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# The Management of Behaviour: Key Lessons from the Inspection of High Support Units

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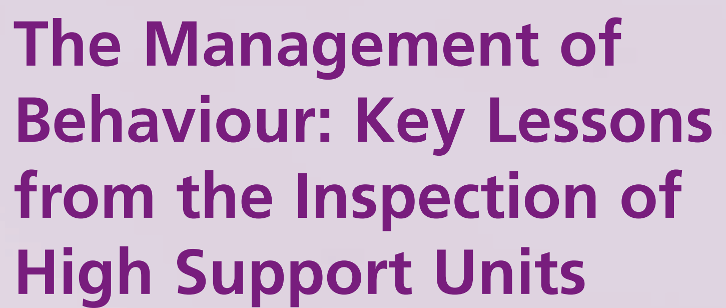

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# Foreword

I am delighted to present this overview report on the management of behaviour in high support units to the Minister for Children, Mr Brian Lenihan, TD. The aim of the Social Services Inspectorate in publishing this report is to identify those factors that help residential units effectively manage challenging behaviour in a manner consistent with the needs and rights of young people and the purpose of the unit.

High support units provide a service for young people in care who need more support and specialist involvement than is available in foster care and residential centres. These units act as a support when these services struggle to meet a child's needs. High support units may also offer a step down service for young people leaving special care units. This report acknowledges that there are many other forms in which high support may be delivered; however, the focus of this report is the 13 designated high support units.

The development of high support units in this country is relatively recent, and has evolved differently in different regions. A characteristic of the units is that they manage difficult, testing and complex behaviour; consequently, a key standard by which they are measured is how well they care for young people with this type of behaviour.

High support units are open units. They do not have authority to detain young people. They rely on the routines, relationships, care, activities and individual programmes of the unit to engage with young people. They are underpinned by enhanced resources as expressed by high levels of staffing, education on site (where required) and good access to specialist services.

The Inspectorate acknowledges the assistance provided by the managers and staff, the resident young people and all others in the course of this themed inspection. The objective of the Inspectorate in undertaking this overview report is to support the ongoing development of quality and choice of services in this area.  This report adds to the small, but growing body of knowledge about high support units. It will hopefully prove to be of value to those who plan and provide high support services, and to the families and different professionals who have responsibility for the wellbeing of the young people placed there.

**Michèle Clarke**
**Chief Inspector**

# 1 Executive summary

This is a report on the findings and key lessons from the inspections of all 13 high support units (HSU) in the country. The twelve units operated by the Health Services Executive (HSE) were inspected by the Social Services Inspectorate (SSI) between January and July 2005. The other unit, run by a non-statutory agency, was inspected by the HSE during the same period.

High support units were first set up in the middle of the 1990s to provide a service for young people whose needs were not being met within existing care services. The young people placed in them have usually experienced a number of adverse events and circumstances in their lives, and this is sometimes reflected in behaviour that is troubled and destructive to themselves or others. High support units offer an enhanced service compared to mainstream foster and residential care placements. There is a high ratio of staff to young people, the young people have access to education or training tailored to their needs, and they usually have ready access to assessment and therapy provided on site by specialist staff. High support units are open units. They are not places of detention.

One HSU, referred to in this report as Unit #1, provided an excellent service. Another five HSUs (numbered 2 to 6) provided a good service, that is, one that met the required standard in most respects. Seven HSUs were not providing a service of the required standard. Apart from #1, the HSUs were not graded in relation to each other. The charts that present information about all of the HSUs are not to be read as league tables.

There were 56 young people placed in the HSUs during the inspections, just over 10% of the total number of children and young people in residential care as of December 31st 2003[1]. The average age of the young people was 14 years. There were more boys than girls, and they had spent on average just over ten months in the units. A relatively high proportion (36%) of the young people had either no previous care placements or just one, although, most had numerous previous placements. The average number of previous care placements was four, with a minority having experienced ten or more. It is generally accepted that it is difficult to engage with young people who have experienced significant instability and disrupted attachments in their lives.

There were 83 places in the 13 HSUs. The overall occupancy rate was 67%. The occupancy rate was higher in well run units than in those that failed to meet the required standard. Well run HSUs delivered better value for money because they provided a better service to more young people.

There was some regional variation. In the eastern region of Dublin, Wicklow and Kildare the young people in the HSUs were somewhat younger, they had more previous placements, and there were more girls than boys. There was a mis-match of needs and resources in this region. There were fewer high support places relative to the number of children and young people in care than in the southern part of the country, and the units employed less qualified staff teams.

There were 51 discharges from the HSUs in the year leading up to inspection. Three quarters of the young people were discharged to mainstream placements, home, after-care or independent living. The remainder were discharged to short-term placements including eight (16% of the total) who went to places of detention.

Some of the young people were clearly benefiting from their placement in a HSU. The findings of these inspections indicate, however, a need to consider how best to use high support services. Official reports on the use of specialist residential services have outlined options such as delivering high support services to young people in mainstream placements, and protecting the (mainstream) placements of young people who move to dedicated high support residential units so that they can return to them. This level of integration of services had not been achieved at the time of these inspections.

[1] Department of Health and Children Analysis of Child Care Interim Minimum Dataset 2003

The focus of the inspections of the HSUs was on their capacity to manage safely and well the behaviour of the young people placed in them. The findings of this round of inspections indicate that young people's behaviour is more likely to be managed well in units that:

- are well managed,
- have a clear statement of purpose and function that is reflected in practice,
- operate to an agreed model of care that is understood by the care staff team,
- provide a good standard of primary care, and
- respect the rights of the young people.

Of these factors, it is clear that the most significant is good management. This finding is consistent with research and other inspection findings. It serves as a timely reminder of the priority that needs to be given to the recruitment and retention of good managers in residential child care, and the implications of this in terms of remuneration and opportunities for training and career development.

While the findings on management were to be expected it is, perhaps, less clearly understood that respecting the rights of young people is essential to the management of behaviour. Care staff exercise authority over the young people in their care. The appropriate exercise of authority is enhanced, not undermined, by sharing information with young people, addressing their concerns and consulting with them. An approach that relies on efforts to impose control is likely to be counter-productive as it often leads to young people withholding their consent to be cared for and taking up an adversarial position in relation to care staff. Good order involves a degree of negotiation between staff and young people, within which different positions and responsibilities are acknowledged and affirmed.

Among those units where management of behaviour did not meet the required standard a number of factors emerged. Difficulties associated with the use of external consultants in a number of units and the excessive use of non-routine behaviour management interventions were of particular concern.

External consultants play an important role in many children's residential centres, but in some of the HSUs inspected, their role encroached on the care planning process and on the role of the unit managers.

Some HSUs relied on non-routine behaviour management interventions such as physical restraint and detention to maintain order. Such reliance was ineffective as well as unacceptable. Excessive use of such interventions was indicative of wider failings within the units, such as poor management practice.

The individual inspection reports of the HSUs each contain recommendations for improvements to the services inspected. This report also contains recommendations to the HSE for improvements to the HSU sector as a whole.

This report brings together the findings of the inspection of 13 HSUs. It provides evidence that HSUs can make a contribution to the care of some of the more troubled young people in the care of the HSE. By comparing practices in the various units, it is hoped that good practice can be generalised across the units. This report makes the case for a more rational and co-ordinated use and equitable distribution of high support services.

# 2 Introduction

## 2.1 The Inspections

The Social Services Inspectorate (SSI) carried out inspections of the 12 High Support Units (HSUs) operated by the Health Services Executive (HSE) between January and July 2005. During this time, the HSE carried out an inspection of the only HSU in the non-statutory sector. The SSI inspection reports have been posted on the SSI website (www.issi.ie) as inspection reports numbers 119 to 130. This report deals with the findings of all 13 inspections.

The focus of the inspections was on the management of behaviour. The SSI has completed a full round of inspections of all the HSE children's residential centres. The management of behaviour emerges as a critical challenge. The Inspectorate believes that it can best support the development of good practice in the management of behaviour by identifying the factors that promote it.

## 2.2 Inspection methodology

All of the SSI inspections were announced in advance and the process was that used in any inspection of a children's residential centre. The inspectors examined documentation provided by the units in advance of the fieldwork, spent three days in each of the units, observed practice, read unit records, and interviewed as many of the young people and their families as were happy to meet with inspectors. They also interviewed the managers and staff of the units, those attached to the regional residential service (where applicable), external managers, social workers, and others involved with the service. The inspections differed from other SSI inspections of residential centres in that inspectors inspected against a limited number of the standards of the *National Standards for Children's Residential Centres*. These were:

**Standard 1** **Purpose and Function**
**Standard 2** **Management and Staffing**
**Standard 4** **Children's Rights**
**Standard 5** **Planning for Children and Young People**
**Standard 6** **Care of Young People**

The relevant standards and criteria are set out in full in Appendix 2.

Based on past experience of inspections, inspectors believe these standards impinge most directly on the capacity of children's residential centres to manage the behaviour of young people safely and well.

The inspection of the HSU in the non-statutory sector was, by contrast, against all ten standards of the National Standards for Children's Residential Centres.

## 2.3 High support units

High support units were established with a specific remit to work with the more difficult to manage young people in the care system. They typically have a higher ratio of care staff to young people than ordinary children's residential centres, have a school on site or access to places in schools, and usually, but not always, have assessment and therapy provided by specialist professionals employed within the service.

High support units differ from special care units (SCU) which were also established to provide a service to difficult to manage young people. Young people in special care units are detained there on a short-term basis by court order to ensure their safety or that of others. At the time these inspections were conducted there were two special care units in operation with a total of 25 places in them.

As of October 2005[2], there were, in addition, 13 young people in open single occupancy units. These units, sometimes referred to as special arrangements, also provide a service for some of the more difficult to manage young people in the care system.[3]

The term 'high support unit' is not defined in statute, as are, for example, the terms 'children's residential centre' or 'special care unit' (defined in the *Child Care Act 1991* and the *Children Act 2001* respectively). Some mainstream children's residential centres have features of HSUs and many children's residential centres care for a number of young people who present with challenging behaviour. In deciding which units to include in this round of inspections, the SSI included only those units described by the HSE as HSUs.

High support units are open centres and the National Standards for Children's Residential Centres apply to them.

### *2.3.1 Background to the setting up of high support units*

As of December 31st 2003[4], there were nearly 5,000 children and young people in the care of the [then] health boards. The majority (80%) of these children and young people were placed with foster families. A smaller number (10.6%) were placed in children's residential centres. The number of young people in HSUs represents approximately 1% of the total number of children and young people in care.

Within the last two decades it has become apparent that a small proportion of the children and young people within the care system need a more specialised service than current foster care and mainstream residential care can provide. This issue came to national prominence when a number of cases were taken to the High Court by way of judicial review. The case was made, and accepted by the Court in a number of instances, that the state had failed in its duty to such children and young people by not providing services that adequately addressed their needs. This led to the setting up of specialist residential services.

High support units are, therefore, a relatively new addition to the range of services available to young people in care. The oldest of the 13 HSUs inspected was established in 1996. On average, they were five years in operation.

[2] Based on SSI's Census of Children's Residential Centres 2005

[3] There were also three units that had just one young person in them, though they had not been set up as single occupancy units.

[4] Department of Health and Children Analysis of Child Care Interim Minimum Dataset 2003

### *2.3.2 Definitions of high support*

A *Report on the Requirement and Necessity for Special Care and High Support Residential Child Care Provision in Ireland* was published in 1998. It outlined a number of options for the development of these services, and argued that both high support and special care should be seen as interim placements and not as solutions to the complex problems of the young people for whom they were intended. The report argued that the effectiveness of these forms of intervention was directly related to the quality and availability of alternative care services, and that lack of availability, or poor quality alternative care services, would inevitably lead to inappropriate use of specialist provision.

In 2002 a further report entitled: *Definition and Usage of High Support in Ireland* was published. It was commissioned by the Special Residential Services Board (SRSB) to provide a summary of the outcomes of research undertaken on the use and definition of high support in Ireland. Social Information Systems Ltd, the company that undertook the research, met with representatives of the [then] health boards, examined existing service provision, and made recommendations for the future development of high support services. One issue raised with some health board representatives was whether young people referred to HSUs should have their original placements protected. Only some of the health boards had given the issue consideration. The report recommended that high support be re-conceptualised as a methodology that could be delivered in a variety of settings rather than as a particular form of specialised residential care.

A *Review of the Need for High Support Care* was undertaken by the former Eastern Regional Health Authority (ERHA) in 2004. It highlighted the need for early intervention and preventive services, recommended enhancing the capacity of mainstream services to deal with young people with challenging behaviour, and called for closer integration and linkages between services. It followed the SRSB commissioned report in defining high support in terms of a programme or methodology rather than in terms of a particular placement.

# 3 Current concerns and issues in residential child care

## 3.1 The challenge of behaviour management within the care system

Young people in the care system have typically missed out on some essential aspect of a healthy upbringing such as a secure attachment to a stable parental figure. Many have experienced such traumatic life events as abuse, serious neglect, separation and loss. Indeed, a combination of these adverse circumstances is often a feature of the histories of young people in care. These adverse circumstances impact on the behaviour of some young people. They find it difficult to manage their feelings and behaviour. They can harm themselves and others. A helpful way to understand such behaviour is as 'pain-based behaviour', that is, as the outward expression of the internal pain arising from the experience of loss, trauma or whatever adversities the young person has experienced. It is for just such young people that specialist residential services such as HSUs were established. It is not always possible for such behaviour to be managed within mainstream placements such as foster homes and children's residential centres.

The task of the HSUs is to help the young people to begin to come to terms with the adversities and traumas of the past, and to learn appropriate ways of dealing with their feelings and managing their behaviour. The HSU's approach to behaviour management has to be both effective and appropriate. To be effective, the HSUs must prevent the young people from harming themselves and others. They must also help the young people to manage their own behaviour so that they do not remain dependent on limit-setting by others. To be appropriate, the HSUs must avoid reacting to unacceptable behaviour in a punitive or excessively controlling manner and taking measures that impose secondary pain experiences on the young people. There is often a tension between what is effective and what is appropriate. In dealing with very high-risk behaviour, care staff must intervene effectively in order to prevent harm to the young people, themselves, and others. This intervention is legitimate, indeed commendable, however, overly controlling interventions risk exacerbating the very problems they set out to address. Inappropriate interventions to manage unacceptable behaviour can cause further unacceptable behaviour, in part because young people may withdraw their consent to be cared for and take up an adversarial position towards care staff.

## 3.2 Non-routine behaviour management interventions

Throughout this report reference is made to non-routine interventions to manage behaviour. These are the exceptional measures sometimes taken to deal with particularly hard to manage behaviour. They include interventions to manage crises such as the use of detention, physical restraint, and requesting Garda assistance. They also include measures aimed at breaking a pattern of unacceptable behaviour such as making complaints to the Garda about a young person's behaviour in the HSU. While all of these measures have their drawbacks, many have a part to play in good behaviour management practice when used with great care in exceptional circumstances. These measures are inappropriate when they cease to be non-routine and become part of everyday behaviour management in a unit.

In recent years, particular concern has been expressed about the practices of physically restraining young people or placing them on their own in locked rooms (often referred to as seclusion). Both of these practices are used in many parts of the world in the management of high-risk behaviour. They became particularly controversial in the USA following the publication

of a series of articles, in the *Hartford Courant* newspaper, detailing the deaths of adults and children in mental health and other institutions as a result of being restrained or secluded. Subsequent research by Harvard University confirmed that there are a number of fatalities each year as a result of such interventions. In Ireland, there have been no documented fatalities resulting from such interventions. However, the use of physical restraint, for instance, is associated with injuries to both young people and care staff. Fortunately, these injuries have usually been of a minor nature. There are other arguments against the use of physical restraint. It should not be used with young people who have certain medical conditions and is not advised for use with young people who have experienced sexual abuse.

In many services and institutions in America, and in other parts of the world, there has been a concerted effort to minimise and, where possible, eliminate the use of what are termed 'high-risk interventions' such as restraint and seclusion. The key lesson that emerges from these efforts is that it is not enough to decide not to restrain or seclude clients, a more fundamental change is required; a change that puts the concerns of the clients at the centre of the service. Institutions that have succeeded in reducing or eliminating the use of high-risk interventions have done so by improving their service and changing their culture.

Conflicts often arise between clients and members of staff when clients are expected to fit into institutional practices that are not clearly related to meeting their needs. Sometimes these conflicts can lead to high-risk behaviour that is managed through the use of restraint and/or seclusion. In institutions where the interests of the clients are primary, they are consulted and their wishes are accommodated wherever possible. As applied to residential child care such an approach is consistent with a children's rights perspective and with our current understanding of good practice in children's residential centres.

## 3.3 Children's rights

The United Nations Convention on the Rights of the Child was signed in 1989 and ratified by Ireland in 1990. Since then, several key developments have helped to promote the children's rights agenda. The National Children's Strategy was published by the government setting a national goal that "children will have a voice in matters that affect them". Dáil na nÓg has been meeting since 2001, and the Office of the Ombudsman for Children has been established.

These developments have impacted on the position of children and young people in the care system. The Irish Association of Young People in Care (IAYPIC) was set up in 1999 to inform children and young people in the care system of their rights and to advocate on their behalf. There are standards on children's rights in the *National Standards for Children's Residential Centre*s, the *National Standards for Special Care Units* and the *National Standards for Foster* Care. Inspection reports reflect a growing awareness of children's rights issues among service providers. Most children's residential centres now have policies relating to young people's access to information and consultation, and procedures for the resolution of complaints. However, the extent to which policies and procedures are reflected in practice can vary widely.

## 3.4 The concept of congruence

Even the smallest children's residential centre is a complex organisation with different groups of people with different interests: the agency running the centre, the people employed to work in it, and the young people placed there. Each has their own agenda and not all are compatible all of the time. Anyone who has ever worked in a children's residential centre knows, for example, how difficult it can be to organise the shift system in a way that ensures appropriate staffing levels at all times, meets the needs of staff members for adequate time off and their wish to avoid work schedules that conflict with their personal and social lives, and still matches the routines and patterns of everyday living in a way that gives the young people a sense of predictability and continuity of care. A children's residential centre can be evaluated by the degree to which the children's best interests predominate over other considerations. Thus, the starting point for any discussion about the shift system must be what works best for the young people. Once that has been determined, the discussion can turn to how the needs and wishes of staff members may be accommodated.

The concept of congruence provides a way of understanding how activities at different levels of a children's residential centre determine the nature of the service provided to the young people who live in it. Congruence has three elements. The first of these is consistency of philosophy, principles, values and activities across all levels of the service and across time. The second is reciprocity, understood as a degree of mutuality in the interactions between people involved with the service. In the example of the shift system, it is important that the young people experience that which the shift system is intended to achieve, that is, predictability and continuity of care. The third property of congruence is coherence, this is the degree to which things come together to form a whole greater than the sum of the parts (as in the example of good teamwork). A residential centre such as a HSU operates at different levels within an overall hierarchical structure. There are the levels of the young people and their families, the workers and the team, the management, and the external management of the unit. All of these must be oriented to the interests of the young people. Full congruence is an ideal state but the degree to which the unit or centre strives for congruence in the children's interests is the degree to which it provides a 'good enough' service for them.

# 4 Inspection findings on the young people and the units

## 4.1 Data on young people

With one exception (4.1.8) these data concern the 56 young people who were registered with the 13 HSUs at the time of inspection. The units are required to keep a register of the young people living there and to enter such details as the young people's names, dates of birth, parents' names and addresses, and so on. That a young person's name appears in a unit register does not always mean that the young person is living in the unit at a particular point in time. For example, a young person in one of the units inspected was in the UK undergoing a specialist assessment at the time of inspection. His name remained on the unit's register as he was due to return there. The discussion in this section of the report concerns all of the young people whose names were on the units' registers. Most of them were living in the units at the time of the inspections.

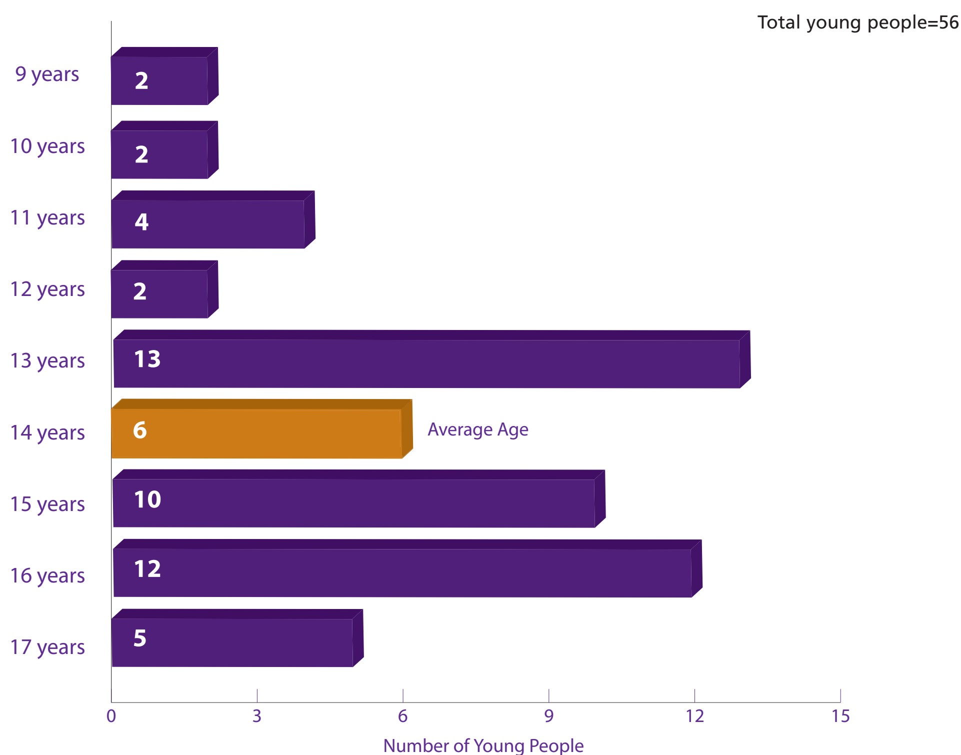
The discussion in 4.1.8 concerns the 50 young people who were discharged from the HSUs in the year leading up to the inspections. They are a different group from those on the units' registers during the inspections.

### *4.1.1 Age of young people*

The average age of the young people was 14 years. Their ages ranged from 9 to 17 years. The age breakdown is given in the chart below.

Twenty-three of the young people were aged 13 years or younger, as against 33 who were aged 14 and over.

**Age of Young People in the High Support Units at the time of Inspection**



### 4.1.2 Gender

At the time of inspection there were more boys (33) than girls (23) in the HSUs.

### 4.1.3 Age and gender

The boys (13.8 years) tended to be somewhat younger than the girls (14.4 years).

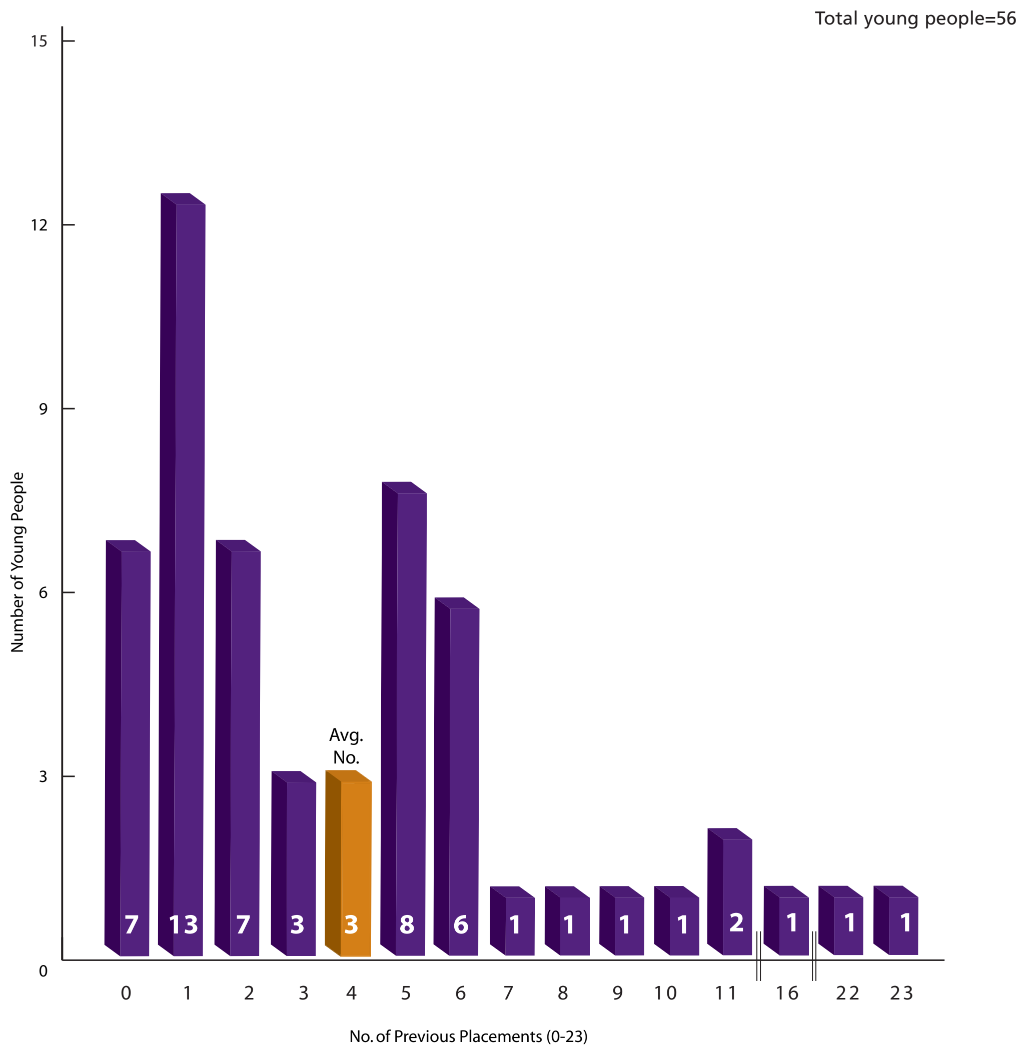
### 4.1.4 Legal status

Thirty young people were in voluntary care and 26 were on care orders.

### 4.1.5 Previous placements

The young people had 241 previous placements between them, an average of four each. The range was wide with some young people having no previous placements and one young person having 23.

**Previous Placements of Young People in the High Support Units at the time of Inspection**



The data on previous placements are significant and give rise to certain concerns. Over one third (36%) of the young people in this round of inspections were in their first or second placement. High support units, as originally envisaged (Chapter 2), were not intended as a first or second option for children and young people in the care system. For these young people, there is a danger that placement in a HSU will reduce the number of care options subsequently available to them as it can be difficult to move from a specialist to a mainstream placement. Furthermore, placement in a HSU can have the effect of labelling a young person as 'difficult' and 'hard to place'. These labels can act as disincentives to providers of mainstream placements considering taking on the task of caring for them. In contrast, nine young people (16%) had experienced seven or more placements and six (11%) were on their tenth or subsequent placement. These six young people accounted for 39% of the total number of placements. It is generally accepted that young people who have experienced multiple placements are likely to be more difficult to engage than those with fewer placements. The more the young people have experienced placement breakdowns with their attendant disrupted attachments and sense of rejection, the more likely it is that each subsequent placement will prove more problematic. There were, in this round of inspections, a number of young people who had experienced a multiplicity of placements, and it was clear that the HSUs in which they were placed were struggling to provide a service that met their needs.

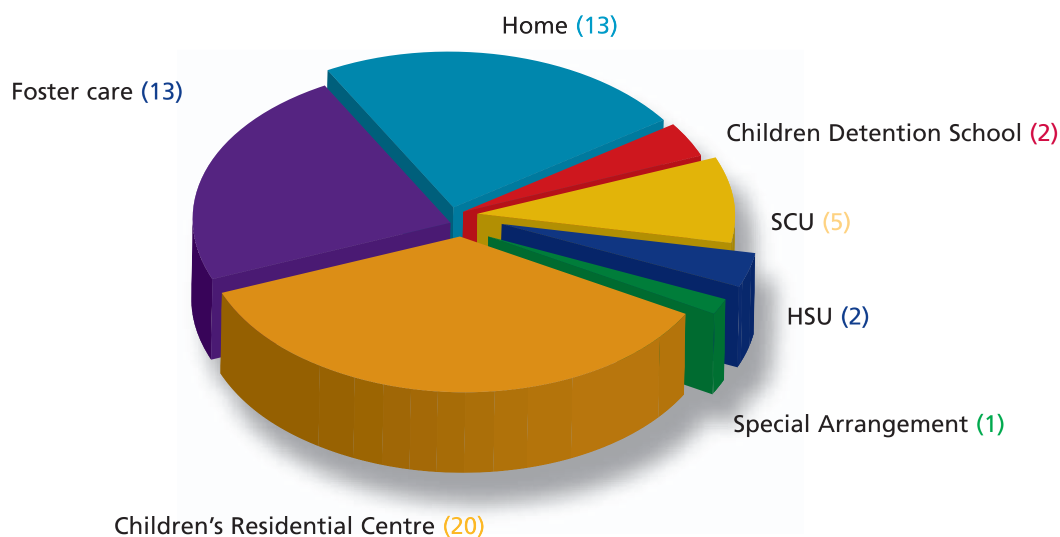
In short, some young people had been placed in HSUs too soon and others too late.

The HSE needs to address the issue of the appropriate use of placement in HSUs. Except in very exceptional circumstances, these should not be used as a placement of first or second recourse. Young people, however, should not have to experience a multiplicity of placement breakdowns before they are considered for the sort of specialised, multi-disciplinary service that HSUs provide.

#### *4.1.6 Placement immediately prior to high support placement*

**Young People's Placement immediately prior to current High Support Placement**

Total young people=56



These data indicate some of the functions of HSUs. The majority of their intake comes from mainstream care placements but they also function as a 'step down' from units where young people are detained such as special care units and children detention schools.

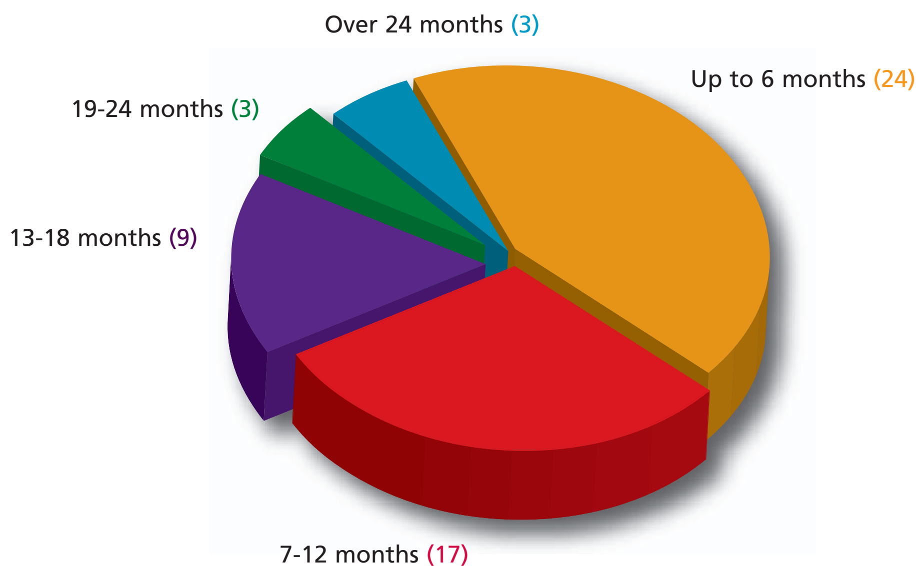
Seven young people had no previous placements (4.1.5) yet 13 were admitted from home (4.1.6). Inspectors did not specifically enquire into the circumstances of these young people. A possible explanation is that the young people in question were placed in mainstream placements that broke down, after which they were returned home pending the availability of a placement in a HSU. Inspectors have heard from social workers of frustration with lengthy referral and admission processes. The HSE should consider the provision of an emergency high support service. If the home circumstances of young people were considered sufficiently unsatisfactory to warrant their removal from them, returning the young people to these same circumstances, albeit temporarily, is not likely to alleviate the difficulties these young people experience. This, in turn, makes the task of the HSUs more difficult as they have to meet the needs of young people whose problems are likely to have become entrenched.

### *4.1.7 Length of placement*

At the time of the inspections, the young people placed in the HSUs had spent an average of just over ten months there. However, fifteen (27%) of the young people had spent more than a year there. Particular attention needs to be given to young people whose placements continue for more than a year as it may prove particularly difficult for them to settle into mainstream placements and to re-integrate into mainstream education.

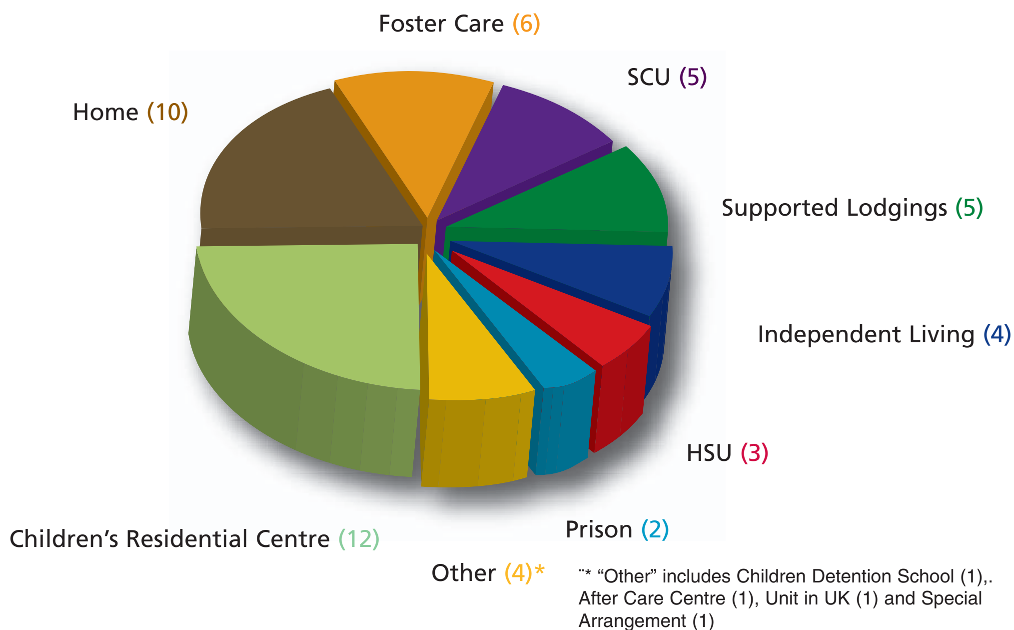
**Length of Young People's Placement in the High Support Unit at the time of Inspection**

Total young people=56



### 4.1.8 Discharges from the HSUs

**First Placements of those discharged from the High Support Units in the twelve months prior to Inspection**




"* "Other" includes Children Detention School (1),. After Care Centre (1), Unit in UK (1) and Special Arrangement (1)

There were 50 young people discharged from the HSUs in the year prior to the inspection fieldwork[5]. Thirty-eight (75%) went from placement in a HSU to independent living (presumably the older ones), home or a mainstream care placement. One quarter of the young people went to some sort of short-term or temporary placement. Eight of the 50 went from placement in the HSUs to places of detention including special care units (5), children detention school (1), and prison (2). These findings are given further consideration in Chapter 7 of this report.

### 4.1.9 Trends

These data indicate that the HSUs mainly offered short to medium-term care for young people in the care system. The young people tended to be in early adolescence and to have experienced a number of previous placements. There was a fairly even distribution between those in voluntary care and those on care orders. There were more boys than girls but the girls tended, on average, to be older than the boys. The situation in the eastern region was somewhat different and this is discussed at the end of the chapter.

[5] There were 51 discharges as one young person was readmitted and discharged a second time during this period.

## 4.2 Data on the units

### 4.2.1 Distribution of units

Places in HSUs were not evenly distributed throughout the country.

There were two units in the eastern region [ERHA area] comprising Dublin, Wicklow and Kildare; one unit provided a maximum of six places for nine to eleven year olds, and the other provided a maximum of 18 places for thirteen to seventeen year olds. There were in total 24 places available in the region.

There were four HSUs with 20 places in the Mid Western Area, and these accepted referrals from that area only.

Four HSUs in the South Eastern Area provided a total of 19 places to children from that area, and also from the Southern and Mid Western areas.

There were two HSUs in the Southern Area which provided eight places exclusively for that area.

There was one HSU in the North Eastern Area and this provided a regional service to the (roughly) northern half of the country, that is, those areas covered by the North Eastern, North Western, Western and Midland Areas of the HSE. It could accommodate a maximum of 12 young people.

This uneven spread of high support places was heightened by neither of the two largest units ever having operated to full capacity, for reasons that included difficulties in staff recruitment and retention.

### 4.2.2 Premises and model of service delivery

There were two types of premises: the 11 smaller HSUs were accommodated in single building premises, and the two larger HSUs were accommodated in campus-style premises.

The 11 smaller HSUs were:
- Eight five-bedded units
- One six-bedded unit
- One four-bedded unit
- One three-bedded unit

These 11 smaller HSUs were based in a variety of premises, mostly in domestic dwellings that had been adapted to their purpose. Two units were based on hospital grounds, and though nicely decorated and well maintained, their locations made them unsuitable as residential centres for young people. This objection was also made by some of the young people in interviews with inspectors. In these single building premises there was a regular coming together of managers, care staff, young people and, sometimes, other professional staff, for meals and other unit routines.

The two larger HSUs were:
- One 12-bedded unit
- One 18-bedded unit

These two campus-style institutions had separate accommodation and well equipped schools and administrative buildings. They provided office accommodation for managers and specialist staff, and had meeting rooms. One had a family accommodation block and the other had a recreation block. These two units were enclosed within high perimeter fences. The administration buildings could not be directly accessed by the young people.

These differences are significant in considering the findings of these inspections. The larger units employed more specialist staff and, therefore, could provide a greater range of services. Management of these units was, however, more complex than in the smaller units. Generally, it can be expected that placing together a greater number of young people whose behaviour is difficult to manage will make the overall task of maintaining order more problematic. In addition, the managers of the two largest units had to co-ordinate the work of a larger number of care and specialist staff. The managers' offices were physically removed from the young people and the care staff and this reduced the opportunities for informal contact between them.

The campus-style institutions were both purpose-built. With their high perimeter fences, they had the appearance of places of detention. Indeed, one was originally intended as a special care unit. In both of these units, young people remarked on their resemblance to places of detention, yet the regime in one unit served to emphasise this similarity, while the regime in the other minimised it. For instance, in one, the young people could only enter or exit through the administration building, in the other there was no physical restriction on the young people entering or exiting. Therefore, while the nature of the premises clearly impacted on the experience of the young people, it was but one of a number of factors that determined the nature of the service provided.

#### *4.2.3 Age range on admission*

Most of the units were set up to provide a service for young people under the age of 18 years. Six units envisaged admissions of children under 12 years old. Two of these were specifically set up to provide a service for this age group: one for nine to eleven year olds, and the other for children from the age of six. It is generally considered inappropriate to place young children in residential care, although there may be circumstances in which a period in a residential unit is deemed necessary to prepare a child for a family placement. All but one of the units was described in its statement of purpose and function as providing a short to medium-term service, understood as anything from two to 24 months. Inspectors found, however, that the programme of care was for up to four years in the unit that accepted referrals of the youngest children. Two

children, at the time of inspection, had each spent over three and a half years there. One child was aged nine and the other child was aged eleven. This falls well outside accepted definitions of the appropriate use of high support as outlined in Chapter 2 of this report and should be changed.

### *4.2.4 Rate of occupancy*

There were a maximum of 83 places available in the HSUs at the time of inspection. This figure was arrived at by adding together the number of places that were stated to be available by the various units. There were 56 young people on the units' registers, giving a 67% rate of occupancy[6].

Six of the HSUs were managing the behaviour of the young people safely and well at the time of inspection. The other seven units were not doing so. There were a maximum of 36 places available in the first six units and they were looking after 27 young people at the time of inspection. This gives an occupancy rate of 75%. There were 47 places available in the other seven units, and between them they had 29 young people on their registers. This gives an occupancy rate of 62%.

High support residential care is a very costly form of intervention. HSE managers have to make decisions about providing this type of service, bearing in mind that other services may not receive funding as a consequence. The issue of costs and value for money is, therefore, an important one. A service that runs at 62% capacity is clearly delivering less value for money than one operating at 75% capacity.

### *4.2.5 Numbers of care staff*

These data relate to the managers and care staff of the HSUs but not any other professional staff such as psychologists or teachers. Ancillary staff, such as housekeepers and maintenance persons, are also excluded.

Number of care staff employed in HSUs and the ratio of young people to care staff

| HSU | Number of care staff* at the time of inspection | Number of places as per statement of purpose and function | Number of young people on unit register | Ratio (approx) of young people to care staff posts assuming full occupancy | Ratio (approx) of young people to care staff posts at time of inspection |
|---|---|---|---|---|---|
| #1 | 25 (20.5) | 5 | 5 | 1: 4 | 1: 4 |
| #2 | 25  (20.5) | 5 | 2 | 1: 4 | 1: 10 |
| #3 | 19 (17.5) | 5 | 5 | 1: 3.5 | 1: 3.5 |
| #4 | 19 | 3 | 3 | 1: 6 | 1: 6 |
| #5 | 20 (19) | 6 | 4 | 1: 3 | 1: 5 |
| #6 | 40 (37.5) | 12 | 8 | 1: 3 | 1: 5 |
| #7 | 27 (20.5) | 5 | 4 | 1: 4 | 1: 5 |
| #8 | 21 (19) | 5 | 2 | 1: 4 | 1: 10 |
| #9 | 23 (19.5) | 5 | 5 | 1: 4 | 1: 4 |
| #10 | 18 (16.5) | 5 | 2 | 1: 3 | 1: 8 |
| #11 | 22 (17) | 5 | 1 | 1: 3 | 1: 17 |
| #12 | 56 (55) | 18 | 11 | 1: 3 | 1: 5 |
| #13 | 16 | 4 | 4 | 1: 4 | 1:4 |
| **Total** | **331 (297.5)** | **83** | **56** | | |
| **Average** | | | | **1: 3.5** | **1: 5.3** |

*Data in brackets are adjusted to take account of part-time staff. The analysis assumes that each part-time worker worked half-time on average.

[6] In October 2003 there were fifteen HSUs offering a total of 103 places. Fifty-one of these places were occupied, giving an occupancy rate of approximately 50%. At that time, six HSUs were run by non-statutory agencies, by 2005, all but one unit was HSE run.

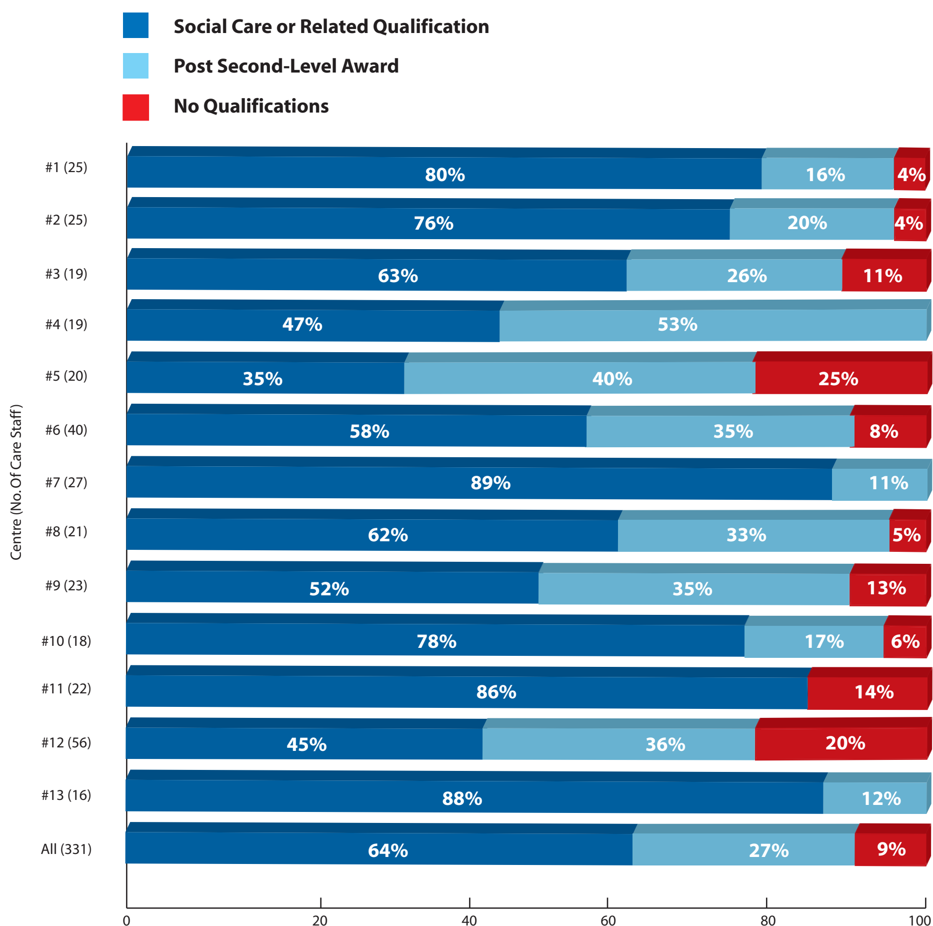
At the time of inspection, there were on average almost five and a half care staff posts to every young person in the HSUs, as compared to a ratio of three and a half posts to every young person were the units fully occupied.

Only two units (those located in the eastern region) used agency workers to cover for times when members of their own teams were sick or absent for some other reason. Units that use agency workers usually have a working understanding with the agencies that the same workers are used as often as possible. This promotes consistency and continuity of care for the young people, however, this cannot be guaranteed. In some instances, agency workers are used who have not been to the units before, do not know the young people, and are unfamiliar with unit routines. There are other disadvantages to the use of agency workers: they do not usually attend team meetings or training sessions, and do not usually have formal supervision sessions. For these reasons, the service provided to the young people suffers to the degree to which agency workers are employed in the unit.

### *4.2.6 Qualifications*

The data on qualifications are presented under three headings. The first of these is staff who, at the time of inspection, held a qualification in social care or a related area such as teaching, nursing, social work, psychology or psychotherapy. The second heading covers people who held another post second-level educational award. This is a broad category and includes people with certificates in areas such as counselling as well as those with degrees. The third category covers those who were returned by the units as having no qualifications.

**Qualifications of Care Staff in each High Support Unit at the time of Inspection**



It might be expected that in a service for young people with particular difficulties, only qualified people would be employed. However, just under two thirds (64%) of those employed held a qualification in social care or a related area. The percentage of these staff in the six units providing a good quality service (61%) was slightly lower than in the other seven (66%) units.

Some of the HSUs that provided a good quality service had a high proportion of qualified staff although #5, for example, delivered a good service with a staff team just over one third of whom held a professional qualification (four of the staff in this unit were, however, studying for a social care qualification at the time of inspection). In contrast #7, with 89% qualified staff, failed to deliver a service to the required standard.

The HSE in many areas has encouraged unqualified staff to pursue professional training by offering them secondment and, in some cases, by entering into agreements with local third level colleges to provide professional training to them. This is highly commendable and will have beneficial consequences in the long term. However, as discussed further in Chapter 5, the quality of the service provided in a HSU is a function of a range of factors. On the evidence of this set of inspections good management practice, for example, would appear to count for more than having a high proportion of staff with professional qualifications.

### *4.2.7 Services provided in the HSUs*

**Education and training**

At the time of inspection, there were arrangements in place for the education of all of the young people. Eight HSUs had their own on-site schools or classes that formed part of a regional school for children in HSUs. The HSUs that lacked their own on-site schools could access places in regional schools for the young people placed in them. These schools, whether on or off site, were set up specifically for young people in high support residential care. Two also accepted referrals from young people in a special care unit. The schools had small classes and operated flexible programmes tailored to the needs of the individual young people. Not all of the young people attended these schools, and young people were encouraged and supported to integrate into mainstream schools where possible. The older young people who did not attend school attended training schemes. The schools worked with the young people in helping them to make these transitions. In general, inspectors found the arrangements for the education and training of the young people were very good.

**On-site assessment and therapeutic services**

Most of the HSUs had some provision for assessment and therapeutic services to be delivered on site. This was most developed in one unit where there was a multi-disciplinary team based in the unit on a part-time basis and comprised of a psychologist, psychotherapist, psychiatrist and speech and language therapist. Another unit had one full-time and a number of sessional psychologists, and yet another had a psychotherapist on the staff team. A more usual arrangement was for a psychologist to be part of a regional service and provide assessment and therapeutic services to a number of units. Where psychologists or others were employed to carry out assessments and therapeutic work with young people, they were also available to staff for consultation. This made sense as not all young people wished to engage in individual therapy and it is generally accepted that much of the important work of healing and helping in residential child care is carried out by care staff. The role of specialist staff in this situation is to help ensure that the interactions between young people and care staff are directed towards the achievement of therapeutic ends. Sometimes external consultants were contracted to assist in the care of young people with particular difficulties. This proved problematic in some instances and the role of external consultants is discussed in Chapter 6 of this report.

## Education, assessment and therapy services available in each HSU

| HSU | Education | Assessment and individual therapy for young people | Consultation for staff | Other arrangements |
|---|---|---|---|---|
| #1 | On-site school | Provided by unit psychotherapist | Provided by unit psychotherapist | Access to consultant child psychiatrist for consultation |
| #2 | On-site school | Provided by clinical psychologist for regional residential service | Provided by clinical psychologist for regional residential service | External consultant contracted to provide consultation in relation to one young person |
| #3 | Access to off-site school | Provided by clinical psychologist and guidance counsellor for regional residential service | Provided by clinical psychologist and guidance counsellor for regional residential service | |
| #4 | Access to off-site school | Provided by clinical psychologist for regional residential service | Provided by clinical psychologist for regional residential service | |
| #5 | On-site school | None | None | Therapeutic services for young people and consultation for staff had to be accessed externally |
| #6 | On-site school | Provided by unit psychologists | Provided by unit psychologists | |
| #7 | On-site school | Provided by clinical psychologist for regional residential service | Provided by clinical psychologist for regional residential service | |
| #8 | Access to off-site school | Provided by clinical psychologist and guidance counsellor for regional residential service | Provided by clinical psychologist and guidance counsellor for regional residential service | External consultant contracted to provide consultation in relation to one young person and access to consultant child psychiatrist for consultation |
| #9 | Access to off-site school | Provided by clinical psychologist and guidance counsellor for regional residential service | Provided by clinical psychologist and guidance counsellor for regional residential service | |
| #10 | Access to off-site school | Provided by clinical psychologist and guidance counsellor for regional residential service | Provided by clinical psychologist and guidance counsellor for regional residential service | External consultant contracted to provide consultation in relation to one young person |
| #11 | On-site school | Not available at time of inspection | Not available at time of inspection | |
| #12 | On-site school | Provided by multi-disciplinary team based in unit part-time | Provided by multi-disciplinary team based in unit part-time | |
| #13 | On-site school | Provided on site by external consultant | Provided onsite by external consultant | External consultant provided on-site consultation in relation to all of the young people |

## 4.3 Regional variations

There were regional variations in the distribution of high support places throughout the country (4.2.1), and this led to an inequitable distribution of resources.

For the purposes of this analysis the country has been divided into three regions. The eastern region covers the area formerly served by the East Coast, Northern Area and South Western Area of the HSE. The two HSUs located within the region provided a service to young people from these three areas only. The northern region covers the North Eastern, North Western, Midland and Western Areas of the HSE. There was only one HSU in this area and it accepted referrals from throughout the northern region. The southern region covers the area served by the Southern, South Eastern and Mid Western Areas of the HSE. This region contained the highest number of HSUs (ten) and there was some sharing of resources between the areas.

As shown in the table below, there was a significantly higher number of HSU places available, relative to the number of children and young people in care, in the southern region than in either of the other two regions.

| Region † | Number of children and young people in care | Number of HSUs | Maximum number of high support places | Number of high support places per 100 children and young people in care |
|---|---|---|---|---|
| Eastern | 2,163 | 2 | 24 | 1.11 |
| Northern | 1,235 | 1 | 12 | 0.97 |
| Southern | 1,586 | 10 | 47 | 2.96 |
| National | 4,984 | 13 | 83 | 1.67 |

† Regions in this context do not relate to HSE areas but referring regions as discussed in the analysis

Inspection findings in relation to the eastern region of the country differed in significant respects from other areas. This region covers Dublin, Wicklow and Kildare - the most densely populated part of the country. There were a total of 24 high support places in two units for a total in-care population of 2,163. Neither unit was operating to full capacity at the time of inspection and only 15 of the places were filled.

The young people from the eastern region in HSUs were, on average, somewhat younger than the national average. There were also slightly more girls (8) than boys (7), reversing the national trend.

More significant were the findings in relation to previous placements. On average, the young people in HSUs had four previous placements. The figure for the eastern region was six. If the smaller of the two units in the eastern region is excluded, the figure for the other one rises to seven[7]. It is likely that there is a relationship between the relative scarcity of high support places in the eastern region and the relatively high number of previous placements of the young people placed in them. Put simply, due to lack of resources, young people have to wait longer before accessing a placement in a HSU. They are placed in more mainstream placements that cannot adequately meet their needs and break down. This exacerbates their difficulties and makes the task of the HSU more difficult for the reasons discussed earlier in this chapter (4.1.5).

The situation in the eastern region differed from the rest of the country in other respects also. The two units had the least qualified staff teams. In the smaller unit, just 35% of care staff held a qualification in social care or a related area. For the larger unit this figure was 45%. One quarter of the care staff in the smaller unit and one fifth in the larger unit had no qualifications at all. Both units fell well below the national average of 64% of care staff with a qualification

[7] Since the smaller of the two units accepted admissions of 9 to 11 year olds, it is to be expected that they would have fewer placements than the older group of young people in the larger of the units.

in social care or a related area, and both had over twice the national average of 9% of care staff with no qualifications.

Finally, the situation in the eastern region differed from the others in that it was only in this region that the HSUs relied on the use of agency workers to ensure adequate levels of staffing.

In the eastern region there was a major mis-match of needs and resources. Compared with the southern region, there were more young people in need of high support care, and there were fewer resources available in terms of places in HSUs and qualified staff. This is inequitable and the HSE must take action to rectify the situation.

The larger of the two units in the eastern region faced challenges that were unique to the sector. It was the largest unit in the sector and contained the highest number of difficult to manage young people. Moreover, most of the young people had experienced a higher number of placement breakdowns compared to their peers in other units. The unit contained the highest concentration of the most needy and difficult to manage young people of any of the units in this round of inspections.

## 4.4 Recommendations

1. **The HSE should develop national guidance on the appropriate use of HSU placements. The guidance should include the following:**

   - **The minimum age at which young people should be considered for placement in a HSU,**
   - **The maximum length of time a young person should spend in a HSU,**
   - **The point in a young person's care career at which placement in a HSU should be considered.**

2. **The HSE should consider the provision of a number of emergency high support placements.**

3. **The HSE should ensure equity of access to all young people in need of high support care throughout the country. In particular, it should take action to rectify the mis-match of needs and resources in the eastern region.**

# 5 Inspection findings on care regimes

Inspectors found that there were two groups of HSUs: a well functioning group, and a group that was not operating effectively at the time of inspection. Six of the 13 units inspected managed the young people's behaviour well. They helped the young people to behave in an acceptable manner most of the time, and when the young people behaved in a manner that was not acceptable the measures taken to correct this were reasonable. The other seven units did not succeed in managing the young people's behaviour well. Either they failed to provide the assistance the young people required to keep their behaviour within acceptable limits or they took measures to deal with unacceptable behaviour that were ineffective and/or inappropriate.

The first group of units provided a service that was largely congruent in the young people's interest, that is, the service at every level was oriented to providing a good quality care to the young people. The others lacked such congruence. In most of these units, there was an awareness that something was wrong, even if people disagreed about where the problems lay. In one unit there was a lack of awareness of the impact of poor care practices on the management of the young people's behaviour.

## 5.1 Characteristics of well run HSUs

All of the units in the first group were well managed. This was a consequence of good management practice and continuity of post holder.

The managers in this group provided leadership and direction to the care staff teams. They used both formal and informal means to manage their units. The formal structures included systems for the supervision, support and professional development of the staff team. These managers did not, however, rely exclusively on formal systems. They were aware of what was happening in the units they managed by knowing the young people and the staff and by listening to what both had to say.

The managers in this group were able to rely on external managers and/ or management advisory groups who provided support and opportunities for planning and reflection. They were also supported by well functioning, competent staff teams that were focused on the needs of the young people. This must be seen as both a consequence and a cause of good management practice. Good managers bring out the best in their staff teams, and cooperative staff teams support their managers. Good management practice is more difficult to achieve in circumstances where managers are in acting positions, where there have been frequent changes of post holder, or where team cohesion is undermined by unresolved industrial relations issues.

There were different structures in place for the internal and external management of the units. Some had a dedicated external line manager for residential child care while others did not. Some had fairly elaborate internal structures, with deputies and child care leaders with management responsibilities, while others had simpler structures. However, the structures were less significant than management practice and the degree of continuity of post holders.

Five of the units had statements of purpose and function that adequately described the service the unit provided. Four of them based their approach on models of care that were described as part of the statement of purpose and function. In the remaining two, the model of care was implicit rather than explicit. It is obviously preferable to have a clearly articulated model of care as this lends coherence and continuity to practice, but even in the two units that lacked this, there was an agreed approach to how the young people should be looked after, and this was a

significant part of the success of all six units. The absence of an agreed model of care caused major difficulties in some of the other units, as discussed later in this chapter.

The standard of primary care in all six units was good. There were good relationships between staff and young people and attention was paid to the personal, social, cultural and other needs of the young people.

Practice in relation to children's rights was found to be good in four of the six units but there were concerns about procedures and practice in relation to complaints in two units, and other concerns about poor children's rights practice in one of these. The area of children's rights is one where practice is generally underdeveloped and this is discussed in more detail later in this report.

The standard of care planning was uneven across the six units. There was generally a good working partnership between social workers and care staff but this was not a universal finding.

## 5.2 Effective and appropriate behaviour management practice

There were similarities in the approach to behaviour management in the six units that were managing the behaviour of the young people safely and well. In general, there was clarity about what behaviour was acceptable and what was not so that the young people knew what was expected of them. Though there were general rules that applied to all of the young people, the manner of their implementation was tailored to the needs and capacities of each of the young people. Perhaps most importantly, the approach to behaviour management was an integral part of the model of care in each of the units. It was not separate from the care that was offered to the young people. Typically the units emphasised the importance of the relationships between the young people and the care staff, and these were the media through which behavioural difficulties were addressed and resolved. These units did not rely on non-routine forms of behavioural intervention. None of them detained the young people. Some used physical restraint and in one of them inspectors considered that it had been used too often but in the other five it was used infrequently or not at all.

All of the six units trained their staff in therapeutic crisis intervention (TCI). SSI does not advocate the use of one form of physical restraint over another, however, it was a significant finding of this round of inspections that staff generally valued the training they received in TCI. They liked the emphasis on de-escalation techniques, planned crisis intervention, the use of life space interviews, and other aspects of the approach. In some areas, such as the Southern Area, the approach to TCI was highly developed with rolling programmes of staff training and good systems for review of critical incidents. Where such systems were in place, they undoubtedly enhanced the approach to behaviour management.

Three of the units had, on occasion, asked for the assistance of the Gardaí in dealing with high-risk situations. In three, complaints had been made which led to young people being charged with offences committed while in the units. These measures can give rise to controversy and they are discussed later in this report.

Three young people in three different units were on medication to help them manage their behaviour.

These six units were, as stated, considered to be managing the behaviour of the young people safely and well. This has to be understood in relative terms. The young people sometimes behaved in ways that were not acceptable and they sometimes put themselves at risk. In one of the units there was concern about a high level of unauthorised absences. In some others, aggressive behaviour sometimes posed a risk to the safety of staff and young people (hence the need for Garda assistance). Nevertheless, these six units were found by inspectors to have been reasonably successful in minimising the number of such incidents and in responding to those that occurred in an appropriate and effective manner, at least most of the time.

## 5.3 Unit #1: a case study in excellence

Unit #1 was highly congruent in the service of the young people's interests. That is, at every level, the service was geared to provide the best possible care to the young people.

Inspectors found that there were ten key elements in the success of the unit:

- There was a clear statement of purpose and function that was reflected in the admissions policy.
- There was a clearly articulated and well worked out model of care that was reflected in practice.
- The unit provided a highly integrated service that addressed the educational, care and therapeutic needs of the young people through good partnership working on the part of the various professionals employed in the unit.
- The therapeutic intervention was proportionate to the young people's needs.
- The manager carried his authority with confidence. He provided leadership and direction but also a sense of security for the staff team. He instilled confidence in them. He enjoyed the confidence and support of external managers and had access to additional sources of support (such as professional supervision).
- There was a strong emphasis on staff supervision, support, training and development.
- Practice in relation to children's rights was exemplary, especially in relation to consultation.
- The standard of primary care was excellent and this included support and encouragement of the young people's social, sporting, educational and cultural interests.
- There were very clear boundaries that were seen as reasonable by the young people.
- The young people saw themselves as respected, valued and, crucially, liked by the staff.

The young people in Unit #1 got a very good service and they came to recognise that this was the case. They had an investment in the success of the service. The management of behaviour was of a piece with the overall service provided. There was a high degree of consultation with the young people and that extended to discussion about rules and boundaries. This approach was described by an external professional as 'getting the young people to manage their own behaviour'. This basically democratic approach did not lead to anarchy. The experience for the young people was that there were very clear limits to acceptable behaviour - they helped to define what these were. Limits were negotiated rather than imposed.

In Unit #1 the various aspects of good practice reinforced each other. An earlier, more turbulent stage in its development had been successfully negotiated. The basic building blocks of a good service had been put in place. The young people responded positively. This raised staff morale which led to further improvements in the service.

## 5.4 Characteristics of HSUs where the service did not meet the required standard

There were problems in the internal management of the seven units that did not meet the required standard. These did not all concern poor management practice. For instance, a number of units had experienced frequent changes of post holder and this had led to instability. One unit did not have a manager at the time of inspection, and in another there was a problem with the availability of the manager due to other demands on his time. In some units external consultants inadvertently encroached on the role of the unit managers. There were instances of poor management practice also, such as managers being too reliant on formal systems and not making themselves available to the young people.

There were reasonable arrangements in place for the external management of the HSUs in this group, although, in one unit the manager was not getting an adequate level of support from her line manager. One of the units had an elaborate internal management structure, but all of them had some staff other than the unit managers with management responsibilities. However, as stated earlier, management practice was more significant than structure.

Some of these units had good systems in place for the supervision, training and support of staff. In one unit these systems had broken down completely in the absence of a manager, and in two others the systems were simply inadequate to the task faced by the staff. In one further instance, what systems were in place were undermined by tensions within the care staff team.

In none of these seven units could the care staff teams be considered to be operating to their potential. While well functioning staff teams are both cause and consequence of good management practice, the opposite also holds true. Some of the care staff teams did not function well because they did not get the training, supervision and support from their managers that they needed to do the job. Some teams, however, impeded the efforts of managers to improve the service provided to the young people. In a number of units, the care staff teams had responded to the absence or frequent changes of manager by closing ranks and operating without management. Newly appointed managers then met resistance to their efforts to provide leadership and direction, and the service provided to the young people suffered as a consequence.

None of the seven units in this group had adequate statements of purpose and function. Two had statements that were not reflected in practice, and another had a draft statement only that did not clearly set out the service the unit was to provide. Of more fundamental importance though, was that all of them lacked an agreed model of care. Either there was no particular model on which practice was based, or there was a model of care that was inadequately understood by the care staff team. This led to particular difficulties in a number of units that are discussed in Chapter 6 of this report.

Practice in relation to children's rights was found to be problematic in many of the units in this group. The difficulties involved inadequacies in relation to complaints or consultation with young people, or both.

The standard of care planning was uneven across all 13 HSUs. In three of the seven units failing to meet the required standard, the care planning process was relegated somewhat with primacy given to therapy. Inspectors consider this an inversion of the proper order of things. Therapeutic inputs should be directed to the achievement of care plan goals.

The standard of primary care was good in these units, at least some of the time. It was clear that the care staff attended to the various needs of the young people and endeavoured to ensure that

they had an experience of being cared for and respected. Many of the young people understood and appreciated this and for some, particularly those who did not present with particularly hard to manage behaviours, their placements were positive experiences for them. However, the standard of primary care was impaired in situations where there were high levels of assault on staff, where there were lots of uses of physical restraints or detention, and also in those units where the staff teams had become inward looking and had lost focus on the needs of the young people. These units lacked the relaxed atmosphere and opportunities for fun that were a feature of the well run units.

## 5.5 Behaviour management practice that did not meet the required standard

The seven units in this group did not manage the behaviour of the young people safely and well. These units tended to be less successful than those in the first group in minimising situations in which the young people behaved in unacceptable ways, and when such situations occurred, they did not deal with them in an effective and appropriate manner much of the time. Only one of these seven units could be considered to have had an agreed approach to behaviour management, however, it was one that relied on excessive use of non-routine forms of behavioural intervention. The approach was ineffective and probably counterproductive.

Some units applied general rules in a manner that took little account of the differing needs and capacities of the young people. This approach also tended to exacerbate the problems with behaviour management. Some of the units failed to make explicit how they expected the young people to behave. All of the units lacked an integration of care and behaviour management so that staff tended to be either in caring or controlling mode.

In a number of these units the young people were clearly out of control some of the time. Four units had high rates of assaults on staff, often resulting in injuries and usually resulting in a lowering of staff morale. In addition, injuries to young people were common, though usually minor, in those units where physical restraint was frequently used.

Five of the units had used the Gardaí to help them deal with potentially dangerous situations. A number of young people had been charged with offences committed in the units. Eight of the young people in five units were on medication to help manage their behaviour.

Two units made extensive use of detention as a routine form of behaviour management. Despite this, there were concerns about high levels of unauthorised absences in both.

All of these units had also trained their staff in TCI, but they lacked adequate systems for monitoring the use of physical restraint and for review of critical incidents.

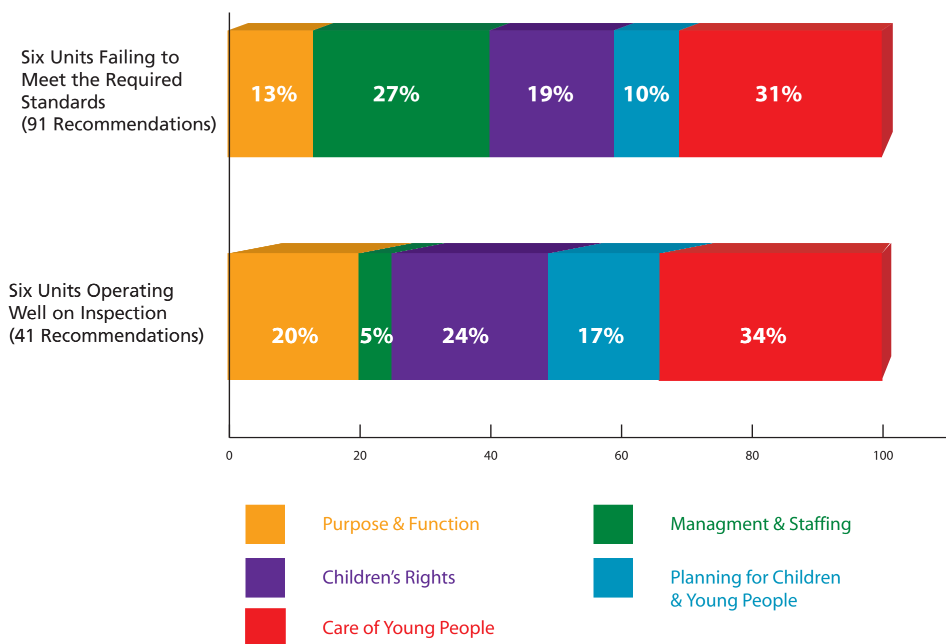
The six units that managed the behaviour of the young people safely and well used the same range of behavioural interventions as the other seven units, with one exception. None of the units in the first group detained the young people. Two in the second group did so. Apart from that, the use of physical restraint, the charging of young people with offences committed in the units and the various other interventions were common to both groups. The differences lay in the frequency with which some interventions were used and the way that they were understood by staff and young people. In some units in the second group, the use of some non-routine behavioural interventions was so frequent that they could not be considered exceptional. They had become part of routine behaviour management and were understood as such by many of the staff and young people.

## 5.6 Breakdown of recommendations of individual inspection reports

These data refer only to the 12 HSUs that were inspected by SSI. This is because the basis for the inspection of the non-statutory unit was somewhat different (2.2).

There were a total of 41 recommendations in the inspection reports of the six units that were operating well at the time of inspection, an average of seven per unit. By contrast, there were 91 recommendations in the reports of the other six units, an average of 15 per unit. The recommendations break down as follows:

**Breakdown of Recommendations under Five Standards for:**
**a) High Support Units Failing to meet Required Standards and**
**b) High Support Units Operating Well**




Note: Data is based on the twelve SSI inspections, the HSE inspection of the non-statutory unit is excluded (see 2.2 Inspection methodology)

The most significant contrast concerns management and staffing. There were two recommendations under this standard in one unit in the first group, but all of the other units met the required standard. There were, on average, four recommendations per unit under this standard in the reports of the units in the second group. There were also significant differences in the number of recommendations in relation to children's rights and care practices. The central importance of good management practice is underlined by these statistics.

# 6 Emergent themes

## 6.1 The use of external consultants

As outlined in Chapter 3 all of the HSUs provided a multi-disciplinary service. In all but one unit, there was an assessment and therapy service available either on site or as part of a regional residential service. A common arrangement was one where a psychologist worked with a number of units in a particular area. Whatever the particular arrangements, the roles of these specialist professionals tended to be broadly similar in each of the units. They worked directly with the young people in carrying out assessments and providing therapy, where the young people were willing to engage, and they provided a consultation service for the care staff team. For the most part these arrangements worked well. The care staff valued the input of the psychologists/ therapists; they saw them as part of the team and found them to be accessible and supportive.

Some of the units also sought and received specialist advice from professionals outside their own service in relation to particular issues, and this enhanced the capacity of staff to manage particular situations. However, there were difficulties associated with the use of external consultants in four of the units inspected. These consultants played a very particular role in the units in question and the concerns raised in this section of the report relate to the role the consultants played in these units, rather than to the use of external consultants per se.

### 6.1.1 The introduction of a new model of care

The consultants in the four units introduced a new model of care, one that differed from previous practice in the units. Inspectors found that the care staff teams in these units were struggling to implement a model of care that they did not fully understand. Many of those interviewed by inspectors stated that they found the input of the external consultants confusing and disempowering. They were unclear about how they were expected to respond to the young people's challenging behaviour. Management of behaviour had all but broken down in three units. In two units in particular, there were high levels of assaults on staff, leading to staff injuries and absences, thus making it even more difficult to manage the young people's behaviour.

Since there was such a limited understanding of the new models being introduced, the role of the external consultant became central to the operation of the units. This inevitably led to a blurring of the boundaries of their role vis-a-vis that of the unit managers. The external consultants often made themselves available to be contacted by telephone or email outside of scheduled consultations and advised those members of the teams who contacted them on how to deal with particular situations. When this occurred the managers were often by-passed. The internal consultants, by contrast, typically worked in close cooperation with unit managers and sometimes formed part of the senior management team in the units.

In the four units where external consultants were used, there was, or had been, crises of authority. One unit that used an external consultant was operating much better at the time of inspection. It had been through a turbulent period during which its capacity to manage the young people's behaviour had been seriously impaired. These difficulties had led to a degree of internal conflict, some of which related to the role of the external consultant. A crisis point was reached when staff believed that they were being blamed for the difficulties faced by the unit. This galvanised the staff team and they sought and implemented creative solutions to the problems they were having with behaviour management. This empowered them and changed the relationship between the consultant and the care staff team. At the time of inspection, a degree of congruence existed in this unit that was missing in the others. This suggests that it is

less the principle of using external consultants that is problematic, but rather how their role is understood and the boundaries that are established around it. The timing of the introduction of the external consultant is also significant. If the consultant is introduced at a point where the staff team is in crisis, the team members are more likely to look to him or her for the solution to their difficulties, rather than looking to their own resources.

### 6.1.2 Accountability and safeguarding

The use of external consultants in these four units also raised some safeguarding concerns.

The external consultants were not part of the line management structure of the HSE or the non-statutory agency and, therefore, were not accountable to line managers within the organisation in the same way that internal consultants were.

In one unit a model of care had been introduced by an external consultant without senior managers checking whether it had been subject to independent evaluation.

The statutory care planning and review processes for a number of the young people were subordinated to the requirements of the model of care. There was a sense, particularly in relation to some of these young people, that the HSE had entrusted the care of these young people almost exclusively to the external consultants.

These combined factors left the young people concerned in a vulnerable position. They were exposed to therapeutic interventions the validity of which was not clearly established in every instance, without the usual checks and balances that normally operate with regard to young people in the care system.

## 6.2 The use of non-routine behaviour management interventions

In response to very challenging behaviour, some care staff teams made extensive use of non-routine measures of control including: physical restraint, detention, and in one case temporary discharge.

### 6.2.1 Physical restraint

The use of physical restraint involves up to three care staff holding a young person, sometimes on the floor, to prevent harm to the young person or others. It is a high-risk intervention as discussed earlier in this report (3.2). Despite this, it is generally accepted that the use of physical restraint has a place in residential child care in certain very limited circumstances. Some of the units inspected made only very occasional use of physical restraint. In Unit #1 no young person had been physically restrained for over two years prior to the inspection.

Inspectors in this round of inspections were concerned about a number of aspects of the use of physical restraint. Firstly, in a number of units its use was so frequent that it had become a routine part of behaviour management. Secondly, there were concerns about the frequent and repeated use of physical restraint on individual young people. Thirdly, some restraints went on for far too long, increasing the risk of injury to the young person. Finally, in those units where the use of restraint was most problematic there were inadequate systems in place for monitoring its overall use and for the review of critical incidents.

### 6.2.2 The use of detention

Only two of the units inspected detained the young people to manage their behaviour. The use of detention is, if anything, even more problematic than physical restraint. There is no consensus that it has any place in residential child care outside of special care units. Some managers were clearly surprised to be asked by inspectors whether they ever detained the young people.

The terminology used to describe detention varied according to the circumstances. The terms 'restricted entry', 'restricted exit' and 'single separation' were all used in this round of inspections to describe situations in which young people were confined to a room or to part of a building.

Much of the concerns about the use of detention related to the lack of safeguards around its use. What starts out as a non-routine intervention can come to be relied on more and more until it becomes routine. In the process, the regime in the unit undergoes a transformation and becomes something other than what was intended when it was established. At the time of inspection, one of the units was operating, at least in some respects, as a detention centre.

The use of detention in the two units where it became part of the routine, was not just inappropriate, it was also ineffective. Neither unit was managing the young people's behaviour well.

### 6.2.3 The use of the Garda Síochana

Many of the units called on the assistance of the Garda Síochana in managing behaviour. They did so in two ways: to ask them to attend the unit to help deal with a situation that had got beyond the control of the care staff, or to make complaints to the Gardaí in relation to the behaviour of the young people. Sometimes this led to the young people being cautioned or charged with offences.

In reply to a question about calling the Gardaí to help manage difficult situations, the manager of a well run unit stated that in order to provide a good service the unit had to be viable. By this he meant that there had to be effective means of ensuring the safety of the staff and young people. If all else failed, he believed that calling the Gardaí was an appropriate thing to do. Using the Gardaí in this way was not problematic in that unit, however, there are dangers. If the Gardaí are called too often the young people may conclude that the care staff cannot contain their behaviour and this may encourage further unacceptable behaviour. Another danger is that once the Gardaí are called the care staff are no longer in control of what happens in the unit or how the crisis is resolved.

The issue of making complaints to the Gardaí about incidents that occur in HSUs is controversial. In certain cases it can lead to young people getting criminal convictions. Young people are placed in HSUs because their behaviour causes problems. Some people argue it is wrong that the young people should be charged with offences for the very behaviour that led to them being placed in the HSU to begin with. While sympathetic to this argument, the SSI believes that different situations call for different responses, and that there may be situations where it is appropriate for young people to be charged with offences, for example, where this is seen as part of an effort to help young people understand the consequences of very destructive behaviour. In this round of inspections, inspectors had concerns about this practice in certain units.

There was a lack of policy or guidance for staff in relation to making a complaint to the Gardaí if assaulted by a young person in the unit. Individuals were left to decide for themselves. This allowed for inconsistencies and placed an onerous responsibility on individuals. The SSI has recommended that the HSE develop a policy and guidance on the making of complaints to the

Gardaí relating to incidents that occur in the units or centres where it has placed the young people. In one of the units inspected, any situation where the Gardaí were summoned to the unit was considered a critical incident and was reviewed by a group, chaired by a HSE manager who was not part of the line management structure of the unit. This had led to improvements in practice. It was an example of good practice that other units should consider following.

### 6.2.4 Temporary discharge

In one of the units inspected two young people had been temporarily discharged because their behaviour could not be safely managed within the unit. One had been placed in a unit run by a privately owned company and the other had been sent home. In one case in particular, it was unclear at the time of inspection whether the young person would be returning to the unit. Neither situation was satisfactory.

### 6.2.5 Use of medication in the management of behavioural problems

Three young people in the well run centres were on medication to help with the management of their behaviour. Over twice that number (8) were on medication in the other seven units where the management of behaviour was not found to be of the required standard. Inspectors found that where medication was used it was reviewed regularly by the young person's psychiatrist. However, taken together the findings suggest that medication may sometimes be used in the absence of more effective means of behaviour management.

## 6.3 A collaborative approach

Practice in relation to children's rights has undoubtedly improved in residential child care in recent years. Young people have better access to information, their complaints are more likely to be heard and dealt with appropriately, and they are more likely to be consulted about aspects of their care than was the case five years ago. These improvements are not apparent everywhere and, in this round of inspections, inspectors came across some poor practice in relation to complaints and consultation. In addition, even in those units where consultation was found to be a reality, the range of issues on which young people were consulted tended to be fairly narrow. Young people's meetings, where held, often only involved discussion of the following week's menu or the choice of DVD to rent at the weekend. While these are not unimportant matters, and while recognising that the true significance of the meetings is the opportunity they provide for young people to engage in problem-solving and responsibility taking, consultation can be used over a wider range of issues. In Unit #1 and, to a lesser extent, in one other unit, consultation was taken to another level; everything was up for discussion, including behaviour management issues. Indeed, Unit #1 had moved beyond the point where the young people were consulted to one where the young people participated in decision-making. A case in point concerns the use of mobile phones. This is an issue which has caused acute difficulties in some units and children's residential centres. In Unit #1 the young people were asked to draw up guidelines and agree limits on the use of mobile phones in the unit. They did so. The staff agreed to implement them and the matter caused no further problems.

There are no short cuts to well run services. It is all about attention to detail and keeping the focus directed on the best interests of the young people. In many of the units that struggled to contain the young people's behaviour, the staff and managers were of the mistaken belief that either through the imposition of controls or the application of expert knowledge, they could ensure the safety and welfare of the young people. By contrast, the premise on which Unit #1 was based was that good order cannot be imposed but must be negotiated.

## 6.4 Recommendations

4 The HSE should draw up guidance on the use of external consultants in its services. It should:
- Define the appropriate role of the external consultant,
- Clarify reporting relationships,
- Outline the safeguards necessary to protect young people from inappropriate or improperly applied therapeutic interventions.

5 The HSE should ensure that all planned interventions with young people in care are consistent with the objectives of their care plans and that they are considered and approved by the relevant care planning group prior to implementation.

6 The HSE should ensure that there are robust systems in place for monitoring and review of physical restraints.

7 The HSE should issue guidance on whether, and in what circumstances, it is ever permissible to detain a young person in an open children's residential centre or HSU.

# 7 High support and the continuum of care

## 7.1 Benefits of high support units

In the units inspected, the young people enjoyed several advantages over their peers in mainstream care placements. All of them had the opportunity to attend an education programme tailored to their needs. The educational provision for the young people in all of the HSUs was of a very good quality. Most of the units had access to on-site assessment and therapeutic services. This is a considerable advantage, given that accessing specialist services for children and young people in care is often problematic. Within the units, there were enhanced staffing levels that delivered a more intensive and individualised programme of care than would be possible in a mainstream placement. Most of the young people in the HSUs who were interviewed by inspectors were happy to be in them and those in the best run units were very satisfied with their care.

Inspection findings indicate that there is often no clear distinction between those young people in mainstream children's residential centres and those in HSUs. A well run centre can often accommodate one or two young people whose behaviour is problematic. Nonetheless, it has to be recognised that specialist units such as HSUs perform functions on behalf of the wider system and not just for the young people placed in them. While many children's residential centres can accommodate one or two young people with behavioural difficulties they cannot cope if all of the young people placed in them present with such difficulties. Mainstream placements (both residential and foster care) are viable, to some extent, to the degree to which there is a safety net within the wider system that ensures that they are not stretched beyond their resources. It is not just the viability of the placements and units that is at stake, it is also the experience of the other young people placed in them. Young people with behavioural difficulties typically consume a disproportionate amount of the time and energy of their carers. Their behaviour tends to disrupt everyday routines and provokes anxiety in others. They occasionally assault carers and peers. All of this inevitably impoverishes the care experience of the young people placed with them.

## 7.2 Costs of high support units

High support units are resource intensive as described earlier in this report (4.2.3, 4.2.4)

The provision of high support residential places is problematic for service providers as evidenced by the fact that three of the inspected units that were not functioning to the required standard were closed by the HSE post inspection.

Placement in a specialist residential unit also comes at a cost to the young person involved. For many of the young people met by inspectors during these inspections, placement in a HSU marked the end of their previous placement. Such endings were often accompanied by feelings of loss and rejection. The young people had to find a place for themselves in the new unit, begin to make new relationships, address their difficulties and so on. They had to think about where they would be moving to once their high support placement ended. It is hardly surprising that so many of them were overwhelmed and acted out in aggressive and self-destructive ways.

One in four of the young people discharged in the year leading up to the inspections went to some sort of short-term or temporary placement, including eight who went to places of detention. Some of these young people may not have been appropriately placed in a HSU in the first place. From the young person's perspective movement from a HSU to another specialist residential unit meant repeating all of the challenges that placement in the HSU involved for them.

## 7.3 Models of care

The units inspected operated different models of care. To some degree, this reflected differences in the presenting problems of the young people placed in them. It also reflected some confusion as to the appropriate place of high support in the continuum of services to young people in care. HSUs were set up at around the same time, and in response to the same set of issues as special care units. Some of the HSUs inspected were closely linked to special care units. For example, they were expected to serve as step-down units for young people coming out of special care and/or had looked after young people who went on to special care units. Other units had more tenuous links with special care. The units with close links to special care were, to some extent, defined by that relationship. That is, they saw themselves as providing, and were expected by others to provide, a service similar to that provided in a special care unit but without detaining the young people. In some HSUs consideration was given to detaining some young people some of the time and a small number did so in circumstances described earlier in this report (6.2.2). Other HSUs were not defined by their relationship to special care. There was little overlap in client groups and the units did not see themselves as providing a similar service. This allowed them the freedom to develop a distinctive model of care (as in Unit #1). Some of the units were caught somewhere in the middle. They were tied to special care by virtue of the expectation that they provide step-down places but were also struggling to locate themselves within the continuum of care and to define a role that was not dependent on their relationship to special care units.

## 7.4 Size of units

Young people typically get referred to HSUs because they cannot be managed in mainstream placements. The decision to place them in a HSU is usually taken on the grounds that they present a danger to themselves or to others. Though the categories are not mutually exclusive, HSUs often contain a mixture of highly vulnerable young people whose behaviour mainly represents a risk to their own safety and young people whose behaviour represents primarily a risk to their carers or to other young people. The needs of these two groups do not always coincide. In a small, well run unit these different needs can be accommodated. Larger units often have more specialist staff and can provide a greater range of services. However, if they contain a concentration of young people whose behaviour presents a risk to others, the difficulties of ensuring the safety of the care staff and the more vulnerable young people become acute. In this context, the extensive use of non-routine behavioural interventions becomes understandable, even though it cannot be commended.

The *Review of the Need for High Support Care* in the eastern region reported that there was unanimity amongst those consulted, that a single campus 24-bedded unit was not a structure or environment suited to delivering high support care. This was a reference to the larger of the two units within the region. This unit subsequently reduced its capacity to 18 beds. As discussed in Chapter 4 of this report, at the time of inspection, this unit contained a concentration of young people with multiple previous placements. While the Review did not indicate the optimal capacity of this unit, successive inspection reports would suggest that this unit is unlikely to be able to accommodate 18 young people.

## 7.5 The future of high support services

High support units are a relatively recent addition to the range of services for young people in care and the service is at a relatively early stage in its development. That six of the units inspected were delivering a good standard of care is evidence that much has already been learned about what constitutes good practice in the care of some of the more vulnerable and troubled young people in the care system.

Specialist residential placements were originally envisaged as interim placements *(A Report on the Requirement and Necessity for Special Care and High Support Residential Child Care Provision in Ireland* (1998)). This report referred to the fact that the difficulties faced by young people in care can be exacerbated by being moved around the care system from one placement to another. If specialist residential facilities merely increase the options for moving young people around the system, they risk becoming part of the problem rather than part of the solution for these young people. The SRSB commissioned report (*Definition and Usage of High Support In Ireland* (2002)) suggested that high support be understood as a methodology rather than as a particular placement and that high support services should be delivered to young people at home or in mainstream placements. The report makes reference to protecting the primary placements of those who move temporarily to dedicated HSUs so that they can return to them.

There will continue to be dedicated HSUs. It is important to consider, therefore, how to maximise their contribution. The evidence of this round of inspections suggests that high support needs to be considered separately from special care, that HSUs cannot provide a good service if expected to combine incompatible functions, and that HSUs may not be viable at all if they are expected to accommodate a large number of young people whose behaviour presents a risk to carers and peers.

Service planners need to consider the following questions:

- How many young people require high support services?
- What type of high support service do they require?
- Where can the required services be most appropriately delivered?
- How can mainstream and high support services be integrated so as to allow young people to avail of either or both according to their needs?

# Appendix 1- Guidance note on behaviour management

## Introduction

This guidance note has been developed for all children's residential centres. It does not provide advice on dealing with particular behavioural difficulties. It indicates the conditions that are needed for centres to be able to manage challenging behaviour safely and well.

## 1. Good management is essential

Managers set the tone of the units they run. They establish and maintain the unit's values and ethos.

Good managers provide leadership and direction for the teams they manage. They give the care staff confidence and a sense of security. They should have systems in place for managing their centres, such as formal supervision of staff, in-service training, regular team meetings and so on, but should not rely on these exclusively. Good managers make themselves available to staff members outside of the formal structures. They understand that while the cohesion of the team is important it cannot be achieved by tolerating poor practice.

Good managers are the primary internal guarantors of the rights of the young people. The young people should understand that any perceived injustice can be appealed to the manager. They should have confidence that the manager will put it right.

For managers to do the job that is required of them certain conditions must apply:

- *They must be clear about their roles and responsibilities*. This necessarily involves clarity of expectation on the part of the agency, conveyed through senior managers.
- *They must be available.* Good managers make themselves available to young people, parents, and other professionals. This is not easy, especially in larger units, as managers often have many demands on their time. Some balance needs to be struck between being available within the unit and being available to the wider organisation. A perfect balance is impossible to achieve but good managers understand how to strike a reasonable one over time.
- *There must be reasonable continuity.* Frequent changes of post holder make it almost impossible to ensure that a unit is well managed.
- *The authority of the manager must be understood, respected and asserted.* The manager directs the care staff and they must account for their actions to him or her. S/he carries executive responsibility within the unit or centre. There needs to be a clear boundary around the authority of the manager. Where the authority of the manager is eroded, the maintenance of good order becomes problematic.
- *The manager must support the care staff in the achievement of the centre's objectives.* S/he must expect and insist on high standards of practice.
- *The manager must be able to rely on the co-operation of the care staff team.* The manager should listen to the concerns of team members and respond positively to constructive criticism, however, a centre or unit cannot deliver a quality service if members of the care staff team either actively or passively obstruct the manager.
- *The manager must be accountable to young people, parents, professional colleagues and the agency.* The manager should be prepared to explain and defend and, as appropriate, reconsider and change his/ her decisions and those of the team.
- *The manager must be able to rely on the support and co-operation of external managers.* A key task is to ensure that the unit or centre is not expected to meet unrealistic or conflicting expectations, while also making sure that the service provided is relevant to the needs of young people for care and protection. The centre or unit must operate within an agreed and clearly understood statement of purpose and function, but that statement must relate to the needs of the children and young people for whom the HSE has responsibility.

## 2. The primacy of relationships

Behavioural difficulties within children's residential centres are addressed primarily through the medium of relationships, rather than through the application of systems or techniques of behaviour management. This is not to say that systems and techniques are unimportant but only that they cannot work unless trusting relationships are established between the young people and those caring for them.

Behaviour management is most successful when it is integrated into a model of care so that it becomes one aspect of caring for young people in children's residential centres.

A preoccupation with control is inimical to good behaviour management. Young people resist and resent being controlled. Most young people, even when they are very troubled, can exercise self control in certain situations and they should be encouraged and facilitated to do so. In a centre where the primacy of relationships is clearly understood, the staff and young people co-operate. Indeed, a major part of the work of the care staff is about winning the co-operation of the young people. This co-operation takes place in a context in which the differences of role, responsibility, capability and status between staff and young people are understood and respected. This necessarily involves recognition that, from time to time, members of staff must take charge of situations where there is a risk to the welfare or safety of the young person and that, sometimes, this taking charge will be despite the wishes of the young person concerned. Like managers, members of the care staff team must understand and assert their authority.

## 3. A good standard of primary care

The basis for positive relationships in children's residential centres is provided by having a good standard of primary care. This starts with an assurance of safety. Young people in care must know that that care staff are there to keep them safe from any threat from within or outside the centre. There must be good policies and practices in relation to safeguarding and child protection, including effective measures to prevent and deal with bullying and all of these must be explained, repeatedly if necessary, to the young people.

Good primary care recognises the importance of structure and routine. The life of the unit should reflect the ordinary rhythms of a home so that young people live in a predictable and familiar world.

Young people's basic needs such as those for shelter, food and clothing must be recognised and met in a manner that recognises and respects each young person as a unique and valuable individual.

Individualised care involves an awareness of and response to the young person's history, preferences, abilities and interests. It also involves understanding and respecting the young person's world including his or her family, culture and ethnicity. It means respecting and facilitating appropriate expression of the various aspects of the young person's identity including his or her religious, cultural, linguistic and sexual identity.

No young person should believe that there is some part of his or her identity that must be suppressed in order to find acceptance in the children's residential centre.

## 4. The participation of the young people

Over time the maintenance of good order can only be achieved in a children's residential centre with the consent of the young people.

Respect for the rights of children should be central to the model of care that guides practice within a centre. It should be standard practice to share information with the young people, to consult with them, and to listen to and resolve their expressions of dissatisfaction in an expeditious, fair and transparent way.

Young people should be consulted about behaviour management issues and centres should have agreed rules and codes of conduct. This is consistent with respecting children's rights. It is also important from a developmental point of view to give young people opportunities for age and developmentally appropriate responsibility taking. It is also likely to be more effective, as the young people are much more likely to accept the need for rules if they have been involved in formulating them.

Young people should always be treated in a manner that is both fair and is seen to be fair. No consideration of the 'greater good' or reference to a therapeutic goal should interfere with the requirements of justice. Young people should never 'be made an example of' by care staff anxious to convey a message to other young people in the centre about the unacceptability of some piece of behaviour.

Young people should have redress if they consider that they have been treated unfairly. Good complaints practices and procedures are vital. Young people should know that they can take their complaints outside of the centre if they cannot be satisfactorily resolved internally. Practice experience suggests that where there is good practice in relation to complaints within centres, young people rarely feel the need to go outside of them for resolution.

Winning the consent of young people to good order can be very problematic with some, particularly those who have experienced multiple placement breakdowns and have little faith in adults. Some placements break down because the young people do not to co-operate, however, this is not inevitable. The key task for care staff and other professionals working with these young people, is to help them reach a point where they can begin to recognise and respond to attempts to offer them assistance. This is highly skilled work that requires persistence and resilience on the part of the workers. It proceeds by small steps. Progress is often painstakingly slow. Care staff teams need a lot of assistance and support with this work through supervision, training and access to specialist advice and consultation.

## 5. Team work

Young people in care need to experience consistency and continuity of care. This can only be achieved if each staff member operates as part of the team. It is not reasonable to expect that every member of the care staff team will respond in an identical way to each situation that arises in the unit. Consistency is achieved through each team member operating from the same set of basic values and by each member applying and being bound by the decisions of the team, operating under the direction of the manager.

Good care teams anticipate and plan for crises. Training in systems of behaviour management such as therapeutic crisis intervention (TCI) and the use of individualised crisis management plans for each young person, have an important role to play in good behaviour management. Managers must ensure, however, that any 'off-the-shelf' package used in the unit is consistent

with the unit's philosophy, ethos and values. Managers must also ensure that use of such interventions as physical restraint does not become part of routine behaviour management practice and that there are systems in place for the notification, review and external monitoring of such interventions to ensure this does not happen.

The staff team need to be clear about what they expect of the young people and what will happen if a young person does not behave as expected. The team needs to ensure that this is clear to the young people. Young people should not learn about a rule for the first time when they are reprimanded for breaking it. They should not be reprimanded for behaviour by one staff member if the same behaviour is tolerated by other team members. A degree of pragmatism is required at times. Some minor misdemeanours may have to be overlooked, to concentrate on those areas of a young person's behaviour that most need to change, so as to avoid the young person becoming overwhelmed and demoralised by excessive demands. On the other hand, setting too low a standard of behaviour may do a young person a serious injustice. The right balance is most likely to emerge through continuing team discussion and review.

Care staff teams that look after young people with emotional and behavioural problems need to be pragmatic, flexible and resilient:

- A pragmatic approach requires that care staff adapt theoretical knowledge to practical experience. That a certain intervention is consistent with the centre's model of care is of little value to a young person if it does not help him or her.
- Flexibility requires that care staff are prepared to try different approaches. No two young people are the same and no two situations identical. Care staff have to make judgements and continually adjust their practice to the demands of the particular situations they find themselves in.
- Sometimes, nothing seems to work and in such situations care staff teams need to be resilient enough to hang in with a young person until things come right.

## 6. Multi-disciplinary working

Young people in care are involved with a number of professionals. Most have care staff, teachers and social workers looking after them. Those with particular needs may also be involved with other professionals such as child psychiatrists and therapists. The more these various professionals co-operate with each other, the better the service provided to the young person. For those young people who do not require particular assistance to manage their behaviour, co-operation between the various professionals is highly desirable. For those whose behaviour is particularly difficult to manage, however, it is absolutely essential.

No one professional can provide a solution to the difficulties posed by young people whose behaviour presents an acute risk to their safety and that of others. Indeed, there is rarely a 'solution' as such and sometimes the search for one can be counter-productive. It is more productive to think in terms of professionals working with the young person to help him or her overcome various obstacles and to meet various challenges. This time the input of the psychiatrist is crucial. On another occasion, the speech and language therapist resolves a communication problem. On still another, the relationship between the young person and the key worker provides the confidence the young person needs to face up to a difficult challenge.

As each problem is successfully overcome, the young person acquires new skills and confidence. There is rarely, however, a linear progression and there are likely to be times when the participants doubt that any progress is being made at all. Nevertheless, such close co-operation between professionals can often be the difference between the continuation and the breakdown of a placement.

The co-operation outlined above assumes, of course, that young people can access the services they need. This can be problematic and the HSE must work to remove what obstacles exist to access to specialist services for the most troubled children and young people in its care. However, access itself does not guarantee co-operation.

For multi-disciplinary work to be effective there must be:

- *A willingness to co-operate* on the part of every professional with colleagues in his or her own and other agencies.
- *A client focus*. Different professional groups and agencies can often be involved in disputes with each other over various issues. Each has a professional responsibility to ensure that these disputes do not get in the way of co-operating to provide a service to particular young people.
- *An understanding and respect for the role of each professional.* Co-operation does not imply that everyone agrees with everyone else but rather that each member of the professional network supports each other in the discharge of his or her particular responsibilities. For example, in a dispute between care staff and a young person over a disciplinary matter, it may be much more appropriate for the social worker to listen to the concerns of his or her client and try to find a way to resolve them rather than to explain to the young person the reasonableness of the demands of the care staff.
- *A clear definition of roles and responsibilities.* Understanding and respecting the roles of other professionals implies that professional roles are clearly defined. Poorly defined roles are unhelpful in allocating tasks within the professional network. On the other hand, rigidity in role definitions can also be unhelpful and lead to disputes.
- *Responsibility sharing*. Each professional has responsibility for the performance of those tasks that fall within his or her own area of competence. However, there are areas where responsibilities are shared. For example, the care planning process involves allocation of tasks to various people, some of them professionals, some service users. By agreeing to co-operate with the plan all of these various people accept some degree of responsibility for its overall implementation. In trying to assist a young person whose behaviour is very problematic, professionals must be prepared to share responsibility in decision-making which almost always involves a degree of risk taking.

## 7. A proportionate response to the young people's difficulties

Residential care should provide young people with a living experience that resembles that of their peers living in families as closely as possible. Interactions between young people and care staff should have the relaxed informality that characterises a well functioning home. Young people should live in domestic type buildings that are furnished to provide a high standard of comfort. The young people should be encouraged to participate in the life of the local community by attending ordinary schools, joining clubs, having friends and so on. Any intervention in a young person's life that makes these things less likely to occur should be avoided wherever possible, and provided only after a comprehensive assessment.

A particular hazard for young people in specialist services is that they come to be defined by their difficulties. The services that are provided for them can focus on the problematic to the detriment of other areas of their lives. Even the most troubled young people are much like other young people much of the time. Any tendency to 'pathologise' every aspect of their personalities and behaviour has to be resisted and they must be provided with opportunities to be 'normal'. Efforts to help the young person overcome difficulties should be proportionate to the difficulties and should recognise that their need for special help exists alongside their general needs as young people, those that they share with their peers.

The principle of proportionality should be applied both to the decisions about what services to provide to a young person and to dealing with particular situations.

A young person should not be placed in a specialist residential unit unless a comprehensive assessment indicates that his or her needs cannot be met in a mainstream foster or residential placement.

Therapeutic interventions should be targeted at the resolution of assessed problem areas, agreed within a care planning forum. Young people should not be subjected to therapeutic interventions without their knowledge and informed consent and that of their parents or guardians.

Specialist interventions should be time limited and subject to review and evaluation. Any intervention that shows little sign of bringing about the desired changes within a reasonable length of time should be discontinued.

# Appendix 2 - Standards against which the inspections were conducted

Note: As described in Chapter 2 of this report SSI inspected the 12 HSUs that were operated by the HSE. The other inspection was of the one HSU in the non statutory sector. This was conducted by the HSE.

The SSI inspections were conducted against selected criteria of five of the standards of the National Standards for Children's Residential Centres. The HSE inspection was against all of the standards and criteria of the National Standards.

The standards and criteria selected by SSI are outlined below.

## Standard 1: PURPOSE AND FUNCTION

***Standard***

*The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.*

***Criteria***

1.1 The centre has a statement that clearly defines the purpose and function of the centre, specifies the population it caters for and the service it aims to provide. Centres have agreed this statement with the HSE.

1.2 The statement is kept up to date, with responsibility for this clearly identified.

1.3 The statement is available in a form that is accessible to young people, families, supervising social workers and any other persons with a legitimate interest in the work of the centre.

1.4 The statement lists the key policies that are in place and outlines their availability to young people, their families, social workers and other persons with a legitimate interest in the work of the centre.

1.5 Staff are familiar with the content of the statement, understand it and are confident that the statement is reflected in care practice.

1.6 The day-to-day operation of the centre reflects the statement of purpose and function.

## Standard 2: MANAGEMENT AND STAFFING

*Standard*

> *The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.*

*Criteria*

**Management**

2.1 The centre is managed by an appropriately qualified person.

2.2 The centre has external management that oversees the work of the centre, approves the statement of purpose and function and all policies, and supports the work of the centre with adequate resources.

2.3 The centre manager and external managers satisfy themselves that appropriate and suitable care practices and operational policies are in place, having regard to the number of children living in the centre and the nature of their needs. *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part III, Article 5.*

2.4 Managers have in place mechanisms for assessing the quality and effectiveness of the services provided by the unit, particularly outcomes for the young people.

2.5 Where the HSE does not run a centre, the registered proprietor shall notify the HSE of a change in the person in charge. *Child Care (Standards in Residential Centres) Regulations, 1996, Part III, Article 6.*

2.6 The HSE notifies the Social Services Inspectorate of the establishment of a new centre for the residential care of children. This applies to a planned centre or to a centre opened on a temporary basis irrespective of the number of young people who will be accommodated.

**Staffing**

2.10 The centre has adequate levels of staff to fulfil its purpose and function. Staff are qualified and have the ability to communicate effectively with children. There is a balance of experienced to inexperienced staff on the team to carry out their duties. The centre aims to have at least one qualified staff member at child care leader level on each shift. *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part III, Article 6.*

2.11 All staff, relief staff, students and volunteers are appropriately vetted before taking up duties, through the taking up of past employer references, including the most recent reference and requesting criminal records checks from An Garda Siochana, or other police authorities as appropriate.3

2.12 All new staff members receive formal induction.

**Supervision and support**

2.13 All staff members receive regular and formal supervision, the details of which are recorded.

2.14 There is an effective link between supervision and the implementation of individual placement plans.

2.15 Staff meetings, hand-over meetings and other forums take place regularly to facilitate good communication, co-operation and consistency between staff in implementing care plans, providing consistency of care and maintaining safety.

2.16 The employer ensures that there are support mechanisms in place for staff, in particular for those who have suffered stress or injury in the course of their work.

2.17 The employer ensures that all statutory provisions in relation to employment law are adhered to.

**Training and development**

2.18 There is an effective ongoing staff development and training programme for care and education of staff. The HSE or organisation supports staff members to do qualifying or post qualifying training, consistent with the need for continuity of the service.

## Standard 4: CHILDREN'S RIGHTS

*Standard*

> *The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.*

*Criteria*

**Consultation:**

> *Young people's views are sought when decisions are being made that affect their daily life and their future. Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 4.*

4.1 Supervising social workers, managers and staff members consult with young people and their families about decisions that affect their lives and future.

4.2 The opinions and views of young people are sought and valued. They help inform policies and practice and the daily running of the centre.

**Complaints:**

> *Young people in residential care are able to express concerns or complain about their care.*

4.3 There is a complaints procedure agreed by the HSE and written information about it is given to children, their parents, staff members, social workers and others with a legitimate interest in the centre.

4.4 The complaints procedure clearly outlines the following:
- what constitutes a complaint;
- how a young person can be helped to make a complaint;
- who they can complain to, in and outside the centre;
- the procedure to be followed (steps to be taken, time scale, who investigates the complaint, where and how it is recorded, feedback to the complainant);
- how a person making a complaint can appeal a decision if they are unhappy with the outcome.

4.5 Staff understand the purpose of a complaints procedure and treat complaints professionally. They routinely record how an individual's concerns are resolved.

4.6 Young people and parents are able to make a complaint and understand how it will be dealt with.

4.7 All serious complaints are promptly notified to the appropriate person in the HSE.

4.8 Complaints made by young people and parents are recorded and taken seriously, and clear conclusions are reached.

4.9 There are systems in place to monitor the incidence and outcomes of all complaints.

**Access to information:**

> *The centre has written policy on young people's access to information. Young people are given access to information about themselves and services available in accordance with their age and level of experience.*

4.10 Young people have access to information about their rights under the United Nations Convention on the Rights of the Child, 1989 and the Freedom of Information Act, 1997.

4.11 Young people are given information verbally and in writing of their right to access their records and information recorded about them, and are guided in how to exercise this right.

4.12 Young people and their families receive written information about their placement.

## Standard 5: PLANNING FOR CHILDREN AND YOUNG PEOPLE

*Standard*

> *There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. This plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.*

*Criteria*

**Statutory care plans**

5.7 Placements are supported by a statutory comprehensive written care plan, developed by the supervising social worker in consultation with others, based on
- the aims and objectives of the placement;
- the support to be provided to the young person, to the residential centre and where appropriate to the parents of the young person by the HSE;
- the arrangements for access to the young person by a parent, relative or other named person subject to any court order;
- the arrangements to review the plan.

5.8 Individual statutory care plans include an assessment of each young person's educational, social, emotional, behavioural and health requirements and identify how the placement will support and promote the welfare of each young person.

5.9 The plan is in place before or as soon as is practicable after the young person comes to live in the centre. *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 23*. In the case of emergency admissions a statutory care plan should be prepared within seven working days.

5.10 The statutory care plan distinguishes between the overall long-term plan and the plan dealing with the period the young person is in the centre (placement plan). The placement plan should operate within the wider care plan being implemented by the placing authority.

5.11 The young person, their parents and significant others are consulted in the process of drawing up the statutory care plan and confirm that they are aware of the way it is being implemented. *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 23*.

5.12 A written copy of the statutory care plan is forwarded to the parents, the manager and the young person.

**Statutory care plan reviews**

5.13 Each young person's care plan is subject to formal, systematic and regular review in accordance with the directions outlined in the *Child Care (Placement of Children in Residential Care) Regulations 1995, Part V, Articles 25 & 26*.

5.14 Statutory care plan reviews assess the effectiveness of the care plan, take into account developments and update the care plan giving named people responsibility for pursuing achievable objectives of the plan within a time scale.

5.15 Young people and their families are helped prepare for reviews, are invited to attend review meetings, are aware of their purpose, are satisfied with the way they are conducted and receive copies of the documentation, including decisions made.

5.16 Copies of decisions made at review meetings are forwarded to parents, even where they have not attended meetings, unless this is regarded as putting the welfare of the child at risk.

5.17 The supervising social worker in conjunction with the residential centre ensures that arrangements for conducting the review process are in place. These include the responsibility for convening, chairing and recording the review process, the venue, the method of issuing invitations and seeking reports, and the distribution of minutes that state the date of the next review.

### *Social Work Role*

*Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to any aspects of their care.*

5.26 Social work management ensures that supervising social workers:

- provide sufficient background information about the young person to the centre;
- prepare a care plan;
- make arrangements to hold care plan reviews;
- ensure that young people and parents are invited and their views are represented during the review and are reflected in decisions;
- visit the young person in the centre and see the young person privately;
- are aware of all significant incidents involving the young person and take appropriate action on receipt of written notifications;
- receive written notification of all incidents of physical restraint or unauthorised absence of a young person;
- are satisfied that the young person is safe and well cared for in the centre;
- from time to time read the child's case file and daily diary;
- keep an up to date case file including a record of every visit to the child *Child Care (Placement of Children in Residential Care) Regulations 1995, Part IV, Article 22*.

**Emotional and specialist support**

5.27 Staff are aware of the emotional and psychological needs of young people, and through the key worker role and the general ethos of the centre, facilitate the assessment and meeting of those needs.

5.28 The external manager arranges for external support to staff to provide for assessments, consultancy and treatment or counselling for individual young people. *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part III, Article 9.*

5.29 All children in care shall have early access to specialist services they may require. Supervising social workers and centre staff should keep a record of attempts to access these services.

5.30 All professionals involved with the young person will co-ordinate their work and will ensure that any interdisciplinary differences are overcome in the best interests of the young person.

5.31 The findings and recommendations of specialist professionals are reflected in the care plan and the work of the centre with the young person.

5.32 Where a young person becomes a parent while in the care of the HSE, the HSE shall have due regard to their overall and developmental needs as well as to those of their infant.

5.44 All case and care files are kept in perpetuity using an appropriate medium.

## Standard 6: CARE OF YOUNG PEOPLE

***Standard***

*Staff relate to young people in an open, positive and respectful manner. Care practices take account of young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities and leisure experiences to their peers and have opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.*

***Criteria***

**Individual care in group living**

6.1 Young people are cared for in a manner that respects and takes account of their wishes, preferences and individuality.

6.2 The emotional life of young people in care is given particular attention. Young people know that there is a responsible adult available to them who is capable of understanding and supporting them.

6.3 Young people are encouraged to make choices about their personal appearance and clothing, with support and advice from their carers.

6.4 Issues of personal hygiene are dealt with sensitively and with dignity.

6.5 Young people have opportunities to develop and maintain interests, talents and hobbies and to participate regularly in a range of leisure and recreational opportunities of their choice.

6.6 Certificates of achievement, photographs, home videos and other memorabilia are kept safely for the young person.

6.7 The centre celebrates festive occasions and young people's birthdays in a special way, with gifts and activities similar to those of their peers.

6.8 The care experience provides young people with the skills, competencies and knowledge necessary for adulthood and citizenship.

**Managing behaviour**

6.18 The centre has a written policy for responding to inappropriate behaviour that clarifies the rights and responsibilities of both young people and staff members. All staff are encouraged to consider the underlying causes of inappropriate behaviour and day-to-day practices are in place to support children in managing their behaviour.

6.19 Young people understand the behaviour expected of them. They know that positive behaviour will be rewarded and that sanctions can be applied for unacceptable conduct.

6.20 Young people are not subject to any form of treatment that is humiliating or degrading.

6.21 The centre has a written policy on bullying that promotes a positive and safe environment.

6.22 The centre has a written policy on sanctions that is entirely consistent with promoting the developmental needs of young people as accounted for in their placement plan. It should state what sanctions are permitted and prohibited.

6.23 All sanctions are reasonable, humane and age appropriate. They are in proportion to the misbehaviour addressed and are effective in managing it.

6.24 All sanctions are recorded in a separate book for monitoring purposes.

**Restraint**

6.25 The centre uses a method of physical restraint that has been researched and is based on reputable practice. There is a written policy that is understood by all staff and young people in the centre. Where physical restraint is used, it is applied in a way that is consistent with the requirements of the policy.

6.26 There is evidence to show that staff have used other methods to try and deescalate the situation before using physical restraint.

6.27 Physical restraint is never used as a sanction or punishment, but only to protect children from immediate risk of injury to self or others, or serious damage to property.

6.28 Physical restraint is deployed using the minimum amount of force necessary and for the shortest period of time. The actions of staff are proportionate to the circumstances that led to a child needing to be physically restrained.

6.29 Physical restraint is not a regular feature of the care a young person experiences. If a young person is frequently physically restrained a review of the care plan should be arranged as a priority

6.30 Staff are appropriately and sufficiently trained in the use of physical restraint. Only those so trained should ever be involved in it. Their competence is checked regularly and refresher training is provided.

6.31 The use of physical restraint is recorded in a separate book and closely monitored by the unit manager and line manager for the centre. Social workers see copies of the record of physical restraint and parents are informed of its use. *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part III, Article 15*.

**Absence without authority**

6.32 There is a written policy and procedure for staff to follow when a young person is absent without authority. This includes who should be notified and within what timeframe.

6.33 The policy dealing with children who are absent without authority takes into account the age, developmental stage and personal circumstances of the young person. This is accounted for in the young person's care plan.

The Management of Behaviour: Key Lessons from the Inspection of High Support Units

No. 2

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