“Accepting as a founding principle that the detention of Children is a matter of last resort and that it should be for the shortest period of time possible the Special Residential Services Board, working in close co-operation with all relevant bodies, will facilitate and ensure the co-ordinated provision of child care, therapy and education in the best interest of children in special care and children detention school placement.”
Conference on Education in Care

The Special Residential Services Board organised a conference entitled “Education in Care” on 30th & 31st March 2004 in the Hodson Bay Hotel, Athlone. Chairperson Maureen Lynott welcomed everyone and explained the remit of the Board.

Different Perspectives:

**Michael Doyle**
The conference continued with a session entitled “Different Perspectives”. Mr. Michael Doyle gave us the Education & Welfare Perspective. He presented the School Attendees Act 1926 and its functions. Michael also spoke about the main issues facing the Educational Welfare Officers, such as suspension, expulsion, refusal by school to enrol, unexplained absences and school refusal. He concluded with the point that on average, 1200 young people fail to transfer from primary to secondary school each year.

**Donal McCormack**
Mr. Donal McCormack, Regional Manager for the Child Care Services in the NEHB expressed the view that the majority of young people who are cared for will have gone through mainstream Residential Care and the majority of children in mainstream care have gone through foster care. By the time a child reaches that stage, it becomes increasingly difficult to reverse the child’s thinking regarding education. Donal also discussed the issues surrounding care staff or social workers who, much of the time, are left with the responsibility of the child’s education. In order to adequately deal with this, Donal recommended mutual respect and meaningful team work, valuing each individual in the equation, and having flexible and creative arrangements. Such flexibility would enable young people to take time out when personal issues become problematic to learning, and then reintegrate back when they are ready to do so.

**Ann O’Sullivan**
Ms. Ann O’Sullivan from Oberstown Education Centre, Lusk, spoke of how frequently matters relating to education are often swept aside by other overriding care issues. Ann went on to give a background to Oberstown Education Centre, where boys and girls are able to experience learning side by side. She also discussed various difficulties attributed to the nature of the work and the type of child. Ann stressed the importance of students achieving through the curriculum and how the young person must always be the focus, and where staff must share this vision. All children are working towards national accreditation and want achievements, this is the reason all pupils attend school every day; they feel that they are achieving.
Dr. Bill Lockhart & Ms. Gráinne O'Sullivan from the Extern Organisation, discussed the building of a continuum of services for children in crisis. More and more children are finding themselves in crisis where they are lacking a sense of connectiveness to others and a lack of deep connection and spiritual meaning. Bill & Gráinne described one way of combating that crisis: Authoritative Communities--this is where groups of people live out the type of connectiveness that is missing in so many of these children’s lives. They see each child as an end in themselves, reflecting a strong value base while providing nurturing and warmth. As a result of this, “Extern has developed a continuum of community based services which aim to maintain young people with complex needs in the community”. Extern uses a resiliency model of intervention tailored to meet the individual needs of the child. Examples of this tailored approach can be seen in their methods of Prevention (Kickstart & Summercamp), Diversion (Passport & Early Years) Intervention (Youth Support) and Crisis (Janus, Time out, Link & MST).

**Plenary Session:**

**Personal Experiences**

Our Plenary Session related to Personal Experiences of Education in Care. Principal Joan McGrath began this session by relaying her personal experiences of working with children in care and the issues surrounding this difficult work. Child Care Leader Emeline O'Flaherty also shared her experiences with us. Both Maria Roughan and Sharon O'Loughlin were parents of children that had been in care. They explained the situation surrounding their particular circumstances and how they felt that they had no voice. Maria touched on a feeling of losing her rights of motherhood, and how once the child turned 18 years there was no back up available.

Finally, to conclude our conference, Louise McGaughran courageously spoke of her personal experiences of the service and her education while in residential care from 1991. Louise is a success story, and clearly demonstrates that when a system is working and a young person has determination to heal and a will to succeed, great things can be achieved. Louise completed her primary and secondary education and went on to successfully complete a degree in Business Administration.

**In Summary**

All of the presentations brought up varying issues for most members of the audience. However, most speakers’ words had common characteristics such as the following:

All children who come into Residential Care, come from homes in which they were struggling, whether it be from their parental home, foster care, adoption or unknown, as in the case of unaccompanied children. Many have suffered physical, emotional and sexual abuse, deprivation neglect and rejection. Many also have been involved in alcohol and drug abuse as well as engaged in unacceptable sexual and social behaviour. Due to the potential risk they pose to themselves, society or both, the Courts or Health Boards have acknowledged that they are in need of Residential Care. The fundamental question underpinning the conference was “How can they be helped while in Residential Care?” Various answers were considered such as the following: Creating a safe and secure place in which they can learn and develop. This can be done by having well trained, well resourced staff both in the care and educational sections, who work together to create an ethos in which the child’s feels wanted, appreciated, esteemed, respected, has his/her battles fought for them, learns to respect themselves and others and generally speaking, is supported in such or way that when they begin the arduous task of standing on their own two feet, they feel confident in doing so. In order to achieve the above, staff must have appropriate training and this must be constantly updated. They must also have intense back up and assistance from good solid management that is open to new ideas and enthusiasm from staff, the children and the parents.

There must be a three way communication between the child, the staff, management and the parents. If all of the above are concentrated on,

Videos of the conference are available on loan from Phoenix House.
Ph: 01 6724100
Workplace Violence
By Kevin McKenna

In this first of a series of articles, Kevin McKenna outlines the background and work to date of the North Eastern Health Board’s Committee on Workplace Violence. A later article will describe the Committee’s development of a programme in the professional management of aggression and violence which is currently awaiting accreditation as a higher level academic award.

Extensive international professional healthcare literature and data from regulatory agencies have consistently described the exposure of healthcare staff to violence in their workplace. The U.S. National Institute of Occupational Safety and Health reported that healthcare workers are at “greatly increased risk of nonfatal assault” (NIOHS, 1996 p.13) while the U.K. Health Services Advisory Committee (HSAC 1987) concluded that “violence is a significant problem affecting a wide range of occupations and may affect staff at almost any location whatever their occupation or department”. While attention to this problem has been more recent in the Irish context, the Advisory Committee on the Health Services Sector have identified “assaults on personnel” as an occupational risk “peculiar to the health services” and reported that “assault” is now the third leading cause of accidents for healthcare staff, accounting for 14.9% of all occupational injuries reported in 2000 and for 19% of insurance carrier notifications between 1994 and 2000.

While national media coverage has given considerable attention to work related violence within Psychiatric and Accident & Emergency settings, the issue remains largely unacknowledged within childcare services generally and in residential services in particular. There may be multiple reasons for this. The image of the violent youth may be less appealing or credible to the popular and professional media than that of the violent mentally ill patient. Additionally actuarial estimations that rely on the total numbers of occurrences rather than relative risks may reflect the lower volume of residential childcare services compared to those of psychiatry and A&E. Whatever the reasons, the failure to systematically evaluate the extent of the problem in all services presents inherent dangers in that the need for proactive and responsive strategies may not be fully appreciated.

In 2001 the North Eastern Health Board established a Committee on Workplace Violence, which is representative of all stakeholders and services, to develop a comprehensive organizational plan for the management of aggression and violence within the board’s services. Conscious of the dearth of Irish research evidence to guide their work the Committee secured support from the Department of Health and Children to conduct a study to systematically investigate the problem and to develop an evidence based model of best practice in the management of work related violence. The study is being conducted along four strands which will investigate the:

- Prevalence of work related violence within the NEHB
- Provision, content, and appropriateness of staff training
- Issues related to staff reporting such occurrences
- Provision, content, and appropriateness of staff support

The first strand of the study was a survey which investigated the extent to which staff within the NEHB encounter work-related violence; whether staff have received training in the management of work related violence; whether staff report occurrences of work related violence; and what support systems are sought and utilised by staff following such occurrences. The study used a questionnaire entitled the “Survey of Violence Experienced by Staff” (SOVES) which was developed and adapted from a previous Irish study (McKenna 1999), was content validated by a panel of national and international subject experts, and pilot tested prior to use. The composition and size of the randomly selected sample was statistically determined to ensure that all grades of staff were proportionally represented. The response rate was sixty per cent. The methodological rigour of the study was externally overseen in association with the Royal College of Surgeons.

While the report of this study will be published later this year, preliminary findings are compelling that aggression and violence pose a significant problem within Irish healthcare to the extent reported internationally, and that again consistent with international studies, many health and social care occupations within diverse settings are affected. (HSAC1987, Manitoba 1989, Ontario 1992, Rosenthal et al 1992, Whittington and Shuttleworth 1996). One indication of the pervasiveness of the problem across services is reflected in the fact that over two thirds of all respondents rated their need for training in the management of aggression and violence as “essential”.

Twenty eight per cent of staff reported having received training which is typical of rates reported in previous studies. The proportion of staff trained, when examined by occupational group, correlated remarkably with the risk for each category suggesting that the training provided is being received by those most at risk. While this finding was encouraging, the staff’s reported confidence in utilizing the training, particularly physical interventions, was a cause of concern, with staff who had received training reporting poor levels of confidence in their ability to apply the interventions in practice.

The management of aggression and violence encountered within the health and social care settings is a complex issue that presents a unique challenge both to staff and to healthcare providers. The uniqueness of this challenge rests upon the fact that aggression and violence must be understood and managed within the context of diverse health and social care settings and within the duty of care owed to individuals exhibiting such behaviours. Meeting this challenge poses legal, professional, ethical, risk management and health and safety concerns and, while addressing this challenge is complex, one critical component of any approach is the provision of training to staff in the management of aggression and violence.

From a statutory perspective, the Health Safety and Welfare at Work Act (1989) and
subsequent regulations require that employers monitor the workplace to identify hazardous conditions, to provide the appropriate training and equipment necessary to mitigate against these risks, and to have in place support measures for those exposed to such risks. Inherent in the recognition that "assaults on personnel" represents an occupation-specific hazard "peculiar to the healthcare" is the mandate to provide staff with the necessary training to minimise the associated risks (ACHSS 2001).

From a regulatory perspective, the National Standards for Childrens Residential Centres document published by the Department of Health & Children is explicit that the management of aggression and violence must be proportionate and effective and that intervention must rely on de-escalation whenever possible. Should physical intervention become necessary, such interventions should utilise the minimum amount of force necessary for the shortest period of time possible and should only be instituted by staff who have completed "appropriate" and "sufficient" training and whose competence has been established. The standards further require that all physical interventions are researched and based on "reputable" practice.

The provision of training should not however be considered solely in the context of a regulatory and statutory obligations. From a health and social care perspective, what is also demanded is the compassionate and skilful care of those involved. Twenty years ago Reid et al (1983) cautioned that to accept all violence within healthcare as being inevitable is "fatalistic and nihilistic" and contended that violent behaviours are symptoms "crying out for treatment". Lion (1987) suggested that the "compassionate and intelligent care" of individuals experiencing difficulty controlling their behaviour demands that staff "be fully competent and skilled in the management of such behaviours".

These assertions are supported by evidence that suggests that the provision of training to staff in the management of aggression and violence reduces both the frequency and the magnitude of injuries subsequent to such occurrences, results in significant cost savings from reduced staff injury and related expenses, and has been demonstrated to improve staffs' clinical effectiveness (Infantino and Musingo 1985, Thackery 1987, Carmel and Hunter 1990, Wondrak 1992, Martin 1995). The training subgroup of the NEHB committee on workplace violence has conducted a thorough review of training currently provided within Irish health and social care. The group expressed concern that much training currently relies upon proprietary programmes, often developed as a market driven response to the unmet demand, and that contrary to cautions in professional literature, has originated from the contexts outside of health and social care (Paterson and Leadbetter, 1999). The selection of training is frequently deferred to health and safety departments and while programmes selected administratively rather than professionally, might meet organizational health and safety requirements, such training frequently fails to acknowledge the contextual relevance of the diverse care settings within which staff must manage aggression and violence.

This situation, while typical within Irish healthcare organizations, has resulted in training that is currently unregulated, inconsistent, sometimes contradictory, and which often relies upon interventions that are unproven from either safety or clinical effectiveness perspectives. Furthermore "systems" approaches that deliver training generically without reference to the professional, legal, or legislative frameworks of the care setting within which the training will be applied may be difficult to defend either legally or morally.

In the final analysis, care providers face a difficult dilemma. While there are clear legislative and statutory obligations to provide staff with training, there remains an absence of consensus on what constitutes safe, effective, and acceptable practice. This dilemma is reflected in the report of the Health and Safety Authority's Advisory Committee on Health Services (2001) which concluded that there is clearly a need for the availability of authoritative advice on best practice in training staff to deal with aggression and violence and that this need should be addressed by the Health & Safety Authority in conjunction with the Department of Health and Children, the health boards, and the professional and representative organisations 'as a priority'.

While this is a serious concern for healthcare organizations from health and safety, risk management, and resource utilisation perspectives, it has more profound implications for care delivery within health and social care, considering the inherent physical and psychological risks to both patients and staff (Carmel, and Hunter, 1989; Lanza, 199; Meehan et al 2000) The employment of physical interventions poses inherent risks as highlighted by the recent restraint related death of 15 year old in a UK residential facility. While no speculation is being made here as to the cause of this fatality, the case does highlight a risk that has previously been reported within North American residential childcare settings. In addition to the risk of serious physical injury recent studies have identified significant psychological trauma associated with the use of physical interventions (Bonner 2002).

In their commitment to address this issue, the NEHB Committee on Workplace Violence has consulted widely with clinical, professional, academic and regulatory bodies and developed a programme of training entitled the Professional Management of Aggression and Violence (PMAV). This programme is currently in the process of seeking accreditation as a higher level academic award. The programme development and details will be described in a future article.

The problem of work related violence described as "universal" in healthcare, remains relatively uninvestigated within the Irish context. The work being conducted within the North Eastern Health Board suggests that work related violence is a feature of Irish healthcare to an extent similar to that reported internationally. Any successful program on work related violence must be clinically effective in meeting the needs of patients and clients, while simultaneously, and in a balanced way address the personal safety needs of staff, and the health safety and risk management concerns of the organization. The Committee on Workplace Violence is convinced that the development of an effective training response is an essential step in the quest for clinical and organisational excellence in the management of aggression and violence health and social care.

References available upon request.
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The Assessment and Treatment of Juvenile Sex Offenders in Ireland

Alan Carr and Gary O'Reilly
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Summary
Child sexual abuse (CSA) is a widespread national problem. Evidence indicates that in between one-quarter to one-third of all cases the perpetrator is a juvenile sex offender. In the Republic of Ireland there are only 4 juvenile sex offender treatment programmes staffed by interagency, multidisciplinary teams. These teams have developed rigorous assessment and treatment procedures. The programmes take account of the multifactorial causation of juvenile sexual offending and the need to involve families and a variety of agencies in helping these youngsters develop more productive lives and avoid recidivism. There is a need to develop and evaluate similar programmes in each region of the country.

Prevalence of CSA in Ireland
Child sexual abuse is a major problem in Ireland. The SAVI Report (McGee et al., 2002) based on a random sample of over 3,000 Irish adults found that 24% of men and 30% of women have been victims of child sexual abuse (CSA). 3% of males and 6% of females reported penetrative CSA.

The Age Distribution of CSA Perpetrators
Adolescents are responsible for about a third of all cases of CSA in Ireland according to comprehensive studies of 512 confirmed cases of CSA in the Eastern Health Board Region (McKeown et al., 1989) and 408 cases in Northern Ireland (The Research Team, 1990). The SAVI Report indicated that 25% of those who reported sexual victimisation in childhood identified the age of the perpetrator as less than 17 years of age (McGee et al., 2002).

Multifactorial Causation of Juvenile Sexual Offending
There is no single cause for juvenile sexual offending. Multiple factors may predispose youngsters to engage in sexually abusive behaviour. A variety of events and circumstances can precipitate specific sexual offences. Many factors can maintain a pattern of re-offending (Carr, 1999; Carr & O'Reilly, In Press; O'Reilly & Carr, 1998; O'Reilly, Marshall, Beckett & Carr, 2004).

Predisposing Factors
Being brought up in a disorganized, violent or abusive family environment may render adolescents vulnerable to sexual offending. In disorganized family environments many youngsters develop insecure attachment styles, low self-esteem, empathy deficits and social skills deficits, all of which are risk factors for sexual offending. In violent families some youngsters learn to use coercion for getting their needs met. In families where CSA occurs, some victims learn to sexually victimize others. Intellectual disability may render youngsters vulnerable to sexual offending. Difficult temperament and poor impulse control are also predisposing factors for sexual offending. Some youngsters with difficult temperaments and poor impulse control find it very challenging to regulate strong emotions and urges including anger, fear, sadness, and sexual desire. As such they are at risk for expressing rather than inhibiting strong sexual urges. When combined with a coercive interpersonal style such adolescents may find it difficult to make and maintain appropriate romantic relationships, and so may attempt to have their sexual needs met through abusive behaviour. Deviant sexual arousal is a further predisposing factor for sexual offending. Some youngsters for temperamental reasons or as a result of deviant socialization, become sexually aroused in response to deviant sexual situations such as those involving violence or CSA.

Precipitating Factors
Specific sexually abusive acts may be precipitated by a combination of factors. These include the onset of puberty; easy access to potential victims; access to particularly vulnerable victims such as those with disabilities; lack of access to normal romantic relationships; increased stress and neediness due to life events such as bereavement, loss or failure; and reduced inhibitions due to intoxication with alcohol or drugs.

Maintaining Factors
Once a youngster has sexually offended, a pattern of re-offending may be maintained by a variety of factors. These include cognitive distortions or beliefs that allow the youngster to either deny, minimize or justify their abusive behaviour and its impact on their victims. Where the pattern of re-offending involves the same victim, the victim’s decreasing resistance abuse may maintain the offending behaviour. A pattern of sexual re-offending may also be maintained by the absence of parental monitoring and supervision of adolescents’ daily routines. Masturbation to memories and fantasies associated with past sexual offences may also maintain a pattern of sexual offending. Broader cultural factors such as living in a society that undervalues children and in which child pornography is widely available may also maintain CSA.

Protective Factors
From this cursory account it is clear that no single factor causes juvenile sexual offending, but rather in any given case, it is possible though careful assessment to identify specific predisposing, precipitating and maintaining factors associated with that particular adolescent’s pattern of sexual offending. On the positive side, a number of individual and family strengths may function as protective factors. These include acceptance of some degree of responsibility for the abuse; making a commitment to change the offending behaviour pattern; high self-esteem; an internal locus of control; social skills required make and maintain appropriate relationships;
involvement in a supportive educational placements; a strong social and family support network; effective parental supervision; and the capacity to acquire relapse prevention skills. The more protective factors that are present in a particular case the better the prognosis.

Assessment and Intervention Services

There are four juvenile sex offender treatment programmes in the Republic of Ireland and three in Northern Ireland. Some of these programmes are staffed by interagency multidisciplinary teams with input from professionals in community care services, child and adolescent psychiatry services, residential child care services, Garda, probation and welfare services, the judicial system, educational psychology services, schools, and vocational training services. Programme staff are released on a regular sessional basis, from their employing agency, to offer assessment and intervention for juvenile sex offenders as part of the interagency multidisciplinary team. This is a valuable model for practice because it facilitates interagency collaboration which is essential for child protection.

Assessment of Juvenile Sex Offenders

The two main functions of assessment are (1) to develop a therapeutic relationship with the juvenile offender and his family and maintain good professional relationships with members of the involved interagency network; (2) to gather sufficient information to construct a formulation and treatment plan. A formal contract for assessment should be signed by the juvenile offender and his family. A more detailed account of the clinical assessment of juvenile sexual offenders and their families can be found in O’Reilly and Carr (2004a).

Treatment of Juvenile Sex Offenders

Juvenile sex offender treatment tends to use a parallel adolescent and parent group format. Adolescents attend a weekly group meetings for 12-18 months and concurrently their parents attend a parent support group. In the adolescent programme the following topics are covered: understanding the rules of the group; giving an initial account of sexually abusive behaviour; building motivation to change sexually abusive behaviour; modifying cognitive distortions; taking responsibility for sexually abusive behaviour; developing victim awareness; autobiographical review; relationships and sexuality education; anger management and social problem solving skills training; and relapse prevention planning. Parent support groups help families come to terms with their child’s sexually abusive behaviour, to modify family factors that may have contributed to the occurrence of the abusive behaviour, and to develop ways to contribute to the adolescents relapse prevention support system. Further information on therapeutic work with adolescents and their families can be found in Print and O’Callaghan (2004) and Thomas (2004).

Treatment Effectiveness

While controlled treatment outcome studies of adult sexual offenders have been conducted (O’Reilly & Carr, 2004b) similar evaluations of programmes for juvenile sex offenders are sorely lacking. However, two studies illustrate the magnitude of the benefit to society from supporting the development of such programmes. Abel et al., (1985) found that 240 untreated adult sex offenders who began their sexual offending as juveniles had an average of 580 sexual offences. In contrast, Alexander (1999) found a recidivism rate of only 7.5% in a sample of 875 treated juvenile sexual offenders. These results point to the value of developing such programmes throughout Ireland and to the importance of routinely evaluating their effectiveness. Finally a recent meta-analytical report (Hanson et al., 2002) by an expert committee comprised of both critics and advocates of sexual offender intervention concluded that current approaches to intervention (mostly based on studies of adults but including a small number of adolescent studies) reduced both sexual and non-sexual recidivism (sexual recidivism: treated offenders 9.9%, untreated offenders 17.4%; general recidivism: treated offenders 32.3%, untreated offenders 51.3%). On balance the evidence on treatment effectiveness is very encouraging but indicates that much research and therapeutic work remains to be done with juveniles who sexually offend.

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Further Reading

References available upon request.
An Evaluation of Criteria for Admission to Special Care Units

The Special Residential Services Board is currently in the process of commissioning a research project that will examine the criteria used for admission to Special Care Units.

Background
The Special Residential Services Board has developed a set of criteria to be followed when young people are being considered for admission to Special Care Units. These criteria were developed in agreement with the admission committees of the Special Care Units, and are based upon the conditions laid down in the Children Act 2001, adhering to the principle that deprivation of a child's liberty must be an option of last resort. At present, pending full implementation of the Children Act 2001, admission to a SCU can only be secured by an order of the high court made on the basis of individual cases. This means that the pathway to care laid down in the Act, i.e. Family Welfare Conference followed by consultation with the SRSB followed by an application to the district court, is not being consistently followed. However, the admission criteria set out by the SRSB are currently in operation by the units, and it is now appropriate to evaluate their effectiveness and establish whether they are suitable for the needs of the children for whom special care is considered inevitable. Statistics are currently available on the numbers that are admitted and the numbers of applications and refusals. However, they do not provide information on cases where applications for special care are considered necessary but do not qualify for the admission process because of lack of congruence with the criteria. There exists a perception, based on anecdotal evidence, that the numbers of young people for whom special care is considered and rejected far exceeds the numbers of refusals evidenced in statistics. This evaluation will seek to establish if the criteria are appropriate by providing qualitative contextual information on all cases, but particularly those cases where young people are considered for special care but are potentially excluded at an early stage of the process.

Objectives
- To go beyond current statistical information to examine all cases in the community that have been considered for special care and either conform to or fail to fit in with the criteria developed by the SRSB.
- To specifically explore the appropriateness of the criteria, and identify any aspects that are causing particular difficulty
- To establish, as far as possible, the decision making process that led to consideration of a special care placement in the case of a young person
- To establish, as far as possible, whether the current availability of special placements is greater or lesser than the need perceived by practitioners and managers on the ground.
- To look at the regional spread of applications for Special Care and the usage of Special Care Units across the country.

The Special Residential Services Network

The Network was set up in July 2002 under the auspices of the Special Residential Services Board. Essentially it is a practice forum, for those providing specialised services for ‘troubled and troublesome’ young people. It comprises of representatives from the Children Detention Centre (St Pats), Children Detention Schools, Special Care Units, High Support Units and other specialised community based services. The most recent Network event took place in the Heritage Hotel in Portlaoise on 16th and 17th June 2004. The focus of the event was — Positive Approaches to Challenging Behaviour and for this Network event we sought to look at good practice in an Irish context. The speakers were practitioners working in Ireland.

Jackie McLaughlin, Unit Manager in Crannóg Nua High Support Unit looked at the challenges that are being faced to both new and existing organisations, particularly in the context of much of the recent changes.

Lucinda O’Mahony, formerly Manager of Creag Aran High Support Unit concentrated on the current systems in place to safeguard young people and staff in our approaches to working with challenging behaviour and Noel Howard, Deputy Director from St Joseph’s School looked at the issue of gender — focussing on our preconceptions and approaches to working with young people.

These presentations were in a workshop forum, with 55 delegates from across the Children Detention Schools, Special Care Units and High Support Units. In addition to this, representatives from the Health Board areas not previously represented in the Network attended and a delegate from the Irish National Teachers Association (INTO), who are currently devising a policy on working with challenging behaviour in schools.

The second day of the conference looked at current research been undertaken in the Irish context and examples of best practice. There were presentations on:

‘Child Physical Restraint — Observations from an Audit’ Sophy Cawdry, Psychologist, St Joseph’s Clonmel
‘The Outcome of a three month Review of Critical Incidents at Trinity House School’ John Smith, Activity Manager, Trinity House School
‘The Review and Adaptation of an appropriate physical restraint model’ Michael Dunne, Trinity House School
‘Youth Advocate Programme — an evaluation of the project in the Western Health Board Area’ Georgina Kilcoyne and Dr Patricia O’Flynn
‘Children Act Services Manager, Western Health Board
‘Working with Sexually Reactive Young People’ Brian Hogan, Director, Oberstown Boys School

There was interest in the services being developed and the research been undertaken in the various centres and this session provided a good opportunity for discussion and contact.

A report of the conference and information will be sent to the centres. If anyone else requires any further information, they can contact the SRSB email: info@srsb.ie
Developing Special Care — A View Point

By John Martin

“If I had been shut up in any place to pine and suffer, I should always hate that place and wish to burn it down or raze it to the ground” (Dickens, 1857).

Introduction:
The establishment of children’s rights to care and protection has been a subject for much discussion in the past one hundred years. “Until the early nineteenth century there was no readily available concept of juvenile delinquency. This is not to deny that youngsters committed crimes, that the period we would now term “adolescence” was perceived to be “difficult”, that there existed humane judges, or that day-to-day accommodations were made to what was, then as now, perceived as the immaturity of youth. It is rather to argue that since “juvenile delinquency” was not of a distinctive form no specific strategies had been created to deal with it.(Harris and Timms, 1993).

Situation Historically in Ireland:
The history of child welfare in Ireland and the consequences for children who have been removed by the state from their families is only recently been written. (Ferguson, 1993). The Irish state has enjoyed the facility of providing minimum financial input to voluntary organisations and religious congregations to primarily provide the care system for children and young persons who have been deemed to be out of parental control or a danger to themselves or others (Kennedy, 1970; Ferguson, 1993 and Ferguson, Gilligan & Torrode, 1993). This situation has been identified in the late 1990’s by King who writes “the industrial and reformatory school system in Ireland differed from the start from their English counterparts in that, according to the Reformatory and Industrial Schools Systems Report 1970 “the Local authorities were unwilling to contribute to the establishment of these schools or even to contribute to the maintenance of the children.” As a result, various Religious Orders were requested to undertake the work.” Religious and voluntary organizations continued to be the primary providers of residential child care services in Ireland until the late 1980’s. This absence of the State in the affairs of families has been reinforced in the Constitution of Ireland which affirms the primacy of the family (Stationery Office, 1937). In the midst of the absence of the State in the development of children’s alternative care systems in Ireland a number of high profile care proceedings have come before the senior courts in Ireland in relation to the State’s apparent failure to provide for children in need (Kenny, 2000). These happenings have had the combined effect of focusing child care service planning on a significant issue, albeit affecting a small number of children and succeeding in providing resources for such children at a considerable cost to the Regional Health Board. This development has been further assisted by the impending introduction of the relevant parts of the Children Act, 2001 which now places a legal mandate on the state, through the operation of the Regional Health Boards, to provide special care for children in the cachment area of each Health Board.

Findings from Literature:
In attempting to understand the complexity of childhood behaviours, particularly those behaviours that transcend the morals, mores or standards of society, there has been considerable debate over the centuries about the causations of such behaviours. These conflicting viewpoints appear to hinge on a paradigm between opposing perspectives of welfare and justice. The conflicting ideologies between the child welfare model and criminal justice model of understanding juvenile behaviour is further addressed by O’Neill (2000) who argues “Ideological confusion about the underlying causes of offending and the most appropriate approaches to children in trouble continued through the 1970’s. The late 1970’s and 1980’s witnessed a shift from the welfare to the justice paradigm, with a revival of traditional criminal justice values, driven by political ideology and by concerns about the unanticipated consequence of the 1969 Act”. O’Neill (2000) continues to argue that “academics and pressure groups for children promoted an alternative “justice” or just deserts’ perspective, the principles of which were seen as oppositional to those underlying a welfare perspective.”

The prognosis for the future of children who have been through the special care systems has been portrayed by O’Neill (1999) as “unsuccessful” and continues “what is known from previous research is that secure accommodation is generally unsuccessful in treating or modifying behaviour such as running away and prostitution and that the experience increases the chance of re-offending for younger children and for those who were admitted as non offenders” What is also known is that there are dangers of serious psychological and social damage being inflicted on children if secure placements are not managed well and that for some young people, particularly those who present a risk to themselves and for young women, the experience may compound violent and destructive behaviours.” Harris and Timms (1993) described a study by the Dartington Social Research Unit on young persons who were in a long stay secure treatment unit. Whereas some of these young people “made progress”, 23% of them were in prison after 2 years and a further 65% continued to have problems. Borduin (1999) describes reviews of the literature pertaining to working with difficult adolescents and concludes “unfortunately, the development of effective treatments for violence and criminality in adolescents has been an extremely difficult task. Indeed, several reviews of the delinquency treatment literature in the 1970’s concluded that
nothing works”. Kazdin, (1995) described some success with behaviour modification approaches with children who, though difficult were not exhibiting major behavioural and self harm episodes.

Current Situation in Ireland:
The current structure of residential child care in Ireland reflects a complex system of caring arrangements for children varying from infants to adolescents, with or without a disability and the responsibility for these services falls between three Government Departments. Briefly, those children who are in need of welfare or protection are the responsibility of the Department of Health and Children, and this responding service is administered through the Regional Health Boards (in 2005 the Regional Health Boards will be replaced by four Regional Health Authorities). Those young people who are in conflict with the law or breaching school attendance regulations are the responsibility of the Department of Justice, Equality and Law criminally active is administered by the Department of Education and Science. Those young people who are in need of welfare or protection are the responsibility of the Department of Education and Science.

Focus Group Research:
In light of the foregoing dilemmas within the child care services I conducted some limited research with significant managers of the statutory child care services of the South Eastern Health Board. This included focus group research with General Managers of Community Care, Child Care Managers, the Regional Co-ordinator of Child Care and Principal Social Workers within the South Eastern Health Board in 2002 to ascertain their opinions on how to plan for the development of special care within this region. The principal findings from this research are outlined below and obviously reflect the benefit of multi-disciplinary planning.

Principal Outcomes from Focus Groups:
- Early Intervention and Prevention Services Required
- Current Structures in Community Care unable to address new need
- Critical Assessment Techniques need to be developed and implemented
- Ethical issues regarding both care and its cost need to be addressed
- Future role of child care within the health services is questionable
- Need to expand the concept of Special Care as a Process of intervention and not only be restricted to a location for practice
- Securing proper and adequate Budgets is critical
- Need to develop specialist, multi-disciplinary services to plan, deliver and account for Special Care Services.

Conclusion:
Children may enter the state care system for a variety of reasons. Some return home after short periods in care. However, the majority of children who enter the state care system remain there for a considerable period of time and many until they reach the age of majority. Equally, children who are placed in the state care system are drawn disproportionately from the poorer classes and lower socio economic backgrounds (Kennedy, 1998; Berridge and Brodie, 1998). The importance of developing a caring ethos for children in care is highlighted by a participant within the focus group research who said, “in general it would be my approach to working in the human services that people change on the basis of relationships, that they form and I think irrespective of the type of alternative care, if children don’t get actually an opportunity to form relationships with benign, skilled, constant, stable adults, nothing of real significance is going to happen to them. There is no model yet in the Republic of Ireland of a special care unit that incorporates secure care with therapy and education.”

The National Children’s Strategy informs us that “children in care are a particularly vulnerable group and institutional life, while conferring many benefits, can also have damaging effects on them. While recognising staff commitment, recreating a family environment remains a challenge to be addressed (Stationery Office, 2000).

John Martin is a Principal Social Worker in Children & Families Services in the Wexford Community Care Area of the South Eastern Health Board. This article is based on research conducted for the purposes of an MSc in Health Services Management, at Trinity College Dublin, which was completed in 2002.
What’s the Alternative?
Youth Advocate Programme (YAP)

In 2002, the WEB introduced a new programme that promoted a mentoring-based ‘wraparound’ form of intervention in an attempt to address the needs of ‘out-of control’ young people who had come to be well known to its services. The Youth Advocate Programme (YAP), which was developed in the United States, is a private, community-based programme that aims to reintegrate this group into the community and to create effective long-term links with formal and informal services such as schools, recreational clubs, employers, welfare services and religious organisations. The ‘wraparound’ model characteristic of the programme refers to a mix of individualised in-home and community-based services that are developed around each young person and their family structure. At the core of the programme is a mentoring service that matches a young person for a six month period with a locally recruited adult ‘advocate’ who has little or no formal training, in the hope that the adult will advise and guide the young person to choose wisely and resist from partaking in antisocial behaviours. Where this programme particularly differs from other services currently available for the group is the fact that it offers 24-hour intervention. Intervention is always available when the client is in need.

Multisystemic Therapy Programme (MST)

Multisystemic Therapy (MST) is an intensive family and community based treatment that addresses the multiple determinants of serious antisocial behaviour in young people (aged 13 to 17 years old). Scott Henggeler et al at the Medical University of South Carolina developed the model. MST addresses the multiple factors recognised to be related to delinquency across the key setting, or systems, within which young people are embedded (e.g. family, peers, school, neighbourhood, community). The model strives to promote behaviour change in the young person’s natural environment, using the strengths of each system to facilitate change.

The MST Team work with (a) young people who have been placed in the residential unit prior to returning home and (b) young people who have remained in their own home without going through the Unit. In relation to the latter category an audit for the period of March 2001 to November 2002 highlighted that 88% of those young people continued to remain at home after MST intervention.

Linden Services for Children was the first programme in the United Kingdom to use the Multisystemic model as a method of intervention in working with young people and their families.

Executive Update

Announcements

The Special Residential Services Board would like to offer our congratulations to Dr. Bill Lockhart who was recently appointed Chief Executive of the Youth Justice Agency in Northern Ireland. Due to this appointment, Bill has been informed that he must resign from all public appointments. Therefore, it is with great regret that we must announce his resignation from the Board. Bill has served on the Board for the past 4 years, and his dedication, commitment and foresight will be sorely missed.

Staff

To-date, 10 staff have been recruited to the executive of the Board to carry out the operational role as contained in Part 11, Section 227 of the Children Act 2001. An additional two Court Officers are due to come on board in the near future.

On Call facility

The SRSB operates a 24 hour On-Call facility to co-ordinate and provide assistance to the key agencies. This was initially a pilot project which has proved successful in co-ordinating requests. All requests for residential accommodation are co-ordinated by the SRSB in consultation with the five Children Detention Schools. In addition there is on-going liaison and consultation by the Court Officers with the Courts Service, An Garda Siochana, Probation and Welfare Service, Health Boards and voluntary organisations. The SRSB has intervened in specific cases where alternatives to detention have been arranged.

24 hr on call 087 203 9200
Forthcoming Conferences and Events

Irish Association of Social Care

The Irish Association of Social Care Workers (IASCW) was established in 2004 to provide professional support and representation to social care workers and students. The aim of the association is to provide representation at public and policy making level, establish and maintain standards of best practice in social care and raise the public awareness/profile of social care in Ireland.

So far this year the Association have had two meetings with the Minister relating to registration, training, title designation, TCI etc. Several submissions have been made to publications and links have been forged to both national and international associations. The association also conducted a piece of research on the issue of drug use in residential child care that raised the issue of social care with an estimated 500,000 people nationally.

The IASCW will hold its autumn conference in the Radisson Hotel Galway on the 18th and 19th of November 2004. The line up for the conference is as follows:

- Ursula O’Farrell, (author of First Steps in Counselling and Courage to Change,) on the professional helping relationship in social care Dr. Pat Dolan (Head of the Child and Family Research Centre at NUIG) on social care work with families

- Adrian Ward (founder of the MA in Therapeutic Child-Care in Redding University, and author of Intuition is Not Enough, and Therapeutic Communities for Children and Young People) on therapeutic social care with children in residential care

- Forum titled “Responding to Violence in Social Care” will include demonstrations on TCI, C&R and the Garda response to violence, followed by open floor discussion/debate on the most appropriate and/or successful response.

- Three workshops titled:
  - “Responding to Victims of Domestic Violence”, “Social Care Work with People with Intellectual Disabilities”, and
  - “Working Therapeutically with Young People in Care.”

The conference will be followed by a gala dinner with free draw with a top prize of a night for two with evening meal at the Galway Radisson, second prize a DVD player, and lots of other spot prizes.

For more information on membership and or/conference contact John Byrne @ (0402) 34931.

The Resident Managers’ Association Annual Conference & A.G.M.
EVOLVING MODELS OF PRACTICE IN SOCIAL CARE
MANAGEMENT A REFLECTION

This conference will look at the growth and development of models of practise that provide significant outcomes for young people in the care system, their carers and their communities.

- Keynote speakers will include
  - Nick Leeson — Rogue Trader
  - John Diamond — Mulberry Bush School
  - Kamini Rambellas — Borough of Hillingdon
  - Michael Murray — Eastern Health & Social Services Board

The Resident Manager’s Association is a professional organisation whose members manage residential and day care centres in Ireland. We currently provide homes and care for over 600 children and young people.

Dates: 3rd - 5th November, 2004-08-05
Venue: Heritage Hotel, Portlaoise, Co. Laois
Cost: RMA members from €210
Non-members from €250
Contact: Conference Organisers Ltd — Dublin
Tel: 01 6620125
Email: info@conferenceorganisers.ie

The Irish Association for the Study of Delinquency are holding their Seventh Annual Conference entitled Positive Interventions and Effective Use of Sanctions For Offenders. The conference will be held in Cavan Crystal Hotel, Cavan on 3rd, 4th and 5th November 2004.
Contact Geraldine Comerford

Invitation to Submit Papers

The SRSB Bulletin would like to invite individuals to submit summaries of post graduate research relating to the area of residential child care. We would also be interested in receiving relevant article or journal reviews.
If you are interested in the above please contact phoenix House.
(The editorial Board of the SRSB Bulletin will consider and choose submitted papers at their discretion)

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