Eight children of mixed gender will be cared for in one of the units while the other will care for four. The opening of these units represents a completely new service provision requiring great care and thought. Suitable premises can be difficult to locate for such service and acceptability to local communities ensured. Because of this, existing premises have had to be adapted, thus increasing management difficulties regarding the care of these children. A shortage of suitably experienced and qualified staff was also experienced, delaying the planned opening.

Provision has been made for good staffing levels: a manager has been appointed to each unit along with deputy managers. The units will have 28

staff in total. Secretarial and housekeeping staff are also being employed. It is hoped that a psychologist will be assigned full time to the units and input from the child psychiatric service is also planned. Other specialist staff in drama, art therapy and recreation will be employed as required.

Agreement has been reached with the Department of Education to provide full time educational facilities on site in both centres and the units will each have fully equipped indoor and outdoor leisure facilities.

Children will only be admitted to the units on the basis of very strict criteria. They will have a comprehensive assessment before placement and will be admitted only after individual application to the High Court, pending the introduction of legislation.

Frequent internal and external reviews of each child in the units are essential and the new regulations which govern residential care will also be applicable. Detailed policies will be in place before the admission of the children.

An even greater degree of containment will be required for a certain number of children and a project group has been set up to prepare a planning brief for a purpose-built close supervision unit. A consultant was appointed by the Eastern Health Board to research facilities and experience both in this country and in the U.K. The project team will report to the Department of Health in May. Detailed costs of these units have yet to be elaborated, but are expected to be considerable.

Review of adequacy of residential care

The board is continuing its review by a Head Social Worker of the quality and adequacy of the standards of residential centres for children in the region.

In 1995, the Department of Health circulated draft guidelines to standards in children's residential centres. These guidelines formed the basis of the review this year and a summary of this is given below.

Statement of purpose and function

Almost all residential centres for children have a statement of purpose and function. Many could be now updated in light of changing circumstances and to reflect the changed guidelines. Clear written information should be developed for the parents of children in care and for the children themselves.

Respect for child's dignity and individuality

Most Residential Centres strive to enable children to exercise choice across a range of daily living skills such as buying clothes, use of pocket money, menus etc.

The child's right to be heard

It is important that children's views and opinions are sought on the major issues affecting their lives. Efforts are being made to involve children in their reviews but the process of these could be changed to make children's participation easier and more meaningful.

A number of centres have developed the format of children's meetings as a forum in which complaints can be heard. This is undoubtedly useful but differing age groups within one Centre and the consequent differing levels of ability to participate, can make such meetings difficult. There is a need to strive constantly for informal systems of complaint which can be dealt with easily and where possible, by one person.

Preserving the child's sense of dignity and identity

The draft standard states "In keeping with the child's continued development of a sense of identity, is the need for family involvement." An adequate response to this demands that access facilities in many children's residential centres and health centres need to be upgraded. Additional resources should be available to both residential centres and social work managers to facilitate family contact. As far as possible the concept of shared rearing between parents and care staff must be developed. While examples of good practice exist , for many parents and children contact means only either a treat or tense, artificial visit. This is discussed further below.

Education

Many children in residential care are extremely disadvantaged educationally. Residential centres make great efforts to assist children with homework through the provision of study areas and grinds and by maintaining close liaison between school and care staff. Because of exclusion policies in schools as a response to difficult behaviour, a number of children are effectively excluded from the educational system.

Some residential centres link the admission of a child to the requirement that the child should have a school placement. Where no school can be found for a child, individual tuition based in residential centres should be provided while a

school place is being sought. This response should be sufficient to ensure a child can avail of a residential place. This Review notes that meetings are taking place with the Department of Education at senior level to explore the means by which children can be guaranteed such tuition. A satisfactory solution to the problems of educational provision for children in care is urgently required.

Health Care

Residential care does provide opportunities to ensure that children in care can avail of medical, dental, ophthalmic and other services as required. Clearer policies are required in a number of areas, particularly in regard to smoking and alcohol.

Anecdotal evidence suggests that many children in care prefer a female general practitioner and where possible this should be provided.

Approaches to issues such as sex education and drug abuse should form part of the daily living of residential centres as well as particular programmes being used with children and staff as appropriate.

Child Protection

Residential centres are developing child protection procedures but the degree to which health board staff are involved in these varies considerable across Community Care teams. The new child protection protocol which the Eastern Health Board is preparing should be of assistance in developing a standard response.

Staff in most residential centres are extremely aware of the possibility of allegations of abuse. Many centres have taken steps to ensure the protection of children and staff, e.g. this may involve two members of staff, preferably one male and female, working the same shift along with clear guidelines about physical contact with children.

Meeting with social workers provides children with another outlet outside of the residential centre. However, this contact continue to be uneven and may be dependent on pressure of workloads within the Community Care teams.

Many group homes have children of varying ages. This can work well as it resembles the make up of many families. However, difficulties have arisen when the lifestyle of older teenagers has created risks for younger children particularly in the area of drug and alcohol abuse. Where such a mix of

children exists, extra care is required and it is essential that planning for independent living and aftercare takes place and is acted upon.

Sanctions policy

Centres are developing their sanctions policies in response to the very great level of difficult behaviour which some young people present. The involvement of the health board in this process is variable and depends on the health board involvement in the centre as a whole.

The past two years have seen an emphasis on assisting staff to manage challenging behaviour with a variety of training programmes. Corporal punishment is agreed to be unacceptable. Milhous et al, suggest that the threat of transfer or the threat of removal to another residential setting is also unacceptable. They continue "that while group punishment can be effective in checking a general drift of indicipline its use to get an individual to own up to a misdemeanour is not warranted". They note that it is the ethos of the establishment which effectively controls restraint on members, by fashioning a system of held expectations, values and norms of conduct. While there is no prescription for creating the perfect residential centre, five features are suggested which seem to be common to all successful establishments and it is worth stating them here:

1. Young people should feel enriched by the residential experience.

2. They should see themselves as acquiring clear instrumental skills.

3. The establishment should pursue goals which are matched to the needs which necessitated absence from home rather than those brought about by living away.

4. There should be consensus among staff, children and parents about what these goals should be along with clear and consistent leadership.

5. The establishment should make efforts to fragment the informal world of children for example by creating small group situations.

Personnel Policies

The Department of Health guidelines requiring Garda clearance for all new staff of children's centres has been implemented and the extension of this process to include all volunteers and temporary or casual staff is recommended.

There is a room for some improvement in the lines of a communication and accountability between staff and management of children's centres. Where centres employ directors as well as senior house parents, the responsibility for supervision of staff needs to be explicit.

When the manager of the centre is not present, there is scope for delegating more responsibility to the most senior person. If overused, the system of 24 hour call can be too demanding for the Managers.

Staffing

Inadequacies in staffing levels in residential centres in the region have been addressed in the past two years. A number of centres still require an increase and this is being addressed.

Anecdotal evidence suggests that children and young people often find it very difficult to cope with large numbers of staff and children have commented on how constantly arranging shift systems can impede developing close relationships between children and staff.

Occasionally centres still request additional staffing for short periods to cope with particularly difficult situations and this may be appropriate in certan circumstances. However, since many behaviour difficulties come about as a result of unmet needs, it is time to look at how the needs of children can be met in the residential care system through the new mechanism of care plans and reviews.

As stated above, a number of residential centres and Health Board staff - both administrative and social work - need to work more closely on developing policies such as the purpose of the centre and on child protection policies.

Physical aspects of the home

Generally the basic standard of furnishing and decorating in residential centres is adequate. Improvements could be made in making communal areas more attractive and more homely. In centres providing more long term care, children have often stamped their identity all over their bedrooms. This can be more difficult to achieve when in short stay units.

Access facilities for children to receive visits particularly from family are often inadequate. Access visits can present difficulties for residential centres: managers note that they can cause strains within the centre, placing additional demands on staff if the visits need to be supervised. There is also an impact for children who are not visited regularly or at all and occasionally there can be

embarrassment for children who are being visited. Notwithstanding these difficulties, accommodation and resources need to be improved both in residential centres and in health centres to facilitate regular contact between children and their families as was pointed out above. Given the large number of children who eventually return to their families from care, the need to develop contact cannot be overstated.

The regulations requiring that non toxic fire retardants for soft furnishings are used wherever possible will have a cost implication for centres and the health board.

Records

Records in residential centres should be standardised to allow for summarised account of a child's progress on a monthly or quarterly basis to be available. The development of care plans requires that records are in a format which assists in reviews of children in care.

Preparation for leaving care

While great care is usually taken in admitting children to centres, this attention now must be extended to their discharge from care. The requirement to develop care plans and to hold regular reviews should assist children in making a smooth transition to home or to independent living when they leave residential care.

Development of such schemes as Supported Lodgings have been successful for some children in moving towards independent living. However, the amount of assistance and support these young people continue to need cannot be overstated.

Many residential centres are in contact with numbers of young people years after they leave care. This can put strains on the staff to meet the needs of the children currently in their care and must be carefully managed. Some centres have structured their service to meet this need so that it does not compete with the demands of the children currently in care.

Conclusion

Residential centres and the Eastern Health Board have spent much needed time and resources on improvements to children's residential centres in the past few years. The improvements in the physical standards and staffing levels, together with the reduction in the numbers of children in any one unit, being the most notable results.

It is time now to focus on the actual experience of the children and families who are using this service and to start critically evaluating the impact of all of our care policies and practices in relation to the outcomes for children.

Chapter 14

THE OUT OF HOURS SERVICE

Referrals

There was a slight increase in demand on the Out of Hours Service in 1995. Referrals to the service totalled 1,636 during the year, compared with 1,554 calls in 1994. The referrals concerned almost equal numbers of males and females, but differences in age groups are noticeable. The details are given in the following Table:

Table 46: Referrals to the Out of Hours Service in the Eastern Health Board region in 1995 showing age and gender

Age	Male	Female	Total
Under 12			142
12-16	417	401	818
16-17	295	328	623
Over 18			28
Total	**712**	**729**	**1611***

*Details were not available regarding 25 referrals

As the provision of an Out of Hours service is still relatively new, it is perhaps too soon to see any trends in referrals. It should be pointed out however, that there was a decrease of 135 referrals in the 12-16 year age group when compared to 1994 referrals. Most of this decrease is seen in the reduction of referrals of boys. At the same time, there was a striking increase in the number of referrals from the 16-17 age group. This rose by 236 and the majority of this increase related to males.

Table 47: Referrals to the Out of Hours Service 1994 and 1995 showing age and gender

Age	Male		Female	
	1994	1995	1994	1995
12-16	533	417(-116)	382	401(+19)
16-18	180	295(+180)	272	328((+56)
Total	**713**	**712**	**654**	**729**

Source of referrals

Clear differences between the level of referrals from different parts of the region can be seen and these are demonstrated in the following Table:

Table 48: Referrals to the Out of Hours Service by Community Care Area 1994 and 1995

CCA	1	2	3	4	5	6	7	8	9	10
1994	145	55	81	217	149	328	282	71	15	75
1995	110	43	99	210	239	272	328	109	15	57

Once more, the levels of deprivation in Community Care Areas 4, 5, 6 and 7 are reflected in the high numbers of young people in those areas whose lives reach a position of acute crisis, requiring intervention out of hours.

Legislative provision for emergency care

New sections of the Child Care Act, enacted on 31st October 1995, give obligations and powers to health boards to take children into care. The Out of Hours Service and Community Care Area social work teams can use these new sections as follows:

- Section 4 allows voluntary care agreements to be reached with parents. If at all possible, social workers attempt to obtain the consent of parents to voluntary care agreement, rather than to have recourse to the courts.

- Section 12 gives powers to Gardai to intervene where there are suspicions that children are at serious risk of neglect; the child is then handed over to health board social workers as soon as possible.

- Section 13 allows for Emergency Care Orders: if it is brought to a social workers' attention that a child's health and welfare is immediately and seriously at risk, the health board can apply to the court for an Emergency Care Order. This order allows the health board to care for the child for a period of eight days or shorter.

The Out of Hours Service was initially established to provide a service for those aged over twelve years. Sections of the Child Care Act enacted on 31st October 1995 extended the obligation of health boards to provide services for all children. Funding to expand the Out of Hours service to meet this obligation has been provided. A social work manager has been appointed to lead the proposed expanded service. Three additional Team leader posts were

also approved but it has not been possible to fill these posts as yet. A new emergency residential unit with up to fourteen places which can be accessed by the Out of Hours Service, along with the day service was opened in January 1996. This unit is discussed elsewhere in this document. A particular difficulty in relation to the provision of accommodation of children under ten remains. The recruitment of foster parents specifically for this group is planned. In addition, it is intended to commission a unit in 1996 for these younger children where it has not been possible to place them with foster families.

Emergency Care and Accommodation

To remedy this situation, emergency residential unit provision is planned and this is discussed elsewhere in this document. The need to develop a "bank" of emergency foster families for the Out of Hours service is also apparent. The difficulties in recruiting suitable families for this undertaking should not be underestimated. These families must be able to cope with very young children who may be very distressed and with little prior notice or information.

Conclusion

This Review recommends that the service is fully developed as soon as possible to meet the need for a service for all children which occur out of hours.

Chapter 15

HOMELESS AND OUT OF HOME YOUNG PEOPLE

The Child Care Act placed an obligation on health boards to enquire into the circumstances of young people who are homeless and to provide accommodation for those who, in the opinion of the Board, have no accommodation which they can reasonably occupy. There can be no doubt that this is an onerous and complex obligation, the discharge of which, and the prevention of the circumstances which give rise to it, are complex and multi-faceted. Professionals who work with this group of young people prefer to describe them as being "out of home" rather than "homeless": the former description recognises the fact that family links remain important for the majority of young people who present to the Board's services and recognises also that their families in turn love them.

It should be noted that more than 55% of young people who were placed in bed and breakfast accommodation during 1995 came from Community Care Areas 4, 5, 6 and 7, the Areas in the region which experience the most acute deprivation. The link between deprivation and being at risk of being out of home is clear. Although it was addressed in detail in this Review last year, it must be repeated that whether "homeless" or "out of home", the phenomenon does not have one single cause; policies in education, housing, social welfare, employment and training all play their part. The importance, too, of early childhood intervention should also be stressed and recommendations in this regard are made elsewhere in this document and were addressed in detail in the Review last year.

The complexity of the issue is compounded at the moment by demographic pressures. The region is currently experiencing a bulge in its adolescent population - the age cohort most at risk of being out of home. The Child Care Act also extended health boards' responsibilities towards young people until their 18th birthday, further enlarging the cohort and the impact of this extension upon services has been felt.

Care Services for homeless and out of home young people

In 1995, the Eastern Health Board experienced difficulties in placing a number of young people, especially those whose placements in other caring facilities had not been successful in the past, and who presented with challenging

behaviour. In addition, professionals working in the field report that the growing problem of drug abuse in this population is presenting major new challenges for the Board's services and this group will require substantial additional resources in the years ahead. Young people who are misusing drugs find great difficulty in concentrating and in adhering to behavioural norms of group homes. They have difficulty in engaging in the solutions to their problems which are presented to them. Both of these issues have profound implications for the provision of an adequate service and should be addressed.

In order to reduce the numbers of young people being placed in bed and breakfast accommodation, an emergency short-term unit residential for 12-18 years olds has recently opened. This unit cares for up to fourteen young people who present with challenging and "streetwise" behaviour and who have experienced a number of placement breakdowns. Experience with this group of young people to date has shown that their misuse of drugs has had a profound effect on their lives and presents serious management difficulties to units which attempt to care for them. In future, protocols must be developed to clarify the ways in which such young people can be cared for. The Board is faced with the responsibility for caring for young people, whether or not they misuse drugs; at the same time they have an equal responsibility toward young people in units who do not misuse drugs.

Because of the difficulties experienced in placing young people, recourse was made in the past to bed and breakfast accommodation. In order to eliminate its usage a number of service initiatives were put in place which are outlined below. Consequently, by January 1996 only three young people remained in bed and breakfast accommodation and plans are in place for each of these young people. The reduction in the use of bed and breakfast can be seen in the following Table:

Table 49: Number of young people in bed and breakfast accommodation in EHB region 1994 and 1996

May 1994	44
December 1994	31
January 1996	3

A range of important measures have been put in place to bring about the reduction noted above. One unit was opened which provides accommodation for young people as discussed above. This is staffed by child care workers and access is gained by referral through Community Care Area social work teams and the Out of Hours Service. Supported lodgings are being developed in all Community Care Areas as shown in the following Table:

Table 50 : Supported Lodgings in each Community Care Area showing number of service providers and number of young people.		
Community Care Area	**Number of young people**	**Number of service providers**
1	13	11
2	2	1
3	Nil	Nil
4	2	Nil
5	8	5
6	12	6
7	7	7
8	10	10
9	6	4
10	6	6
Total	**64**	**46**

High levels of satisfaction have been expressed with this initiative. Supported lodgings give added flexibility to the range of placement options available to social workers. The above Table also shows that in the majority of cases, Supported Lodgings help to maintain young people in their area of home origin. In this way, their contacts are maintained with family, friends and social worker and, where applicable with school, training or employment. The city-centre's "culture of homelessness" is also avoided. It is also found that Supported Lodgings give an element of independence to young people which they appreciate but provide support at the same time.

A further initiative which has been expanded is the Emergency Carers project. Through this, a specially selected and trained range of foster families provide care on an emergency basis for young people in crisis. An enhanced rate of payment is made to these families. In addition to these facilities, a number of hostels, managed by voluntary agencies and funded by the Eastern Health Board, continue to provide care for young people who are out of home. These include Focuspoint's Off the Streets project which is further discussed below, Crosscare's hostel in Eccles Street and Sherrard House. The Eastern Health Board also intends to provide additional units for these young people. Expansion in the residential care sector was also a factor and this is discussed elsewhere in this document.

Day project

The Day Project further expands the range of support services offered to young people. Staffed by child care workers and a social worker, the Day Project offers care, welfare and recreation support to approximately ten young people

who are considered to be at risk during daytime. Consideration is being given to opening the Project on a 7-day week basis. During 1995, the Project had to move to a less central location. This new temporary location is far less convenient for the young people and it is hoped that a more suitable premises will be acquired as soon as possible. The staffing numbers of the Project were enhanced during 1995 and this has enabled the Project to develop a strong commitment not to exclude young people whose behaviour is very difficult.

Education

Because it was found that young people who are out of home have experienced disruption in their education, the Eastern Health Board has funded St Vincent's Trust to include out of home young people in the training opportunities which the Trust offers. The Trust reports that young people attending the centre have had an unsatisfactory experience of school: 67% of their trainees either dropped out or were expelled from school before the age of fifteen; 90% left school before the age of sixteen and 82% have never sat a state certificate examination.

Education programmes in the centre address literacy and numeracy problems and Junior Certificate and City Guilds Certificate programmes are taught. Vocational training also takes place in the form of computers, woodwork, office procedures, knitting and catering. A contract has been achieved from a Dublin department store to supply knitted garments to a high standard while catering students obtain CERT VPT1 qualifications.

The profound nature of the problems experienced by the young people attending the Trust can be seen in the following: 49% displayed behaviour problems, 47% experienced emotional difficulties and 39% had been involved in substance misuse. Psychological intervention is therefore required in order to meet these needs of the young people; in the past, access to assessment and counselling services proved extremely difficult. The Trust has therefore established an internal service which is staffed by a social worker, a parent's outreach worker and a part-time psychologist.

Given the enormous difficulties faced by these young people, and their negative school experiences it should be noted that in the last year for which figures are available, fifteen trainees sat the Junior Certificate examination. All passed.

Social Welfare

Last year this Review pointed out that the centralised system of payment of Supplementary Welfare to young people was causing concern. It was feared that mixing with the adult homeless population in Charles Street was putting young people at risk of becoming enmeshed in the culture of homelessness. As

a result of this, a joint working party of social work managers and Superintendent Community Welfare Officers has been meeting to examine the existing payment system. Agreement in principle has been reached to decentralise the payment system as a result of these meetings.

Care and aftercare

Young people who have been in care are at great risk of being homeless and three factors contribute to this. As was pointed out in the Review last year, it appears that the lack of autonomy which children experience on being taken into care and being reared in care, puts their chance of successful independent living at great risk. In addition, the severance of their links with their families means that they often cannot turn to their families for support in their attempts to live independently. Finally, it must also be recognised that the vast majority of young people from intact families are not expected to display fully independent living skills at the age of eighteen. This Review recommends that each group home be encouraged to develop intensive planning for aftercare with each young person in their care. The Eastern Health Board should consider a centralised training programme for managers of group homes to provide impetus to such an initiative.

Partnership with voluntary agencies

The Health Strategy *Health for All* has emphasised the important role which voluntary agencies can play in the provision of services to help achieve health and social gain. The Strategy states:

> *"The voluntary sector plays an integral role in the provision of health and personal social services in Ireland which is perhaps unparalleled in any other country. Traditionally, voluntary organisations have been to the forefront in identifying needs in the community and developing responses to them. Their independence enables them to harness community support and to complement the statutory services in an innovative and flexible manner."* (p33)

An example of the complementary nature of statutory and voluntary service provision can be seen in the services for young people who are homeless and out of home described in this chapter: services provided by the Eastern Health Board are discussed, along with those provided by St Vincent's Trust and others.

Focuspoint

Focuspoint is an important provider in this regard and has provided the following description of some of the services which they provide:

Community Homemaking Service for Youth

Background

This new project, which will be operational in 1996, arose out of the need to provide a home-making settlement service specifically targeted at young homeless people.

Service objectives

The specific objectives of the service are as follows:

1. To maintain and sustain single people in accommodation with a view to their long-term settlement.

2. To provide support on a number of different levels: a)Practical: money management; welfare; entitlements; furnishing; budgeting; cooking; b) personal and emotional c) Educational and vocational; d) Leisure; e) Link into community (church, club,football etc) and/or specialist services (addiction counselling etc) as appropriate

3. To primarily work with young people in an individual, relationship-based way and also to undertake some group work where appropriate.

4. To identify the individual needs of young people and work with them in a youth centred "developmental" way.

5. To liaise with other voluntary and statutory agencies on the young person's behalf.

Target Group

Young people (both male and female) aged 17 - 21 years. Particular attention will be given to young people leaving hostel accommodation who are in the process of settlement in their own accommodation.

Accommodation Finding

The homemaker will not have a role in accommodation finding for young people. This task will be undertaken by the referring agent (i.e. relevant hostel or other agency).

Group Work

The homemaker will undertake group work where feasible and appropriate, particularly in relation to life, social and practical skills.

Caseload

The homemaker will have a maximum caseload of 7 cases at any one time to ensure that the homemaker can give adequate service to each young person.

It is envisaged that the Homemaker will work afternoons and evenings. The importance of time spent with each young person is that it should be "quality time".

Referral/Assessment

Information on the proposed new service to be sent out to other agencies, in particular to young people's hostels. The intention is to make the process young person friendly (i.e. careful re terms and language used).

Stages **1** Referral form sent out to relevant hostels.
2 Referral form returned with potential candidates for service.
3 Three way meeting between referral agent, young person and Homemaker.
4 Decision to offer service in consultation with Focus Point Co-ordinator/Manager.

Duration of Service

Maximum of one year but acknowledgement that some cases may need a shorter period. This will obviously impact on throughput of cases over a year.

Phases of service could break down as follows if young person avails of it for a year:

(i) relationship building (3-4 months)
(ii) working with young person on practical and emotional issues (5 months)
(iii) wind down and phase out (2-3 months)

"Off the Streets"

The Project

This is an emergency hostel for 16 - 18 year old boys and girls who may fall through the net of existing foster care services, residential projects and emergency or semi-independent hostels. The project is almost two years in existence and has been very effective in empowering young adults to move from life on the streets to longer term accommodation options.

Target Group

The hostel is utilised by three different categories of homeless young adults.

1. Newly homeless adolescents who have left their family or care placement. These have often been placed in bed and breakfast accommodation, which is unsuitable. They require a prompt service as a preventative response to being exposed to the negative effects of street culture.

2. Intermittently homeless young people who move between their family, residential or foster care and the streets. Since the concepts of community/family support and of planned respite care are relatively new in Ireland, this cyclical pattern of moving from care to home to care generally was negatively connoted and the young person is alienated more and more over time from both. When these young people reach the streets they need an intervention either to break the cycle or to validate and formalise it.

3. Long-term young homeless people who become fully part of the street culture. They are most often rejected by existing services and in turn have rejected those services. An inter cultural approach is required which respects the antipathy of such young homeless to structures which seek their control and containment.

The Service Process

The unit provides accommodation and emergency care for eight young boys and girls for a period of up to six months. Often the young people have availed of Focus Point's Outreach Service before admission. While resident in the Off-The-Streets Project a young person may avail of the Extension, (Focus Point's Youth Centre) and Crisis Services. These services assist with job search, flat finding etc. "Off-The-Streets" works in partnership with the young adults themselves, with other voluntary agencies, with statutory service and with

families where this is possible. The objective is to move a young person on to independent living, residential care, or a return to their family if appropriate.

Ethos

The ethos of the unit seeks to attain the delicate balance between designing custom-made, self-actualising individual care plans, with participative decision-making by the group of young people and the staff-team. The emphasis is on a co-operative, collaborative programme rather than hierarchical top-down structures. A learning culture is fostered where the Team hears the experience of the young homeless, and where younger and older adults share their values and awareness on issues of justice, equality, oppression. In this way an anti-discriminatory practice is aspired to which seeks a transformation out of classism, sexism and racism.

Conclusion

It is clear from the above that through its own services and through important partnerships with voluntary agencies, the Eastern Health Board has moved much closer to the provision of an adequate range of service provision and options available to young people who are out of home. It can be said that this provision now compares favourably with that in other capital cities of developed societies. Service provision for this age group is fraught, complex and frustrating. It is also very expensive and this Review notes with disappointment that resources directed towards this area have been diverted from the expansion of preventive services, in particular early intervention.

Chapter 16

FAMILY REFUGES

The Child Care Dimension

The report of the *Kilkenny Incest Investigation* highlighted the inter-relationship between domestic violence and child protection concerns. Because of this, the child care dimension of services for victims of domestic violence are incorporated into this Review. The managers of the two services which are directly managed by the Eastern Health Board were asked to evaluate this aspect of their service, particularly in relation to liaison with other services, children's access to medical, nursing, education and psychology services, play facilities, staffing and inservice training.

Two services for women who are out of home due to domestic violence and other causes are managed directly by the Eastern Health Board. The Women's Refuge in Rathmines is exclusively for the use of victims of domestic violence and their children. Haven House is a hostel which caters for women who may be out of home because of eviction or other problems in addition to victims of domestic violence. Other refuges in the region are funded by the Board . These include Aoibhneas in Ballymun and a new purpose-built refuge provided by Bray Women's Refuge. Construction of a new refuge provide by Aoibhneas in Coolock began in 1995. It will provide accommodation for up to ten families and is expected to be in operation in June 1996. This Review focuses exclusively on the services which are directly managed by the Board: Rathmines Women's Refuge and Haven House. In each, the number of children is considerable and, as can be seen in the Table below, shows no sign of abating:

Table 51 : Numbers of children Haven House and Women's Refuge 1993-1995

Service	1993	1995
Haven House	800	708
Women's Refuge	190	316
Total	**990**	**1024**

Play and recreation

Play is extremely important for children whose mothers have experienced domestic violence. Adequate play facilities and supervision of children in refuges and hostels allow their mothers to attend to the very many issues which they face such as counselling, accommodation finding etc. For the children themselves who have witnessed distressing scenes before admission to the service, play has an important therapeutic role.

The Women's Refuge has adequate play and recreation facilities for the children there and these are staffed by fully trained child care workers. Staff in Haven House were involved in fund raising to acquire a play bus; although the child care staffing for this facility was disrupted this year, further child care staff are about to be appointed. It is important that this is done as quickly as possible given the notably high number of children each year in Haven House. The provision of an art room in the Refuge in Rathmines would be invaluable for teenagers as the existing play facilities are appropriate for much younger children. This Review recommends that the provision of such a facility should be considered and that particular attention is paid to the maintenance of adequate play facilities, including staffing by child care workers.

Children's access to services

Schools

Haven House reports excellent relationships with local schools. Similarly, the Women's Refuge in Rathmines finds local primary schools extremely supportive, with regular reports being received by them on the progress of children in their care. However, difficulties have been experienced by the Refuge in placing children in secondary schools. Since continuity of education is vitally important, this situation should be addressed.

Nursing

Public Health Nurses visit each service on a regular basis and babies are examined and health information disseminated. The Women's Refuge reports a high turnover of Public Health Nurses assigned to their service and they request that a Public Health Nurse be attached specifically to hostels and refuges.

Medical

Each service has a house medical card and high satisfaction is reported with the service. The general practitioner holds a surgery twice weekly in the Refuge in

Rathmines. Haven House reports similar satisfaction with this service, particularly in the light of the fact that so many of their clients are drug abusers.

Social Work Service

Women and children in each service remain the responsibility of the Community Care Area in which their family home is located. This involves the service managers in liaison with ten different social work teams and Directors of Community Care. Effective and efficient working relationships are difficult to establish under these circumstances. If child protection concerns arise, this is highly unsatisfactory and the Women's Refuge in Rathmines requests a change in this system. In addition, they point out that maintaining the connection with the family's home Community Care Area may be pointless as many families do not return to live in their home area. This Review recommends that the Eastern Health Board ensures effective and efficient liaison when child protection concerns exist, perhaps through the appointment of a liaison social worker to all refuges.

Child Psychiatry

Once more, the requirement that children are referred back to their area of home origin causes difficulties. In addition, the insistence of some Child and Family Centres that fathers attend clinics with children and their mothers should be reconsidered in the light of most women's fears for their own and their children's safety. Waiting times for the service are also found to be unsatisfactory. As many of the children in both services have had recent, acutely distressing experiences, this Review recommends the provision of a more responsive service to meet their needs.

Clothing

Consideration should be given to the provision of a small clothing budget for some important items of clothing.

Staffing, induction and training

An induction programme for new staff is being completed. Staff in each service are attending a series of workshops which are being organised by the Eastern Health Board, Focuspoint and Dublin Corporation. These have been found to be extremely satisfactory. Attention should be paid to the training needs of managers in each service. There is an unsatisfactory level of temporary staffing in each service although a permanent Assistant Manager is being appointed to each. Counsellors are required in Haven House.

Client groups

The unsatisfactory mixture of client groups in Haven House which was reported in this Review last year still pertains. The Women's Refuge in Rathmines also reports a problem with women who were not co-operative or truthful regarding house rules about drugs and alcohol. The effects of the growing numbers of drug misusers on these as on many parts of the Board's service are considerable. In each of the services under discussion here, these clients are disruptive, abusive, threaten security and are frightening to children. Women referred from the psychiatric service can be equally difficult to contain or to help. Managers request that facilities for women who are addicts, psychiatrically ill or chronically homeless be established. This Review supports that recommendation.

Linkages

Linkages between Haven House, the Women's Refuge and other services within the Board are unsatisfactory. Clear procedures should be in place when child protection concerns exist and more vigorous attempts made to incorporate and involve each service with other Board services.

Domestic Violence Act 1995

The Domestic Violence Act 1995 places new and extensive obligations on health boards. The Act enables health boards to apply for barring orders on behalf of a spouse or partner where their safety and welfare is at risk and where that person is unable or unwilling to apply on their own behalf. It is anticipated that the implementation of this will have major staffing and other resource implications. In view of this legislation and other issues highlighted in this document, this Review strongly recommends that a cross-programme task force on domestic violence be established.

Chapter 17

ADOPTION

The number of babies placed for adoption in the region continues to fall:

Table 52 : Irish Adoptions in EHB region - 1994-1995		
	1994	1995
No of applications	199	list closed
No refused	2	0
No approved	26	22
No of babies taken on adoption list	11	7
No of babies withdrawn	2	0
No of babies placed	9	7

Many changes have taken place in the forty years of the existence of St Louise Adoption Society resulting, in more recent times, in more openness in adoption practices. Many birth mothers who gave up children for adoption in the past are now indicating they would welcome information on them and the chance of contact with them. Adoptive parents are asking for background information to share with their adoptive children as they grow up with them. Studies of adult adoptees have revealed the need for information about roots and genealogy. The numbers of persons returning to the placing agency for information has increased dramatically in the last five years, and there are a number of persons on waiting lists awaiting a social work service.

In Ireland, adult adoptees do not have automatic access to their birth records. The secrecy attached to this stems, as in other countries, from a perceived need to protect each of the parties of the adoption. A voluntary contact register which would enable members of the adoption triangle register a wish to meet, may be started in the future.

The present policy of St Louise Adoption Society is that all adoptive parents get a letter as soon as their adoption order is made, giving details of the background of the child placed with them. For those who adopted earlier, and who approach the society for background information on their adopted child, the policy is to provide them with non-identifying information in a letter. Such written information is first approved by the Placement Committee.

Counselling in the area of adoption disclosure is an integral part of an adoption service. It may be viewed as a process that begins most often with a request for non-identifying information and continue through the various steps in obtaining further information, search and reunion. Counselling should be available to all who approach St Louise Adoption Society to seek identifying and non-identifying information. Those engaged in this work need professional skills as well as personal qualities of maturity, good judgement and communication skills.

Organisations which offer support and counselling to those involved in adoption, frequently find that birth mothers suffer from the effects of relinquishment many years after the event. When such birth mothers return to the agency, their enquiry should be received in the spirit of acceptance that their feelings and concerns about their child are normal and natural.

Intercountry Adoption

Following the fall of Ceausescu and the subsequent adoption of Romanian children by foreigners including Irish couples, the 1991 Adoption Act was introduced to recognise Adoption Orders made abroad and to regulate how intercountry adoption was to take place in the future. Health Boards were given responsibility for undertaking assessment of people wishing to adopt abroad, but the final decision as to their eligibility is taken by the Adoption Board. The Eastern Health Board established their Intercountry Adoption Team in 1991 and there are now four social work posts in the team.

Table 53 : Intercountry Adoption in EHB region 1994-1995

	1994	1995
No. of enquiries	114	170
No. of applicants	52	74
No. of assessments	64	63
No. approved	31	27
No. refused	4	2
No on waiting list for assessment: Dec 1995		38

The flow of enquiries and applications has been constant since 1991 and recently the momentum has increased. There is a waiting list for assessment. The trend in foreign adoptions, initiated by developed Western countries such as U.S., Sweden and the Netherlands, has now become a feature of Irish society.

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Appendix

Child Care Advisory Committee

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

The Committee met on eight occasions during 1995. The Committee decided to concentrate on providing advice to our Board in relation to two specific areas: Teenage Pregnancy/Adoption and Children in Care. Two sub-committees were established to consider and submitted reports on these areas. Copies of the reports appear in the following pages.

The term of office of the present Committee expired on the 31st December 1995. The membership of that Committee and of the new Committee which has just taken up office appears below.

Teenage Pregnancy/Adoption
Sub-Committee Report

The committee was given the task of making proposals in relation to the prevention of teenage pregnancy, supports to teen parents and also to consider issues in relation to adoption.

A number of issues were identified in relation to adoption which necessitated considerable discussion e.g. lack of post adoption supports, adequacy of procedures for selecting adoptive parents, particularly in the past, which has given rise to an over representation of adult adoptees attending the psychological services, etc but time did not permit discussion to the extent desirable.

The committee focused on the issue of teenage pregnancy. Despite a reduction in numbers the committee believes that greater efforts should be made to ensure the numbers are reduced even further. It is acknowledged that a great deal of mis-information abounds on numbers and trends.

The brief submission is broken down as follows :

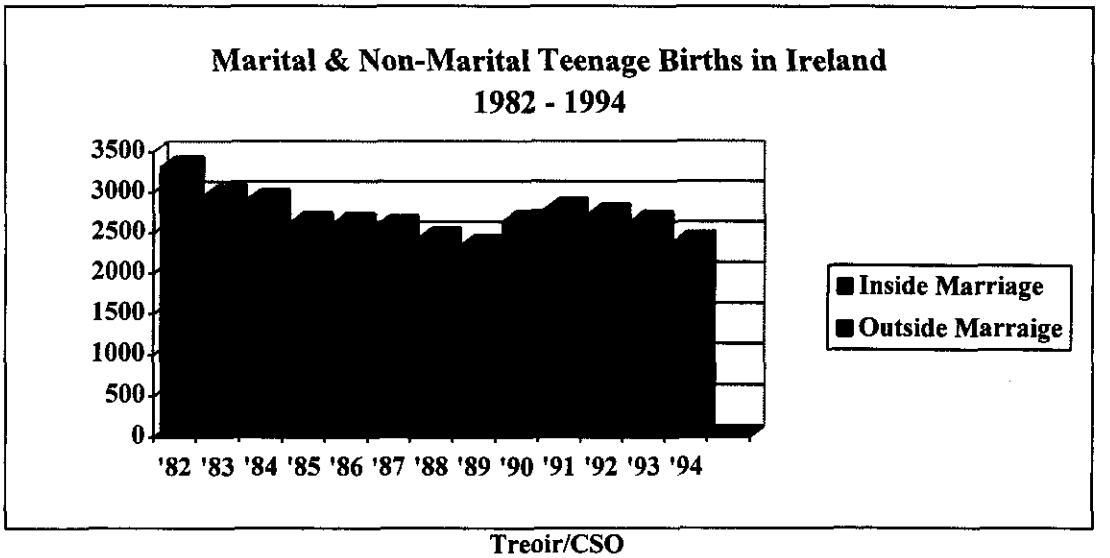
- Trends in relation to teenage pregnancy and
- Recommendations on prevention and support.

TRENDS

Significant changes have taken place in teenage pregnancies in the past 10-15 years

- *Pregnant teenagers are not marrying because of pregnancy, and*
- *The vast majority of unmarried teenage mothers now keep their babies whereas in the past they placed them for adoption.*

As the following chart shows when both marital and non-marital teenage births are combined and viewed in the same context, the overall picture of teenage births is one of decline. There were 2,903 births to teenagers in 1984 and in 1994 the number had dropped to 2,376. In 1984, however, 60% of teenage births were to non-married teenagers and by 1994 93% were to non-married's. This is perhaps partly explained by the change in attitude on the part of parents in not pushing their children into hurried marriages and the change in the preparation and counselling arrangements for Catholic marriages.



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The committee generally agreed that marriage because of pregnancy is not desirable and that research indicates that marriages which take place to teenagers, particularly pregnant teenagers, are more likely to end in separation than other marriages.

RECOMMENDATIONS

The Eastern Health Board should concern itself with the issue of teenage pregnancy generally, irrespective of marital status of parents.

Following a great deal of discussion and deliberation the Committee proposes the following recommendations :

1. Education is a key factor in the area of prevention and teenagers should be encouraged to remain in education for as long as possible. Emphasis on training for employment and job availability are key issues. It has been shown that attitudes to early pregnancy among teenagers in more affluent areas are quite different to those living in areas of deprivation. Careers and independence are seen as a priority and motherhood is not considered an option.

2. The E.H.B. should appoint a committee to liaise with the Department of Education on initiating personal development programmes which would also incorporate life skills, sexuality etc.

3. The Department of Education should be asked to incorporate the best elements of useful preventive projects - Teenage Health Promotion Programme piloted successfully in Community Care Area 8 and now

extended to Areas 1, 2 and 7, Primary Prevention Programme developed in Community Care Area 5, into its programmes. A somewhat similar programme which was devised by the Department of Child Health in the University of Exeter was evaluated and found that the intervention programme was successful in reducing the number of teenage pregnancies. The programmes should be taught to boys as well as girls.

4. Better liaison and co-operation between the community care teams, the maternity hospital social workers and voluntary agencies providing services to unmarried parents is essential in order to ensure that adequate counselling and supports are available to pregnant teenagers and young unmarried parents.

   Ideally social workers should discuss with pregnant teenagers all the options open to them , however, cogniscence must be taken of the difficulties of discussing adoption with some families because of cultural and principled objections to "giving up" a baby.

5. Combined ante-natal care (G.P's and Hospital) should be promoted for young mothers to ensure continuity of care. Mechanisms need to be developed to improve liaison between Maternity Hospitals and Community Care Services, particularly in relation to notification of births and ante and post natal supports.

6. Family Planning Clinics should be user friendly for teenagers. The issue of availability of contraceptives to teenagers who are sexually active must be addressed.

7. Teenage ante natal clinics should be developed at local health centres. Follow on parenting classes should also be developed so that young teenage mothers and fathers learn to care and manage their own health and learn parenting skills.

8. Professionals should recognise the importance to children of having a relationship with both parents and young couples should be helped to co-parent their children even if they do not live together.

9. Immediate steps should be taken to implement the proposal for a pilot project to test a new approach to Early Childhood Programmes in Disadvantaged Communities which was recommended by the Child Care Advisory Committee in 1994. (Attached for easy reference).

Pilot Project

Proposal to test a new approach to Early Childhood Programmes in Disadvantaged Communities

Introduction

The following is a proposal for the launch of new approach to the delivery of health and social support to vulnerable parents and young children in a district of high social stress in the Board's area. The proposed programme embraces a range of elements which would offer a new level of care and support to mother (and father) and child from pregnancy right through to the child starting school. It is considered that a comprehensive and integrated approach of this kind to the needs of these families can produce important health and social gains at the level of the child, the parents and the community. This proposal is strongly rooted in the Board's tradition of special programmes to support vulnerable groups, e.g. the Community Mothers Programme, the special mobile clinic for travellers etc.

Health and social support ante natally is very important for the vulnerable (in terms of social stress) mother. But mothers who are at high risk socially are, classically, difficult to reach. There is a need, therefore, to try out as many imaginative and innovative outreach approaches as possible in order to attract these women to use the services early for the benefit of their own health and that of their child - to - be.

The period around birth and the early months can set the pattern for long term maternal attitudes towards, and relationships with, the new child. Therefore it represents a key time for intervention, in that intervention in this period may offer a very high return on investment in terms of preventive effects. Effort invested at this time may help mother to avoid reactivating any destructive patterns which she may have experienced in her upbringing.

Family and social experiences in the pre-school years are known to have a powerful influence on the child's emotional, social and cognitive development and on the child's readiness to gain and grow through the social and educational experience offered by school.

Key issues for mother of young child in terms of child welfare are

(i) **Importance of access to social support for mother.** This support may be formal in character (that is provided by professionals or organised services) or it may be informal (that is provided by family, neighbours, friends). From

whatever source, support, according to the available research, is found to be particularly effective in situations of high social stress;

(ii) **importance of mother developing a bond to the child.** This means in lay terms that the woman is 'cracked' about her child and that this keeps her going even through the hard times when the child is sick, difficult or demanding and other things are also going wrong in her life.

(iii) **importance of supportive relationship and active help from the partner/father of child**

(iv) **importance of access to practical help, day care, respite care when sick or exhausted etc.**

(v) **importance of mother having realistic view/expectations/understanding about child's developmental stages/needs**

(vi) **importance of recognition of the fact that high social stress is damaging for the child, the mother and their relationship.** Impact of multiple stress operates cumulatively in a multiplier rather than additive way.

(vii) **importance of recognition of the fact that maternal depression is very common in mothers of young children.** Maternal depression is damaging to the mother - child relationship and can persist if not recognised and properly treated.

Lessons for services:

(i) The importance of a comprehensive approach addressing the child's needs **and** the mother's needs - day care **and** home visiting **and** support groups **and** information/education **and** personal development.

(ii) The need for different approaches at different ages (of child) and in different social conditions

(iii) The need for integrated approach (i.e. tightly co-ordinating different services/professionals)

(iv) The need for services to address needs of the parents as parents **and** as adults, that is support to mothers should also offer them support as women, since if at least some of their social and psychological support needs as *women* can be met then as mothers they will be better able to respond to the needs of the child.

(v) The need to prioritise certain potentially high risk groups because of the extra possible disadvantages associated with their status/condition (e.g.)

* teen parents
* low income lone parents (living alone), especially in areas of serious social disadvantage
* travellers
* mothers suffering from depression

Outline Proposal

What is proposed is a Pilot scheme which would try to build on the lessons of experience and the messages from research about the needs of vulnerable young families.

It would aim to offer a guaranteed comprehensive range of supports of the types mentioned above to all mothers in a selected high social stress district. It is envisaged that the Project would be led by EHB but with support from a range of possible sources/partners, viz. Combat Poverty, Van Leer, FAS, EC Urban Programme, ADM programmes, Department of Education Earlystart programme etc.

The Project would include:

(i) intensive PHN/Community Mother support ante - peri - and post - natally;

(ii) close involvement by maternity hospital outreach;

(iii) active outreach to fathers;

(iv) support groups for pregnant women and new mothers;

(v) nutritional and other active health information schemes for pregnant women and new mothers;

(vi) mother and baby/toddler clubs;

(vii) personal development course for parents - as adults rather than only in relation to their parental role;

(viii) adult education, skill development, return to work courses for parents;

(ix) good quality creche/child minding facilities for these courses:

(x) guaranteed high quality day care places for **all** young children over an agreed age from local area;

(xi) extra GP input.

The Project would be led by a Project Director who would lead a multi-disciplinary team of health board personnel. Main costs would be day care and director, since existing services could make much of the contribution.

The aim of the project is to use a comprehensive preventive programme to alter in a positive way the destinies socially and economically the lives of the children born to participating parents, the lives of those parents and the life and fabric of a community which otherwise seems doomed to further economic and social decline. In this positive way, the health prospects of those affected can quite literally be transformed. This is a project with potential to offer high health and social gain on a relatively modest investment. What is required is not so much a large investment of money, but the vision for desired change and the political skill to secure the co-operation of the relevant other services/agencies and the Board's own professionals.

Sub-CommitteeReport

Children in Care

Introduction

The Committee acknowledges and welcomes the introduction of the new Child Care (Placement of Children in Residential Care) Regulations 1995; Child Care (Placement of Children in Foster Care Regulations) 1995 and Child Care (Placement of Children with Relatives Regulations) 1995.

Being in care can mean either foster care, being placed with relatives or in residential care; public care is in reality a substitute for private care within families. The common factor to all children in care is that they are in public care and that parenting tasks are divided amongst various agencies, people and institutions. There are inherent difficulties in the provision of care. If services are to work better, certain things need to be in place and it is hoped that this report will help to highlight the main issues involved. There are huge implications for children in care from the perspective of the children themselves, their families parents, the statutory and voluntary bodies providing the services and in the arena of public policies. One factor that underlines all children in public care is that what is traditionally seen as private - family life - has been disrupted and the family has been opened to public scrutiny.

The fact that these children are in public care is in some respect misleading as there has been very little debate about what happens to children in such public care. At times this can manifest itself in community reluctance to have childrens homes in their area. Often the parents are seen as "bad" irresponsible and as such find themselves polarised from 'good' parents.

Good planning is essential and both children and families need to be involved alongside social workers, foster families and child care workers in the decision making process. It is well documented in research that children can drift in care unless there is effective planning which may mean returning the child or planning for it's long term needs from an early date. Effective assessment identification of needs and planning to meet these must be in place. Structures must be in place to provide supervision which improves decision making.

Services for children must be based on need and these identified needs must be matched. Obviously there is a dilemma for professionals if these needs cannot be met. Often this is the basic question of social workers who are faced with decision making for children: is care better than children remaining at home?

This is the key issue facing all of us who are planning and providing services for children and young people who are very vulnerable.

Reception into care

It is useful to start at the whole issue of reception into care. We need to be aware of the reasons why a child is admitted to care. It is important to recognise the multi- facetedness of the factors leading to a child's reception into care. Services to prevent admission to care should be in place in each area. It is well documented that children are more likely to remain in care if they are not returned home within 6 weeks. This must mean that this period is of paramount importance to the services that are provided to the child and the family to effect a resolution of how the identified factors that have led to the difficulties are changed i.e. what needs to be changed and how this is done for the child and family. Of course, this has clear implications for involving families and children in the process of identifying, clarifying and working on the issues.

Recommendation: Early intervention services which will prevent admission to care should be in place in each area.

Planning for children in care

The new Regulations stipulate that a detailed care plan should be drawn up for each child upon admission to care. This should be done in conjunction with the child, the child's family, foster parents/ residential care staff. Many issues have to be addressed, medical, educational and psychological. All these need to be assessed and the appropriate services found. Gaps in educational provision for children in care should be examine - for example some care facilities require on-site education. There is also a need for access to psychiatric, psychological and therapeutic services. The DHSS Guidance and Regulations regarding admission to care remind us that: *"Patterns of working and attitudes established now will in most cases influence all future work"*. (p48) Very detailed guidance to the content of care plans is given in the DHSS document and these are attached in Appendix One.

Recommendation:

The Committee recommends that full support be provided by the Health Board to social work teams, carers and residential care agencies in drawing up and implementing detailed care plans as outlined in the regulations. In consultation with the Department of Education, the Board should review the education needs of children in care.

Access

Retention of links with the family where at all possible is essential for the wellbeing of children in care. The continuing role of the parent in the life of the child is crucial and should be emphasised where possible at all times. Access (or contact between the parents and child) is associated with earlier discharge from care and with better adjustment in social, emotional, psychological and cognitive development.

Recommendation:

The Committee recommends that residential care agencies and those with responsibility for foster care, should review the access arrangements of children in care. In the light of the new Regulations, these arrangements should allow for access to be as flexible and as frequent as the wellbeing of the child allows. If access cannot occur in the child's own home, it should take place in surroundings which are as relaxed and as home-like as possible.

Reviews

Along with adequate planning, a system of reviews of each child in care is important in order to prevent a child drifting in care. Attention is drawn to the requirements in this regard of Child Care (Placement of Children in Residential Care) Regulations 1995 and Child Care (Placement of Children in Foster Care) 1995 and that reviews of children in care should take place accordingly.

Recommendation:

The Committee recommends that adequate and planned reviews of children in care should take place in accordance with the regulations and that sufficient resources are made available to facilitate this.

Aftercare

After care needs to be planned for probably at the point of reception into care. Children and young people need preparation for leaving care and coping with adulthood and independent living skills should be fostered as much as possible. The discharge cut-off is sometimes seen as age related and other factors such as educational requirements, disability issues and ability to manage oneself are important. It is considered desirable that a designated person is appointed to undertake aftercare tasks.

Recommendation:

The Committee recommends that care plans for children should include arrangements for reunification or adequate aftercare. Residential care agencies should examine if the allocation of a staff member to undertake this role in each group home is possible.

Carers and Care Staff: recruitment and training

The impact of looking after children and young people who have experienced loss, separation or abuse is very high on staff and foster carers. Since children require continuity of quality care, this needs to be recognised in the status accorded to the role which they play. Residential care agencies should have sound recruitment procedures; including the exhaustive checking of references of staff by personal contact.

Basic professional training for staff should include the acquisition of the knowledge, skills and attitudes required to competently undertake the task of caring for children. Ongoing training and support are also essential and are integral to the provision of a care service. Inservice training should be provided along with professional supervision of staff. Needs which should be addressed include working with children who have difficulty with anger control or whose behaviour generally reflects their troubled past. Residential care agencies should explore the provision of the services of staff consultants who can act as a resource for staff in meeting the needs of the children in their care.

With regard to difficulties experienced in recruiting foster parents, consideration should be given to undertaking market research and imaginative recruitment ideas in order to increase participation in fostering. Foster parents who work with challenging children should be supported by professionals and peer support from experienced foster parents. Regular training should be provided for foster parents and participation in training should be a requirement for continuing as a foster parent. Adequate respite should be available to foster parents who care for children with acute behavioural difficulties. Linkages should be developed between foster parents and "best-practice" group homes in order to provide support for foster parents.

Recommendations:

The Department of Health should be requested to ensure that the training and education of care workers be standardised nationally and that it reflects the skill and knowledge requirements of modern residential care. Adequate inservice training should be provided for managers and staff of group homes. The provision of staff consultants to group homes should be

explored. Research into, and improved initiatives for the recruitment of foster parents should take place. Adequate training, professional and peer support should be provided for foster parents and sufficient respite should also be available. Linkages should be formed between foster parents and "best-practice" group homes.

Children's Rights

There needs to be clear policies concerning children in care. This is a broad topic and could be addressed by clarification of the rights of children in care. Policies about abuse in care need to be clear. Children, young people and their families need access to complain and these need to be responded to in an open manner. With regard to the whole issue of child protection and in line with the "An Abuse of Trust" report the recommendations in the appendix are noteworthy. Issues that are problematical concern the question of substance abuse by children/young people in care settings, the placement of known and alleged abusers. Policies around these areas need to be formulated. Anti-discrimination policies regarding ethnic, cultural, religious and sexual orientation must be in place.

Recommendation:

The Committee recommends that children's rights while in care should be clarified. Complaints procedures should be drawn up by each residential care agency and should be brought to the attention of the parents and the child.

Research and Planning

Services must be planned and integrated. We need to look at the needs of children and young people coming into care. What are their needs, how can the existing services meet these needs? We need to identify existing gaps in services and plan to meet these. Foster care and residential care are inter-connected and this needs to be recognised in the integration of services as most children in care experience both. The planning at agency level often mirrors the planning that is done with the carers young persons and their families. Often in child care we are faced with complex issues and dilemmas where easy 'solutions' are not the norm. Perhaps if we can grasp this, our services would be organised in a more effective way.

Research regarding care should therefore have several facets. In the first instance, the Committee wishes to draw attention to the recommendation in this regard contained in the Review of Adequacy of Child Care and Family Support

Services in 1994. This Review recommended that a task force on care placement needs be established in order to give direction and impetus to developments in caring for children. In addition, management information would be obtained so that planned allocation of resources in the coming years can take place. The Committee applauds the initiatives of the Board in establishing Special Care Units; it is recommended that the repertoire of care settings should include adequate numbers of places for disruptive young people.

We also need to look at the profile of the children in care e.g. age, sex, age at admission, legal status on admission to determine what, if any, patterns emerge. It is also significant to study the initial placement patterns of children and a question that is raised is to what extent age or route mediates initial placement choice. This may be determined by the health board policy at this point in time e.g. there is an expectation that younger children will be fostered.

It is important to look at the careers of children in care, placement patterns, length of stay and history of care. Information is required on the numbers of placements which break down and the characteristics of those which do.

Research is required also on children's experience of care.

While we clearly need to analyse the current figures and patterns of children in care we need to be careful about how we do this and what information we are given. "We need to examine the way that we structure that information and examine the implication for our approach and services". (David Berridge) The information that is gained from such research will mean effective planning for services and will influence and underpin decisions around recruitment of foster carers and the types of residential care that is required.

With regard to foster care, information is required regarding the age profile of carers, length of service, reasons for drop-out (if appropriate) and their views regarding morale, natural family contact, support received, training needs etc

Recommendations:

The Committee recommends that a task force into the care needs of the region be established. It is also recommended that research be undertaken to achieve adequate data on the care patterns of children in the region including reasons for admission to care. Research should be undertaken on children's experience of being in care. A profile of foster carers in the region should be established.

Some background information

Children in care represent a significant user of resources in Health Boards. Specifically in the Eastern Health Board the following statistics give the broad canvas which forms the background picture.

The figures of children in care in the Eastern Health Board in 1994 are:

- Total number of children in care: 1,285
- Total number in residential care: 295
- Total number in foster care at 30/9/94: 990 in all forms of foster care
- Total cost of residential care: £8m approx
- Total cost of foster care 1994: £1.8m

Hidden costs involved in care includes social work time, medical time and education costs. The cost to the child and family is much more difficult to quantify and measure.

Conclusion

Care is costly - to the child, young person, their family, to staff and carers. It is a complex issue that places high demands on agencies and staff. It needs to be enshrined in clear policies and philosophies. This needs to be done at agency and institutional and individual level.

SUMMARY OF RECOMMENDATIONS

The Committee recommends that:

- Early intervention services which will prevent admission to care should be in place in each area.

- Full support be provided by the Health Board to social work teams, carers and residential care agencies in drawing up and implementing detailed care plans as outlined in the Regulations. Such plans should be drawn up in consultation with the parents and the child.

- In consultation with the Department of Education, the Board should review the education needs of children in care.

- Residential care agencies and those with responsibility for foster care, should review the access arrangements of children in care. In the light of the new Regulations these arrangements should allow for access to be as flexible and as frequent as the wellbeing of the child allows. If access cannot occur in the child's own home, it should take place in surroundings which are as relaxed and as home-like as possible.

- Adequate and planned reviews of children in care should take place in accordance with the Regulations and sufficient resources should be made available to facilitate this.

- Care plans for children should include arrangements for reunification or adequate aftercare. Residential care agencies should examine if the allocation of a staff member to undertake this role in each group home is possible.

- The Department of Health should be requested to ensure that the training and education of care workers be standardised nationally and that it reflects the skill and knowledge requirements of modern residential care.

- Adequate inservice training should be provided for managers and staff of group homes.

- The provision of staff consultants to group homes should be explored.

- Research into, and improved initiatives for the recruitment of foster parents should take place.

- Adequate training, professional and peer support should be provided for foster parents and sufficient respite should also be available.

- Linkages should be formed between foster parents and "best-practice" group homes.

- Children's rights while in care should be clarified. Complaints procedures should be drawn up by each residential care agency and should be brought to the attention of the parents and the child.

- A task force into the care needs of the region be established.

- Research be undertaken to achieve adequate data on the care patterns of children in the region including reasons for admission to care.

- Research should be undertaken on children's experience of being in care.

- A profile of foster carers in the region should be established.

Appendix One

According to the DHSS, a care plan should include:

- the child's identified need (including education and health)
- how those needs might be met
- aim of plan and timescale
- proposed placement
- other services to be provided
- arrangements for contact and reunification
- support in the placement
- likely duration of placement
- contingency plan, if placement breaks down
- arrangements for ending the placement (if voluntary)
- specific details of the parents' role in day to day arrangements
- arrangements for input by parents, the child and others into the ongoing decision-making process
- arrangements for health care
- arrangement for education
- dates of reviews

Source: The Children Act 1989: Guidance and Regulations; Volume 4; Residential Care. London; HMSO.

Appendix A

1. Agencies providing services to children or vulnerable adults should ensure that culture of openness - trust is fostered within the organisation in which staff can share any concerns about the conduct of colleagues and be assured that these will be received in a sensitive manner. (9)

2. Staff should be encouraged through formal and informal channels of communication to question, express concerns or pass on significant information to management regarding the protection of children or vulnerable adults. (10)

3. Agencies providing services to children are vulnerable adults should ensure that staff who report significant information receive a written acknowledgement of their concerns and confirmation that the organisation has taken appropriate action. (11)

4. Organisations providing services to children or vulnerable adults should ensure that all allegations of sexual misconduct are pursued and their outcomes recorded regardless of the availability of the alleged perpetrator to co-operate with the process of enquiry. (12)

5. Organisations working with children should establish child protection policies and procedures which ensure that all allegations of child abuse are reported to a responsible authority. (38)

6. "Organisations working with children should ensure that staff and volunteers understand their role within the organisation and are familiar with written guidance on the child protection policies of the agency". (41)

7. Organisations should establish procedures for supervisory and monitoring the activity of staff. (42)

8. All staff and volunteers working with children should have access to child protection training. (43)

9. Organisations working with children should provide children and their parents with brief written information about the activities of the organisation, its child protection policy and the name of a person to contact in the event of any concerns. (48)

Source: "An Abuse of Trust". The report of the Social Services Inspectorate Investigation into the case of Martin Huston 1993

Child Care Advisory Committee : 1993-1995

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Cllr Roisin Shortall TD (Vice-Chairperson)
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Ms Brid Clarke, Head Social Worker

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

Residential Care:
Sister Anne 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

Child Care Advisory Committee : 1996-1998

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