The Special Residential Services Board

An Bord Seirbhísí Cónaithe Speisialta

DEFINITION AND USAGE OF HIGH SUPPORT IN IRELAND

- Report to the Special Residential Services Board -

April 2003

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1. INTRODUCTION

This document provides a summary of outcomes from research undertaken on the use and definition of High Support within Ireland. High Support Units are an intermediate residential care service on the continuum of care between mainstream residential care and special residential care (i.e. secure care).

Social Information Systems Ltd were commissioned by the Special Residential Services Board, on behalf of the Minister for Children, to undertake this work. SIS is an independent research and consultancy organisation with over twenty years of experience of operating in the social care arena. SIS operates extensively in the UK advising Social Services Departments, Health Authorities and Voluntary Organisations on their strategies and objectives and monitoring and evaluating their impact. In addition to individual Authority commissions, SIS works with numerous departments of central government on issues relating to children's social work, youth justice and community care.

In the Republic of Ireland SIS has worked with all Boards throughout the Country examining issues of community care, the organisation of social workers and the implications of new or proposed legislation. Recently SIS has been involved with

- Conjoint All Boards Evaluation of the Financial and Resource Implications of the Children Act 2001.
- Proposals for the Revision of the Management Information Requirements on Children and Family Social Work Services for the Department of Health and Children, again a conjoint approach with all Health Boards.
- A piece of work is currently underway on behalf of the HSEA, Impact and Department of Health and Children to examine and make recommendations on social work workload management systems.
- A Review of Children and Families Social Work in the South Eastern Health Board.
- Proposals for the Better Integration of Services for Homeless Children and Young People in Dublin.
- A review of the cost implications of the Ferguson Report for the Mid-Western Health Board.

In the arena of residential care SIS has a longstanding reputation for its evaluations and investigations into re-organising residential provision (including open, secure and specialist e.g. psychiatric services). SIS has undertaken numerous reviews of residential provision for individual social work Authorities. In addition, SIS was commissioned by the UK Government's "Residential Task Force" to develop a framework for the evaluation of Children's needs and regimes to meet those needs.

2. TERMS OF REFERENCE AND METHODOLOGY

SIS undertook to examine the use of High Support facilities throughout the country and to develop, in conjunction with Boards, some proposed criteria for entry into and exit from High Support Units. The work had three phases:

1. **Review of current developments of high support within Health Boards**.

   SIS would meet with representatives from each Board area to examine:

   - The development of high support services within the Board area (or regionally where no Board-specific services exist);
   - Current characteristics of high support provision (a pro-forma on this was developed by SIS and circulated to Boards in advance);
   - The characteristics of children and young people receiving high support services (based on a pre-circulated proforma developed by SIS);
   - The perceived location of high support services on a range of continuum of provision;
   - Perceived strengths and weaknesses in the role, remit and usage of high support services; and
   - Proposed changes desired in the role, remit and provision of high support.

   An additional meeting to discuss the above issues was held with representatives of the Department of Health and Children Child Care Policy Division and SSI.

2. **Analysis of data**

   From the above meetings two reports are to be developed by SIS:

   - Model(s) of high support in Ireland, its usage and its distinguishing characteristics.
   - The current and future role of high support in a continuum of care.

   Drafts of these reports would be presented to the Project Steering Group for their comments and agreed amendments incorporated.

3. **Proposed criteria for admission and discharge to High Support Residential Units**

   From the two reports above SIS would develop proposed criteria for the admission and discharge to High Support provision with particular reference to:

   - Legal status of the child and young person
   - Previous service provision received
   - Needs to be met by accessing the provision
   - Nature, intensity and duration of the provision
   - Gatekeeping arrangements to be employed to quality assure the decisions of admission and discharge

With regard to the review of current developments of High Support, the Boards were visited as follows:

Wednesday June 19th 2002:	North Western Health Board.
Thursday June 20th 2002:	Western Health Board.
Friday June 21st 2002:	Mid-Western Health Board.
Monday June 24th 2002:	Midland Health Board.
Tuesday June 25th 2002:	Southern Health Board.
Wednesday June 26th:	South Eastern Health Board
Friday June 28th 2002:	Northern Area Health Board.
Monday July 15th:	North Eastern Health Board.
Monday July 29th:	South Western Area Health Board.
Thursday August 15th:	East Coast Area Health Board.

3. BACKGROUND

For a number of years before the direct intervention of the High Court in the development of alternative care services in the Republic, all Boards had become aware of a growing number of children and young people who were displaying challenging behaviour in a number of placement settings. The High Court became involved because cases of children for whom no adequate services were being provided were being referred via Judicial Reviews. The High Court referred to these children as requiring "special care and/or protection".

The Department of Health and Children brought in a consultant from Scotland, Mike Laxton, to provide advice. Two reports followed, "On the Requirement and Necessity for Special Care and High Support Residential Child Care Provision in Ireland" (1998) and "The Principles and Policies Underpinning the Development of Special Care and High Support Provision in Ireland" (2000).

Laxton set out four basic premises:

That the development of any specialist provision must be a positive response to the identified needs and problems of the young person. It must be more than a pragmatic response to a crisis.

Restricting a child's liberty in any circumstance, but especially when they have not been charged with committing an offence, must be an action of very last resort and limited to the shortest appropriate time.

There is a direct relationship between the quality of alternative provision and the number of specialist places perceived to be required. Weaknesses and shortfalls in existing child care services will inevitably distort the demand for places and, therefore, the question of how many units must be seen in the context of an overall child care strategy.

Any specialist provision must be effectively integrated with other relevant services to ensure that it can operate flexibly in response to changing needs and circumstances of the young person. This will help to ensure the emphasis is on working towards the least restrictive caring environment.

Laxton also suggested that High Support Units have three potential dimensions:

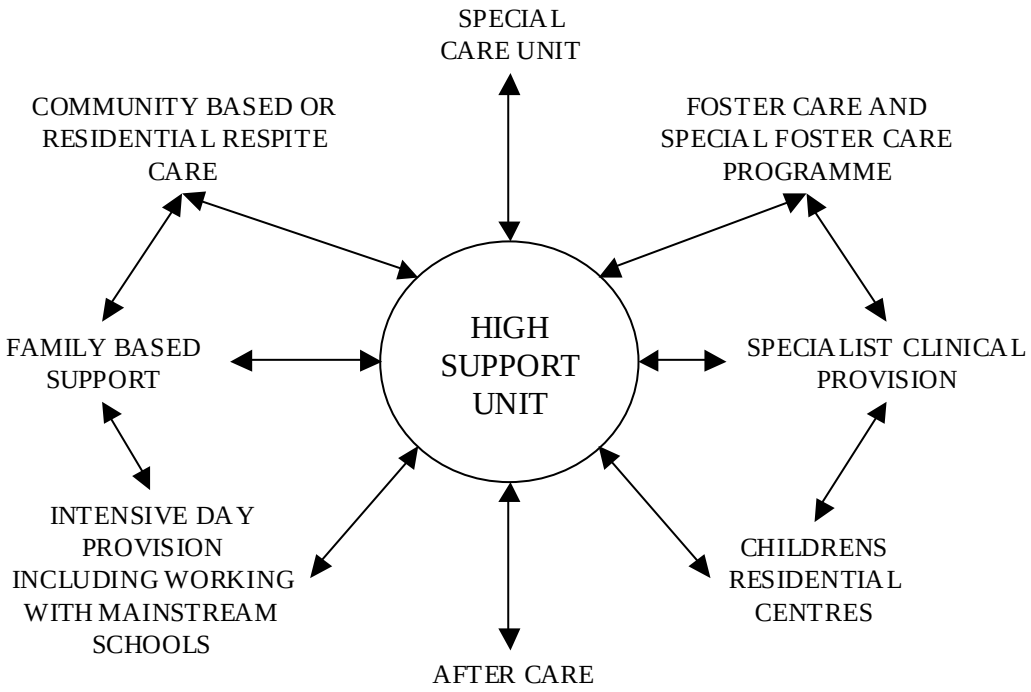
- To act as a gatekeeper for the Special Care unit to ensure that only those at most serious risk are placed there.
- To provide planned follow-on care in a safe and secure, but, by definition, more open environment.
- To act as the core provision within a core and cluster model of child care provision within the health board.

He stated that the difference between High Support and Special Care is essentially about the level of security, with Special Care being the placement of last resort. Staff/child ratios should be largely the same in both types of units, and both should be seen as interim placements, to be used only after careful consideration. "They cannot

in themselves provide 'solutions' to the complex and often long-standing needs and problems of particularly damaged and difficult young people." Laxton emphasised that interventions need to be focussed and short-term and links with the family and other significant adults maintained. The principle of normalisation - finding the least restrictive environment that the young person and their family can cope – should be central.

Laxton also stressed the need to develop the necessary range of alternative provision and improve the quality of some existing services. "In the first instance Health Boards will need to develop a comprehensive three year child care planning strategy."

Thus, he saw the potential role of High Support Units within an integrated residential and community based child care service as shown below.



The period since the second Laxton report has seen Health Boards adopt a more systematic and planned approach to the development of High Support residential care facilities. Most of these Units have been developed in the last two years (see section 4.1 for a summary of this) and some are still in development. In the interim, there has also been a rise in the use of "special arrangements" – many such arrangements provide the high staffing ratios that would be expected in a High Support Unit, but not all such arrangements include therapeutic input. It is usually assumed that the current usage of "special arrangements" would be reduced by the growth of High Support Units.

4. CURRENT POSITION

At the time that this report was written, there were 91 High Support Unit places provided or planned nationally, although many units would not expect to operate at full capacity all the time because of case-mix considerations.

The first part of this section of the report shows an overall summary of the characteristics and usage of High Support, deriving from the questionnaire sent to Boards by SIS and site visits to both commissioners and providers of High Support services. The current position in each Board is then shown in turn.

Each individual Board report is subdivided under the following headings:

- Definition of High Support – from Group Discussion.
- Continuum of Provision within the Board.
- Profile of Placements in High Support in Last Twelve Months.
- Description of High Support Unit(s) to be accessed by the Board.
- Potential candidates for admission to the Unit (where the unit has not yet opened).
- Referral Process.
- Admission Criteria.
- Monitoring and Review Arrangements.
- Discharge Arrangements.

Note that the individual Board commentaries reflect the statistical information supplied by Health Boards and *perceptions* deriving from the site visits. For example, the "definition of High Support" sections merely reflect what the individual participants in the site meetings expressed: on another day, or with another group of people, there might have been slightly different points of emphasis. Equally, some of the factual information recorded may have been true at the time that information was submitted or at the time of the site visits, but may have developed further since (e.g. additional progress towards the opening of specific High Support Units).

4.1 ALL HEALTH BOARDS SUMMARY

Definition of High Support

A range of factors were noted when defining "high support", and these can be clustered into three groupings, as shown below. *Please note that the tick-marks only reflect the response given in the group discussion when asked to define "high support". The absence of a tick does* not *imply that the consultees would not agree with the "characteristic", merely that they did not mention it at the time in response to this specific question.* The intention of the table is simply to illustrate the range of perceived characteristics that immediately came to mind.

	NAHB	SWAHB	ECAHB	MHB	MWHB	NEHB	NWHB	SHB	SEHB	WHB
Characteristics of the Children and Young People										
Children who cannot be contained in mainstream because of aggressive/challenging behaviour		✓		✓		✓		✓	✓	✓
Children with complex multiple needs					✓	✓	✓	✓		
Young people who are hard to place			✓							
Characteristics of the HSU										
Open	✓	✓		✓		✓		✓	✓	✓
High staff ratios	✓	✓	✓		✓			✓	✓	✓
More skilled / experienced staff				✓	✓					
Therapeutic Input	✓	✓			✓	✓	✓		✓	✓
Multi-disciplinary inputs						✓			✓	
Not referred by Court	✓						✓			
Respite to donor units							✓			✓
Education On-site				✓						
More structured environment		✓	✓		✓					
Time-limited, planned			✓							
Assessment						✓				
"High Support" outside HSUs										
Not just a building	✓	✓	✓						✓	✓
Need to revisit continuum of provision	✓		✓	✓	✓	✓				✓
Need to improve fast-track options into other settings	✓			✓			✓			✓
May consider use of FWCs prior to admission								✓		✓

The first two of these, the "characteristics of the children and young people" and "characteristics of the HSUs" are actually quite broad, and, as will be shown, result in differing views of children who are included or excluded from admission to certain units or in the range and length of programmes provided.

The third of these, "high support outside HSUs", refers to a desire to define high support *as a methodology or culture* rather than a specific building. Typically, it might involve higher staff ratios or multi-disciplinary/therapeutic inputs in *any* setting (i.e. including the child's home, foster care, mainstream residential), whether through re-skilling existing staff (i.e. in mainstream residential), developing specialist workers (e.g. specialist foster carers), or improving fast-track access to specialist services provided by other disciplines/agencies for children with particularly complex needs. However, the difficulty with this conceptualisation is it becomes harder to define clearly, both as to the types of arrangements that are included as "high support" by Boards, and comparatively across Board areas.

Profile of Placements in High Support in Last 12 Months

Figures reported from the statistical survey on usage of High Support over a 12-month period were reported as:

	Health Board									
	NAHB	SWAHB	ECAHB	MHB[$]	MWHB	NEHB	NWHB*	SHB	SEHB	WHB
Creag Aran		6[⌘]								
Moyhill					5					
Elm House					8					
Brookside Lodge					6					
Roscrea					4					
Ardee						4				
Brindley House						2				
Ard Doire								2		
Loughmahon								7		
St Bernard's									4	
Kilcreene									7	
Ten Acre									6	
Grangemouth									6	
Community Children Centre									1	
Barr Aille										2

[⌘] Creag Aran supplied details of placements for all of ERHA region.

[$] The MHB reported figures that relate to young people with High Support needs who are currently placed in detention schools or special schools for the purposes of detention: these have been excluded from the "All Boards" aggregated totals but are commented on within the Board's own commentary.

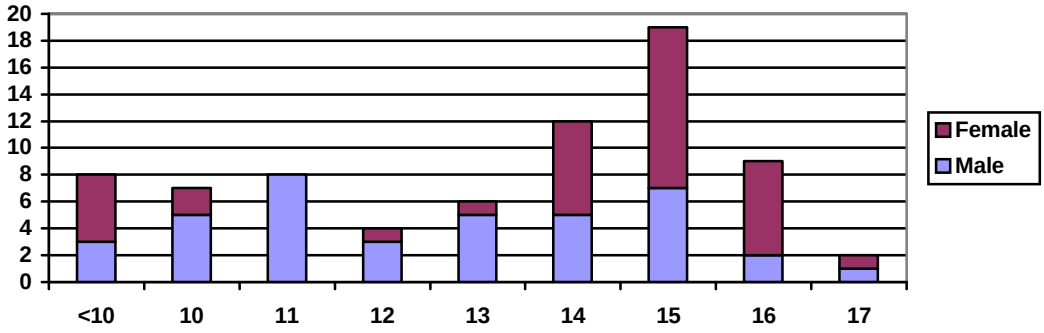
* The NWHB reported no placements in High Support.

Note, however, that these figures do not necessarily paint an accurate picture of need. They are constricted by supply-side factors in the provision of High Support Units. Placements were frequently in establishments that the Boards do no intend to use

again (e.g. because of inappropriate placements in secure placements, or because the Boards intend to make use of new, more appropriately designed, High Support Units such as Castleblaney or Crannog Nua).

Discussions during the site visits suggested that demand for High Support provision far exceeds these figures (rough estimates of the extent of demand are noted in the individual Board reports, but should not be regarded as 100% accurate as this question was asked during the meetings without prior warning).

Age and gender profiles of the 74 young people admitted to High Support were (one was admitted twice, hence the figures total 75):



While this appears to show those aged 15 to be the major need-group, there is considerable variation between Boards, again linked to the nature of provision.

Only one child was admitted under an Emergency Care Order, with an almost even split between Other Care Orders and Voluntary:

Emergency Care Order	Other Care Order	Voluntary Care
1	36	38

The average number of placements prior to admission (mean and mode) was 3, with a significant number having one or fewer prior placements (note: number of prior placements was note recorded for one young person).

0	1	2	3	4	5	6	7	8	9	10+
9	13	15	15	8	8	2	1	0	0	2

This is reflected also in the significant proportion who accessed High Support not in a "linear" fashion (i.e. as a step-up from mainstream), but in a non-linear manner (from home or foster care). Nevertheless, the majority are admitted from mainstream residential care. Again, the profile differs significantly between different Boards (Note: one young person was admitted twice).

At Home	Foster Care	Residential General	Residential Special Care	High Support	Custody/ Detention	Other
18	7	29	9	2	6	4

Length of time in care prior to admission to High Support appears to be polarised. The majority are admitted after a year or more in care, with significant minorities in the 6<12 months category and the <1 week category. Again, the latter probably reflects non-linear admission from home/foster care. (Note: not all young people admitted to high support had a previous care history recorded in the survey).

< 1 weeks	1<2 weeks	2<4 weeks	1<3 months	3<6 months	6<12 months	12 months+
13	0	0	2	1	9	38

Very few stay in High Support for less than 6 months: almost all in the survey had placements of six months or more.

< 1 weeks	1<2 weeks	2<4 weeks	1<3 months	3<6 months	6<12 months	12 months+
1	0	2	4	4	30	27

The majority who left High Support appear to have either returned home or to mainstream residential care. This can be misleading, and should be read in conjunction with the data on duration that suggests that most actually stay in High Support for more than 6 months. (Note these figures only relate to those who have left care).

At Home	Foster Care	Residential General	Residential Special Care	High Support	Custody/ Detention	Other
16	0	8	2	0	2	3

High Support Units to be Accessed by Health Boards

The following provides a summary of HSUs to be accessed by different Health Boards. Some access more than one HSU within their own area (MWHB, SHB, SEHB). Some HSUs will have regional access (Castleblaney, Crannog Nua).

	NAHB	SWAHB	ECAHB	MHB	MWHB	NEHB	NWHB	SHB	SEHB	WHB
Crannog Nua	✓	✓	✓							
Creag Aran	✓	✓	✓							
Castleblaney				✓		✓	✓			✓
Moyhill					✓					
Elm House					✓					
Brookside Lodge					✓					
Cre House					✓					
Ard Doire								✓		
Loughmahon								✓		
Grangemore									✓	
Ten Acre									✓	
Kilkreene									✓	
St Bernard's (Sacre Coeur)									✓	

Functionality of High Support Units

The table below illustrates the considerable variation that has emerged in the functionality of High Support Units. The size of units, their target age ranges, and their programme lengths all display differences. As one participant put it, "there is no one model of care, there are models of care." In addition, very few are at present considering providing an outreach service or specialist consultancy service, and even those that are feel themselves to be in the very early stages of developing this.

	Open / Opens	Places	No. of Units	Gender	Age on admission	Programme Length	Outreach	Specialist consultancy
Crannog Nua	*Aug 2002*	24	3	M/F	12-17	6-12 months	Long-term (5 yr vision)	Long-term (5 yr vision)
Creag Aran	Sept 1997	6	1	M/F	10-12	2 years	×	×
Castleblaney	*Aug 2002*	12	2	M/F	12-17	3-6 months	×	×
Moyhill	Aug 2000	5	1	M	8-13	1-2 yrs	Partial	×
Elm House	Apr 2001	5	1	M	13-17	1-2 yrs	Partial	×
Brookside Lodge	Oct 2001	5	1	F	13-17	1-2 yrs	Partial	×
Cre House	Dec 2001	5	1	F	13-17	1-2 yrs	Partial	×
Ard Doire		5	1	M	12-16		×	×
Loughmahon	Feb 2000	5	1	F	12-16		×	×
Grangemore		5	1	F	12-17	1 yr	Partial	×
Ten Acre	2000	5	1	M/F	8-12	1-2 yrs	Partial	×
Kilkreene	June 2001	5	1	M	12-17	18 months	Partial	×
St Bernard's (Sacre Coeur)		4	1	M/F	Under 12	Up to 4 yrs	Partial	×

Equally, while some HSUs (such as the SHB and MWHB) have actively considered the links between Special Care and High Support, this "step-down" function is generally not well thought through. Most units expect "step-up" to provide the bulk of their admissions, and little consideration has been given to whether the length of programmes that are provided would be suitable for a step-down from Special Care.

Most units will have education facilities on-site. Some teams will be multi-disciplinary in nature, to a greater or lesser degree, but most Boards reported difficulties in gaining fast-track access to specialist off-site services for their high support young people.

	Care Staff	On-site School	Multi-disciplinary team on-site
Crannog Nua	66 Residential Care Workers in total (22 per unit), 1 Manager and 1 Deputy for each of the three units. Approximately 1:3 ratio.	✓	✓
Creag Aran	16 care staff + relief panel, 1 Manager, 7 Deputy Managers, 1 School Principal, 1 Teacher. Approximately 1:3 ratio overall.	✓	×
Castleblaney	5 staff to 6 children in the day in each of the two units, with 3 staff at night (two "live" and one "sleeping"). All will be CCWs but from a range of disciplines	✓	✓
Moyhill	15 staff per unit, mainly CCWs, 95% female. 1:3 ratio.	✓	×
Elm House		✓	×
Brookside Lodge		✓	×
Cre House		✓	×
Ard Doire	Staffing compliment of 28, with 16 staff in post. De facto 1:3 ratio.	✓	×
Loughmahon	Staff compliment of 17.5, with 20.5 in post. De facto 1:3 ratio	×	×
Grangemore	Between 1:1 and 1:3 staff ratios at present.	✓	✓
Ten Acre		✓	✓
Kilkreene		✓	✓
St Bernard's (Sacre Coeur)		✓	✓

Admission Criteria

Specific detailed admissions criteria that go beyond an age/gender definition were patchy. In some cases (e.g. MWHB) it is expected that criteria would be better developed over time as the overall continuum of provision improves. Where criteria were defined, it is as interesting to note those who are excluded. Exclusions tend to be either because the HSU lacks the skills to deal with these young people, or because they feel that the problems involved will prevent the young person from engaging in therapy programmes, or because they see such problems as the primary responsibility of other disciplines/agencies. This raises important issues:

- Is "high support" being defined too much according to current skills within units?
- If it is valid to say that primary responsibility rests with other disciplines/agencies, will they be catered for by those agencies or will the result be that no one deals with the most complex cases?

			Exclusions (✗= excluded from admission, ✓ = accepted, N = Never been an issue)								
	Detailed admission criteria	Admission Panel	Need for secure setting	High risk	Persistent criminal / offending behaviour	Moderate/Severe Learning Diffs	Current Addiction	Psychiatric illness	History of absconding	Emergency Places	Court-directed
Crannog Nua ✓	✓	1 for 3 AHBs. Need to link to B'dowd Panel	✗	✗	✗	✗	✗	✗	✗	✗	
Creag Aran	✗		✗		N	✓/✗	N	N	✓	✗	✓
Castleblaney	✓	1 for 4 HBs				✗	✗	✗	✓	✗	✗
Moyhill	✗	1 for all 4 units in MWHB				✗	✓	✗			✓
Elm House	✗					✗	✓	✗			✓
Brookside Lodge	✗					✗	✓	✗			✓
Cre House	✗					✗	✓	✗			✓
Ard Doire	✓	1 Committee for both units plus Special Care			✗	✗	✗	✗	✓		
Loughmahon	✓				✗	✗	✗	✗			
Grangemore	✗	Individual admissions committees for each of the 4 SEHB HSUs.									✗
Ten Acre	✓										✗
Kilkreene	✗										✗
St Bernard's (SacreCoeur)	✗										✗

Note that where there is neither a tick nor a cross, admissions criteria do not comment on these issues. Note also that the presence of a ✓does not imply this factor to be a valid reason for admission per se, merely that it is not in itself a cause for exclusion

Discharge Arrangements

Very few Boards have contemplated the use of protected placements at discharge, yet several units have an expectation of discharge plans being in place from the point of admission (e.g. Castleblaney). When asked, some Boards commented that they need to think this through.

Identifying suitable discharge placements and arrangements for ongoing support from other services appears to be a major issue in many Boards.

Summary

High Support Units increasingly provide a diverse range of provision with respect to the purposes of the regimes, the age range of children serviced, the duration of their stay and the therapeutic models employed. Indeed, given the growing diversity of approach over time, some question whether at present the term High Support is a meaningful nomenclature.

Health Boards have been exceedingly active in developing High Support Units over a very short timescale. As such, it should not be surprising that the development of the service has been diverse. In part this reflects:

- The extent to which individual Boards engaged with the funding process.
- The extent to which High Support Units represent core residential provision for a Board area.
- The extent to which High Support Units relate to a network of allied residential and non-residential provision.
- The ability to recruit and retain experienced and skilled staff to operate the Units.
- The availability of experienced management personnel with approaches grounded in evidence-based management models.

Until recently the development of High Support has not been against the backdrop, as envisaged by Laxton, of "a comprehensive three year child care planning strategy". Hence, High Support Units do not uniformly sit within a strategic continuum of Board services (social work, physical and mental health). Thus the usage and definition of High Support currently reflects, to a certain extent, historical circumstance as much as planned coherent strategic development. A key issue for the future will be the extent to which common criteria and processes may be superimposed on a diverse service sector.

4.2 NORTHERN AREA HEALTH BOARD

Definition of High Support - from Group Discussion

High Support is seen as providing the opportunity for additional support to young people, via higher staff ratios and higher levels of therapeutic input. It is less restrictive than secure provision. Children who have better internal control mechanisms might benefit from High Support; where these are lacking, Special Care might be more appropriate. Referrals to High Support Units should not come directly from Court.

High Support is also not seen simply in terms of a building/unit. The broadly supported view is that high support can be designed around children living at home or in mainstream care, via tailor-made, wrap-around services. Rethinking provision in these terms will require a shift in culture.

This might involve the development of designated teams or fast-track protocols to access the services of other disciplines or agencies, both statutory and voluntary, not just for those in residential care but for settings. Staffing ratios in residential provision might also need to be increased.

Continuum of Provision within the Board

High Support Unit	:	The NAHB has been involved in the development of Crannog Nua as a High Support Unit serving the whole of the Eastern Region. Crannog Nua is located within the NAHB area.

The following provides an approximate summary of the profile of placements in non-High Support provision within the Board.

Special Care	:	Ballydowd will be used. The Board expects to have access one or two places.
Special Arrangements	:	Fewer than 10 young people are in special arrangements.
Mainstream	:	100 beds in direct provision, excluding voluntaries.
Specialist Foster Care	:	None.

Profile of Placements in High Support in Last Twelve Months

Crannog Nua will receive most placements once open. Placements within Creag Aran for the whole of the ERHA region are reported under the section on the South Western Area Health Board.

Description of High Support Unit to be Accessed by the Board - Crannog Nua

Crannog Nua has been built to the same specification as Ballydowd Secure Unit, although areas will not be locked. There are three separate units on campus, with a

maximum of 24 places being planned for, catering for males and females aged 12-17 on admission.

Crannog Nua will open in August 2002 for its first admissions. Because of difficulties securing staffing and a desire to manage intake, only two young people will be admitted then, and it is expected that it will be two to three years before all beds are on-stream. Lessons will be learnt from the first admissions, and it was estimated that the unit should be functioning at its optimum in three to five years time.

Programmes will be provided for around 6-12 months, but decisions on this will be flexible according to needs. Shorter timescales for placements (e.g. three-months) are not seen as long enough to allow an effective therapeutic input. Placements will be 24/7.

When fully operational, Crannog Nua will have:

- 66 residential care staff (or 22 per unit), plus a Manager and Deputy Manager for each of the three units.
- An on-site Special School comprising an Administrative Principal, four teachers and sessional teachers.
- A therapeutic support team (the Mater Support Team) provided through a service agreement with Mater Child and Adolescent Psychiatry Service. This team will be headed by the Clinical Director at the Mater Child and Adolescent Service, and include Senior Child Psychology, Senior Social Work with experience in family work. Senior Speech and Language Therapy, Counselling Therapists, Sessional Psychiatry, allied therapies as required.

Management of Crannog Nua and representatives of the Board have discussed options for Crannog Nua to provide outreach and respite work and high quality consultancy. In other words, the Unit could have young people on its books who were not in its beds. The Admissions Panel could gatekeep this function as well as access to beds. Longer-term, Crannog Nua see themselves as being a specialist resource that could work with staff teams. The overall vision of Crannog Nua aiding in the provision of outreach and consultancy services was felt to be some five years away from full actualisation, although some progress towards this is likely to be achieved in the intervening period.

Potential Candidates for the Admission to the Unit

In the group discussion, staff from the NAHB were able to identify around 30 potential candidates for admission immediately – i.e. six more than the unit will cater for at its maximum, and this excluding potential candidates from the other two Area Health Boards in the Eastern Region.

Referral Process

Prior to applying for admission, a comprehensive assessment will be required at the Area social work team and signed off at the Area level. All potential admissions must have both a Care Plan and a social worker.

Referral information will be drawn from the Care Plan. There will be a format for providing information, to be followed by all three Area Health Boards: a template is being drawn up. This template will be unique to Crannog Nua.

An Admission and Discharge Group will meet monthly or more frequently if required. Membership will include representatives from Crannog Nua and the three AHBs, plus other key agencies. This group will prioritise referrals.

If the young person is on a waiting list to access the service, they will remain the responsibility of the referring Area. It was suggested by staff on the site-visit that it would be helpful if the Admission and Discharge Group make recommendations from about potential interim or alternative arrangements (i.e. to stop inappropriate applications to, for example, Ballydowd). It was also recognised that there needs to be a link between the Crannog Nua Admissions and Discharge Group and the Ballydowd Admissions Committee to prevent cases from inappropriately being referred to both.

Admission Criteria

Crannog Nua will mainly be a step-up facility. Step-down from Ballydowd will also occur, but such cases will need to go through the same application process as any other case.

The following admission criteria are deemed essential:

- Aged 12-17 on admission.
- Have a history of care arrangements that have broken down.
- The risk behaviour **and** level of need of he child must pose a real risk to his/her health, safety, development and welfare unless placed in a High Support Unit.
- The level of risk of is moderate
- The level of need is high.
- Young person has a history of emotional and behavioural difficulties.
- Young person cannot be supported in mainstream residential care
- Clearly demonstrated by the referring agency that consideration has been given to all alternative care settings and there is no alternative setting in which the young person's needs can be met
- The child/young person has a willingness to engage with the unit.

The admission criteria is also clear about the young people that will not be admitted:

- Those who require a secure setting: it is an open unit.
- High risk.
- History of persistent criminal/offending behaviour: Detention schools are appropriate.
- Moderate/severe learning difficulty: a debate ensued in the site visit about whether all young people with these labels actually had this difficulty or simply had missed too much school. There are thus likely to be some grey areas that the Admissions Group will have to decide upon.
- Medical detoxification required for drug use: The unit can deal with mild to moderate detox, but would not be equipped to meet an ongoing methadone requirement.
- Acute psychiatric illness requiring intensive medical intervention: currently services are generally inadequate within the Board in this area, but there are plans to produce in-patient services for psychiatric illness.
- Established history of absconding from placements (i.e. absconding is part of their behavioural profile rather than a response to situational stressors).

In addition, the Unit is not expecting to take many, if any, emergency admissions. The Court's perception of what High Support is will be important in this respect.

In all the "excluded" categories, there *should*, technically, be alternative services. However, although it is possible to identify the alternative setting, it is not necessarily easy to obtain a place. Parallel developments of services for those who are specifically excluded by Crannog Nua's admission criteria would be required, or pressure might be put on the Unit to accept inappropriate cases. In addition, although emergency admissions were to be discouraged, the speed of admission is likely to be of concern to social workers: this will require both a rapid admissions process and the management of social workers' expectations.

The requirement for the young person to agree to go to Crannog Nua might be problematic in some instances. For example, a representative from Area 6 said that young people from that Area might not wish to be admitted to the facility because of the distance. This will pose a dilemma about what to do in such circumstances.

Monitoring and Review Arrangements

Social workers are expected to maintain contact weekly and undertake fortnightly visits.

Reviews will be between Crannog Nua and Area. The Admissions and Discharge Group will not have an overview of all reviews that occur, except when placement is coming to an end.

Discharge Arrangements

AHB representatives on the Admissions and Discharge Group are key in ensuring that 'Through Care' and 'Exit Strategies' are fully facilitated and honoured.

The placement that the young person will be discharged to should be identified at referral stage. This may be placement at home, in foster care, or in residential care. Crannog Nua recognise the need to work in partnership with mainstream unit to make discharge as seamless as possible.

There has been little thought so far about whether a child who has gone to Crannog Nua from a residential placement will have their original placement protected: participants to the site-visit meeting said that this needs more detailed thought.

There is an expectation that staff from Crannog Nua will continue contact with the young person and even work with them in their new placement.

4.3 SOUTH WESTERN AREA HEALTH BOARD

Definition of High Support - from two Group Discussions (Creag Aran staff; and social work staff)

High Support is for children with severe emotional and behavioural problems, whose presenting difficulties cannot be met in mainstream. The difficulties that young people might present include aggression, absconding, inappropriate sexual activity and absconding.

High Support differs from Special Care in not being secure accommodation nor requiring a court order to access.

High Support will have a high staff/child ratio, thus providing a high level of supervision and the ability to provide more direct work. There should be a high level of flexible therapeutic input on-site. Structured programmes would be provided. There was uncertainty from social work staff about whether it was essential for education to be provided on-site.

There should be role for HSUs in undertaking work with the family.

Continuum of Provision within the Board

High Support Units	:	The South Western Health Board accesses the eastern regional resource at Creag Aran and will also make referrals to Crannog Nua.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Care	:	Ballydowd. Some frustration was expressed that the unit seemed to be opening and closing regularly because of staffing difficulties.
Special Arrangements	:	Dublin West has one young person in a highly staffed arrangement, with no therapeutic input. Dublin South West has six young people in such arrangements, typically either additional support to a residential centre or workers employed specifically to, for example, work with the family at weekend. Kildare/West Wicklow have one young person in a highly staffed arrangements (1:2.5 ratio) with no therapeutic input. Dublin South City have no one in special arrangements.
Mainstream	:	Kildare/West Wicklow have one unit of six beds. Dublin South City have five units of four beds. Dublin South West has 23 places. Dublin West has 32 places.

Foster Care : The SWAHB has no specialist foster carers.

There can be difficulties accessing outside services for more complex young people, particularly for 16 year olds with difficulties that may be alternatively diagnosed as mental health or behavioural.

Profile of Placements in High Support in Last Twelve Months

In the last twelve months, six placements were made in Creag Aran, comprising four young boys and one young girl. The oldest was 11 years on admission, four were age 10, and one was under 10.

Four entered care through voluntary arrangements, and two were on court orders.

Two had had two previous care placements, three had had three, and one had had four. All had been in care for more than twelve months. Five came from a mainstream residential placement and one from custody/detention.

All are still in High Support and have been for more than 12 months.

Staff on the site-visits noted that some young people prior to the 12 months had returned either to home or to mainstream residential care.

Description of High Support Units to be Accessed by the Board

There are two regional resources within the ERHA: Crannog Nua and Creag Aran. At present, there does not appear to be a strong communication link between these, although the former is very new and they cater for different age groups.

Crannog Nua

Crannog Nua is described in detail under the commentary on the Northern Area Health Board. The SWAHB staff interviewed commented that they had little awareness of Crannog Nua, had only just received the referral criteria, and were only just starting to be asked to make referrals. Crannog Nua had not yet opened its doors at the time of the site visit to the SWAHB, so these comments are not altogether surprising.

Creag Aran

As Creag Aran is located within the South Western Area Health Board and will service the three Eastern region Area Health Boards (NAHB, SWAHB, ECAHB), comments within this section are divided into:

- Descriptive details on Creag Aran's function, referral process, admission criteria, monitoring and review arrangements, and discharge arrangements.
- Comments from the SWAHB on the same.

Description of Creag Aran

Functionality

Creag Aran was established in September 1997. It is directly funded and Creag Aran's manager reports directly to an Assistant Chief Executive Officer within the SWAHB, meeting on a monthly basis. Creag Aran is located in a country setting between Naas and Blessington.

There is one mixed gender unit on site, targeted at the 10-12 age group, with six places. An internal evaluation of the unit has begun.

Admissions are for up to two years and generally admissions last that long. This length of placement is felt to provide a sufficiently stable environment. More recently, one-year placements have been considered, with placement cycles geared to matching school years: revisions to the overall length of stay will be considered during the internal evaluation of the unit. Intake has generally been during the summer. Placements are 24/7, 365 days a year.

Referrals are received from the NAHB, SWAHB, and ECAHB.

In relation to staffing issues:

- There are 16 care staff, plus relief panel workers. In the future, only staff with a Diploma in Social Care will be taken on, in accordance with Health Board policy.
- Education is provided on-site in two classrooms. There is a school principal and one teacher.
- There is one Manager and a Deputy Manager.
- There is one clerical worker and three domestic staff.
- Creag Aran has an on-site TCI trainer.
- Shifts involve three-four staff in the morning, five in the evening, and two at night (one waking, one sleep-over).

The unit has been able to maintain adequate staffing levels.

Unit staff feel that in general access to off-site services is good, with the exception of training for staff.

Staff within Creag Aran feel that its strengths of the current arrangements include: motivation of staff; low turnover; child-centred environment, in attractive grounds; high staff ratio; on-site TCI trainer. Recreational facilities are on-site, including a gym. The unit also has a mobile home in Wexford.

Integration with mainstream residential services is limited: Creag Aran reports directly to an ACEO and provides services to the three Eastern region Health Boards.

Description of Creag Aran Referral Process

As Creag Aran is generally full and placements last the full two years, referral cycles are infrequent and there is no set frequency for the Referrals Committee to meet. The Referrals Committee until recently comprised the SWAHB ACEO with line

responsibility, the Manager and Deputy of the unit, and the school Principal: this is in the process of being widened to include social work and child psychiatry representation from the three Area Health Boards. Creag Aran does not operate a waiting list at present. The whole referral process is under review.

The young person being referred must have a named social worker and a care plan. Referrals from social workers are expected to be co-signed by Team Leaders.

Description of Creag Aran Admission Criteria

Admission Criteria are limited to age requirements (10-12 year olds). As it is a younger age group than many other High Support Units, there are few specified "exclusions", as children with such needs are less likely to present.

In general, however, the unit would struggle to cope with severe psychiatric disorders or severe disabilities, but the former in particular often would not be diagnosed at this age. Moderate learning difficulties would not pose problems. Addiction and persistent criminal/offending behaviour are much less likely to present at this age and have not been a feature of previous referrals.

All referred children tend to have a history of absconding, so this would not be a cause for exclusion.

Emergency placements would not be accepted. Creag Aran has in the past accepted some placements directed by the Court, although these tend to be hurried admissions and are not preferred.

The issue of whether a young person would consent to High Support has also not been a significant issue, again possibly because of the target age group.

Description of Creag Aran Monitoring and Review Arrangements

Creag Aran draws up a Placement Plan based on the Care Plan. This involves the young person, the unit, and other relevant staff. Each child has two keyworker within the unit.

Reviews all are held within the three-monthly periods required by Regulation for children in care. These involve Creag Aran staff, the named social worker, the PSW, the child and their parents. These appear to be less prone to postponement than in other settings.

In addition, there is usually a minimum of weekly contact between Creag Aran staff and the named social worker, initiated by both parties but mainly by the unit. A stipulation is made at the point of admission that contact needs to be at this frequency.

Description of Discharge Arrangements Specified by Creag Aran

Options at discharge were described as a particular problem by unit staff. It would not be easy to discharge the young person to their former placement. Many mainstream residential homes are apparently reluctant to take children from High Support, and lack the same staffing levels or links to support services. Also, the division of the Eastern Health Board into three different Area Health Boards means

that the placement that the young person originally came from may no longer be in the same Board as their place of origin, adding a further complication. In addition, the former placement for the young person might have been special arrangements. The age of the young person might be a factor in whether they could return to their originating placement (i.e. left the former placement aged 10-12, so now aged 12-14). Finally, the young person themselves might not wish to return.

Creag Aran staff said that the behaviour of some young people regressed when, having been told that the placement was for a maximum of two years in High Support, that placement dragged on because of the difficulty in securing a move-on option.

Continuity of involvement of off-site professionals is hampered by the patch-based nature of their work – i.e. Creag Aran may not be in the same catchment area as the placement to which the young person returns. Child Guidance is an example of this.

Creag Aran is at an early stage of considering whether there is a need for a step-down unit between Creag Aran and mainstream provision. Creag Aran is located in a rural setting, while most of its young people originate from the city, and any step-down facility might be better located within Dublin.

SWAHB Social Work Comments on Creag Aran and Crannog Nua

Functionality

The comments on functionality relate specifically to Creag Aran, as the social work staff who participated in the meeting on site had little knowledge of Crannog Nua.

There were positive comments about Creag Aran having the time and the physical space to work intensively and flexibly with young people, deriving from the unit's high staffing ratios and physical location.

Potential Candidates for Admission to High Support

A comment was made that a significant proportion of young people in the Board were currently inappropriately placed. As a result "kids don't start out needing High Support, but end up needing it because of failures in the system".

Current estimates of the demand for High Support far exceed places.

- Dublin South City: 12 need High Support
- Kildare/West Wicklow: 10-12
- Dublin West: 10
- Dublin South West: 6

It was suggested that the need to use High Support as a step-down from Special Care would vary from child to child. The above estimates of numbers who need High Support generally exclude these young people.

Referral Process

Staff found the different referral requirements for a range of different residential placements, including Creag Aran, burdensome. Simply to access mainstream

residential provision, it was said to be extremely frustrating to be required to send reports to all the units every time, asking if there is placement availability, when the answer is likely to be negative. One participant commented that "it would make more sense for someone in ERHA to know what is available."

Some said that Creag Aran had been "reluctant" to consult with social work staff about potential admissions. We feel that the process should become more transparent once the plans mentioned earlier for Creag Arran to broaden to the membership of the Referrals Committee are implemented.

It was largely agreed that there should be an allocated social worker prior to admission. There was more doubt about the need for a Care Plan, on the basis that the placement required should be part of the care plan but there are regularly difficulties in obtaining an appropriate placement anyway.

Admission Criteria

In general, there was agreement that many of the reasons for "exclusion" from Crannog Nua seemed justified (i.e. severe learning difficulties and psychiatric disorders), as these ought to be within the remit of other services. Problems would occur where there were multiple needs and it was difficult to identify the primary need. As many Boards comment, it can be difficult to discern responsibilities where a case is borderline between severe behaviour difficulties and psychiatric problems.

There was also agreement that emergency placements and court-directed placements should be excluded.

There was a strong feeling that a history of absconding should not be cause for exclusion. Also, a history of persistent/criminal offending behaviour was not felt to be a sufficient reason for exclusion.

Monitoring and Review Arrangements

Social work staff felt that it *is* appropriate to review High Support cases more regularly than mainstream care cases, and that the requirement for frequent contact is important.

Discharge Arrangements

Significant concerns were expressed about the discharge process. It was not felt possible to identify one or two years in advance what the discharge placement would be. Several examples were given of young people who were due to leave Creag Aran because they were approaching the end of their fixed term admission: difficulties in securing a move-on placement, caused by a general lack of placement options, had led to deterioration in the behaviour of the young people, undoing much of the positive work that had been achieved. This was also stressful for staff. This concern was shared between community care social work staff and Creag Aran staff.

Some said that there is a need for middle ground step-down between High Support and mainstream residential, where some degree of ongoing therapeutic input could be used.

In addition, some concerns were expressed that, to a degree, Creag Aran can institutionalise young people. A step-down *methodology* should begin while the young person was still at the unit: for example, through shared care arrangements, admission to local schools or outside recreational activities.

4.4 EAST COAST AREA HEALTH BOARD

Definition of High Support - from Group Discussion

High Support placements are for young people who are hard to place.

High Support placements provide intensive programmes, with high levels of staffing, and should be needs-led. It is important that such placements are time-limited and have a specific end target, and this in turn means that the placements should be well-planned. High Support placements should offer a degree of containment.

It was commented that at present there is mixed understanding on the part of staff about what the term means: the phrase "high support" itself may not be helpful.

Continuum of Provision within the Board

High Support Units	:	The East Coast Area Health Board will access the Eastern regional resource at Crannog Nua. Technically, the Board is also able to access Creag Aran, but does not have any children placed there and would be reluctant to place any there because the unit caters for younger children for whom alternative arrangements might be more suitable.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Care	:	Ballydowd.
Special Arrangements	:	There are three young people currently in special arrangements, all because of an exhaustion of alternative local options. None would meet Crannog Nua's admission criteria. There are also young people placed in other parts of Ireland and the UK. Three young people are placed at Trinity House, one of whom was subject of a referral to Crannog Nua in its first intake phase (August 2002).
Mainstream	:	1 x Health Board unit (Sandymount) with 12 beds, currently with 9/10 in occupancy.
	:	2 x Special Residential units (one of two young people, one of three).
	:	6 x voluntary providers, approximately 26 beds.
	:	One young person is in a long-term bed in the Crisis Intervention Service, and one is in hospital: neither of these would meet Crannog Nua's criteria for High Support

Specialist Foster Care	:	There are no specialist foster carers at present. A foster care strategy is currently in development.
Aftercare	:	There is capacity for six young people, plus outreach.

The development of Crannog Nua is helping to challenge how the Board thinks of its mainstream provision: in particular, Crannog Nua's planned provision of a consultancy service raises questions about whether the Board could provide such a service itself.

In general, it was felt that there has been insufficient capital funding to develop local specialist units. Mainstream residential provision is in need of review. Many units are not operating at capacity. Enhancing support to mainstream units in the future will be critical to develop, as one person put it, "the concept of people who will come alongside you when the going gets tough."

The concept of a "continuum of care" was said to be new in terms of its penetration into thinking throughout the Board and its partner agencies. One participant commented that young people travel through the system in a linear fashion: having failed in one setting, they move on to another, but there is little cultural appreciation that the young person might improve or mature - "there is no redemption", and more of a feeling that "he was here before and we remember the trouble he caused." For step-down options to be effective along the continuum of care, cultural change is required.

In addition, many placements in care were thought of by providers as being long-term, rather than trying to achieve change and exit. Many providers were geared up for "nice kids" rather than what the Board actually requires, creating a power imbalance between commissioners and providers. In the Board's view, this needs to change, and is changing, and several providers acknowledge the need to refocus.

Comment was also made that the term "high support" had been "hijacked" by High Support Units, and that many young people can and ought to have "high support" throughout their care careers.

Profile of Placements in High Support in Last Twelve Months

There have been no placements at Creag Aran.

Description of High Support Unit to be Accessed by the Board

Crannog Nua is described under the commentary for the Northern Area Health Board.

Comment was made that, on paper, Crannog Nua appears to be a very good resource, with a clear statement of purpose and function, and good support networks (for example, the presence of education and psychology on-site). The unit's induction pack set high standards.

One major disadvantage was location, with Crannog Nua being some 2.5 hours away from part of Wicklow.

It was felt that Crannog Nua was no longer being thought of specifically as a step-down unit from Ballydowd. Comment was also made on the fact that Crannog Nua has the same design as Ballydowd, and the negative impact that this might have on any young person stepping down from Ballydowd.

Potential Candidates for Admission to the Unit

Two referrals were made to the Admissions Panel for Crannog Nua for its first intake in August 2002, although neither were admitted at that time. It was stated that some referrals may be prompted by local resource deficits and "desperation" on the part of social workers.

It was estimated that around seven young people were currently potential candidates for High Support – five from Area 2, and one each from Area 1 and Area 10 (Wicklow).

Referral Process

As with many Boards, concern was expressed about the requirement to specify discharge arrangements at the point of referral, as it would be impossible to know whether the young person would make progress or not within the unit. However, the principle of time-limited placements, with robust review mechanisms, was strongly supported, to prevent drift and passive reviews.

It was felt the it would be useful for Crannog Nua's Admission Panel to provide constructive feedback to Areas on referrals received, and that it might also be useful for there to be research on the characteristics of individual referrals and their outcomes. This might highlight unmet needs

In addition, Crannog Nua will need to actively educate social work staff about its role and remit.

Admission Criteria

No significant issues were raised about Crannog Nua's admission criteria. There were some concerns about how a borderline conduct disorder might be diagnosed (i.e. as a psychiatric case or simply a behavioural problem) and what implications this might have on the service received. The gap in psychiatric services for 16-18 year olds was a particular issue, although it was stated that a new regional service was being planned to address this need.

Discharge Arrangements

Via the Crannog Nua Admissions Panel, the concept of protected placements had been discussed but felt to have major cost implications.

Effective step-down would be critical but mainstream units might be reluctant to accept a young person back as a "changed person". The absence of support services in the community would pose significant problems: access to some specialist services by mainstream units is currently expensive.

4.5 MIDLAND HEALTH BOARD

Definition of High Support - from Group Discussion

High Support is for children with aggressive and challenging behaviour. The emphasis is on therapeutic input.

High Support is unlocked, with facilities for keeping young people safe, whereas Special Care Units are locked. High Support Units should have more skilled and experienced staff and be fairly self-contained in terms of their skills-mix. There should be provision for education on-site, primarily because the young people themselves will often be out of school.

There was some confusion at first on the part of the steering group for Castleblaney, with some confusing High Support with Special Care. There has also needed to be an exercise within Boards to clarify this.

Continuum of Provision within the Board

High Support Units	:	The Midland HB is part of the four-Board group that is seeking to develop a High Support facility at Castleblaney.

On the site-visit, there was support for the development of High Support Units locally in addition to Castleblaney. The Board used to have a High Support facility at Mullingar but this is now an ordinary mainstream unit. This had been used for young people on Detention Orders from the High Court but the building was not felt to be suitable. There is a plan in place to re-evaluate all local mainstream provision, and provision of local HSUs was seen as a serious option. This would allow the young person to maintain links with their home community. When asked whether local HSUs would operate to the same timeframes as Castleblaney (a three-month programme), the answer given was that a longer intervention of 6-12 months might be employed.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Care	:	Have had one young person who needed this and was misplaced at Oberstown. Have struggled to gain admission to Ballydowd. There is no Special Care facility within the Board: if there had been, it would only have required two or three places to meet needs.
Special Arrangements	:	There are no special arrangements.
Mainstream	:	Six units within the Health Board, providing around 25 beds at capacity.
Foster Care	:	There have been great problems obtaining foster carers for the 10-14 age group.

Emergency placements : The Board currently lacks the ability to deal with crisis admission placements.

There is a need to address deficits in mainstream units as part of the review of mainstream residential, as there is currently insufficient therapy, support and training for residential staff. When asked what the difference between mainstream and High Support would be if this was achieved, the answer given was "Good Question" and discussion focused more on staff concerns about working 1:1 (risk of allegations of abuse, risk of violence to staff).

There is also a need for emergency, respite, and step-down provision. Absence of the latter in particular might make it difficult to gain an admission to Castleblaney, as it would limit discharge options. There is also a need for semi-independence provision for 17 year-olds.

Profile of Placements in High Support in Last Twelve Months

The return from the Midland Health Board actually noted several placements that are actually in Department of Education and Science detention centres or special schools for the purposes of detention. Our understanding is that such young people are thought to have High Support-type needs but have not been placed in HSUs because of lack of availability. As a result, we have included a brief analysis of the return here, but have excluded these figures from the "All Boards" summary (section 4.1).

Five placements were listed: one in Oberstown, one in Trinity House, two in St Patrick's Institution, and one in Wheatfield, covering four young men, all aged 15-17. One young person had had two admissions. Court Orders were involved in four of the placements, and one followed on the foot of a High Court Detention Order.

The number of placements prior to admission to high support ranged between one and three. Two of the young people had been in mainstream residential care in their previous placement, one in voluntary care, and two had been in high support. All High Support placements were of more than twelve months in duration.

Two stayed in high support, and two were returned to general residential care.

Description of High Support Unit to be Accessed by the Board - Castleblaney

Castleblaney is described under the return for the NEHB, in whose area it is located. Castleblaney is not yet operational.

Three of the twelve places at Castleblaney are nominally designated for the MHB, although each case will be looked at according to its own merits.

Potential Candidates for Admission to the Unit

Staff on the site-visit felt that they could easily fill all its High Support places at Castleblaney and still have a waiting list. There were four young women for Longford/Westmeath alone.

Referral Process

The referral process for Castleblaney is described in more detail under the return for the NEHB.

The MHB is largely thinking of Castleblaney as a step-up facility. However, it was recognised that it could be a big leap to come from a rule-driven special care facility straight into a much less rule-bound mainstream unit if there was nothing in-between.

Admission Criteria

See NEHB return for details of the young people who are included and excluded from Castleblaney's admission criteria.

Comments expressed in relation to the young people who Castleblaney seeks to *exclude* from admission included that often such young people are placed in mainstream units (for example, young people with severe learning difficulties):

> *"It's alright for them to exclude, but we still have statutory responsibility."*
>
> *"In a sense, we are more specialist than they are."*

There were felt to be potential difficulties as regards exclusion of young people with psychiatric disorders, as often psychiatrists claim that it is a behaviour disorder only and psychologists that it is a psychiatric disorder: "We are caught between two stools."

There was recognition that young people with addiction problems require specialist addiction treatment services, and a feeling that Castleblaney would accept those who had previously abused substances as long as there is no current addiction problem.

Several concerns were expressed in relation to the voluntariness of admission on the part of young people. Young people might be "scared stiff" of going so far away, and sending them there "might be another form of rejection". In addition, if they abscond from local placements there was at least some notion about where they might have gone (i.e. home community). They could be at higher risk in a remote, unfamiliar area.

Monitoring and Review Arrangements

Not all young people in care currently have a social worker because of staff shortages. Reviews of children in residential care tend to be more regular that for foster care, although traditionally the difficulty has been to identify move-on options.

Discharge Arrangements

If the young person went to Castleblaney from a mainstream unit, the placement within the latter would be protected. Note that programmes in Castleblaney only run for three to six months.

Comments from the MHB suggested that placements in Castleblaney would be geared towards short, sharp interventions, with outreach to support the young person once discharged. There was some concern about the reality of outreach actually being provided sufficiently. (Note, however, that Castleblaney staff are actually *not* envisaging providing an outreach function).

4.6 MID-WESTERN HEALTH BOARD

Definition of High Support - from Group Discussion

High Support is for young people with more complex needs. They are often out of school also and have probably had multiple placements, whether in foster care or mainstream residential.

The environment is more structured, with higher staffing levels and a therapeutic input within the setting. There is no single model of care: there are multiple models, reflecting individualised care plans/packages. Staff will be more skilled (and need to be) and require good team building and support structures.

There was a suggestion that, given a choice, many of the participants in the site visit would have found alternative ways to spend "High Support" monies that they feel would have been more effective.

One participant said that the Children Act 2001 states that children under care and protection should not be mixed with those who are delinquent, but this is what often happens in High Support (although delinquency per se is not a primary reason for admission).

Continuum of Provision within the Board

High Support Units	:	There are four High Support Units within the Board – Green Meadow, Moyhill; Elm House, Drombanna; Brookside lodge, O'Briens Bridge; and Cre House, Roscrea. These are described in more detail below.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Care	:	Provision for boys is in Dublin and for girls is in the Southern Health Board Area.
Mainstream Residential	:	There are 20 places in total. Mount St Vincent mainstream units provide ten beds, Eden Villa provides five beds for boys, and Rosemount Centre provides five beds for girls. Both Eden Villa and Rosemount provide a service for young homeless people. There is felt to be a tradition of low provision in the MWHB.
Special Arrangements	:	Special arrangements are not used currently within the Mid-Western Health Board.
Specialist Foster Carers	:	None at present.
Emergency beds	:	Mount St Vincent's provide one emergency beds for boys in St Oliver's. osemount Service has two emergency beds for girls. Eden Villa has one emergency bed for boys.

Out of Hours Service : There is a need for after-hours social work services within the Region. Residential services currently provide an after-hours service.

The absence of a full spectrum of provision (specialist foster care and mainstream) in itself puts pressure on to use High Support beds for mainstream placements: the Admissions Panel has to resist this. Professional carers in particular may need to be considered: it may be possible to provide three of these for every High Support bed.

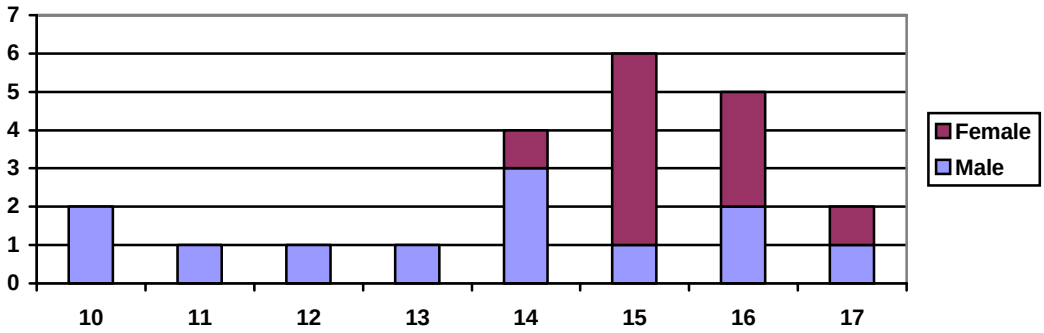
Mainstream residential providers are increasingly dealing with complex behavioural needs.

Profile of Placements in High Support in Last Twelve Months

23 placements of young people were made, involved 22 young people (one was admitted twice). Placement by unit was:

- Five in Moyhill.
- Eight in Elm House.
- Six in Brookside Lodge.
- Four in Roscrea.

Young women were admitted in the 14-17 age range, and young men throughout the 10-17 range.



Ten admissions were under voluntary care arrangements and thirteen were on care orders other than emergency care orders.

Seven (32%) had one or fewer placements prior to their admission to a High Support placement, and none had more than five previous placements.

The profile of last placement types prior to admission was:

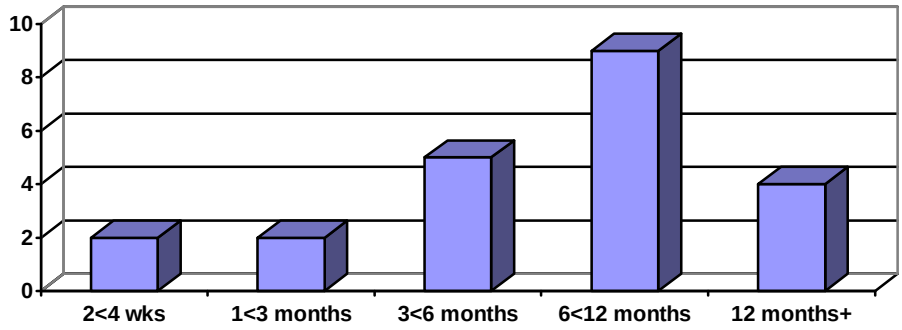
- Six were at home.
- One was in foster care.
- Seven were in residential (general) care.
- One was in residential special care.
- One was in high support.
- Five had been in custody/detention.
- One had been in a shared care package.

- One came from an acute psychiatric ward.

Note that many are said to go straight from home to High Support because of a preference to try to maintain them at home through intensive support.

Thirteen had been in care for twelve months or more at the start of the High Support placement; four had never had a previous care placement.

Nine stayed in the placement for 6<12 months:



Eleven of the young people are still in a High Support placement. Of the rest, three went home, 3 went to custody/detention, two went to mainstream residential care, 1 to foster care, 1 to Ferry House Clonmel, 1 to aftercare, and one had died after a road traffic accident.

High Support Units within the Mid-Western Health Board

There are four units, each with five beds. All are operated by Mount St Vincent. All are fairly new in terms of their operation as High Support Units and were phased in according to a strategy. None are full because of case-mix considerations.

Green Meadow, Moyhill	:	8-12 years on admission for a two-year programme, and age 13 on admission for a one-year programme, to a maximum age of 14. Boys only, although designed for both genders. Opened August 2000.
Elm House, Drombanna	:	Age 13-16 on admission for a two-year programme, and age 17 on admission for a one-year programme, to a maximum age of 18. Designed for boys only. Opened April 2001.
Brookside Lodge, O'Briens Bridge	:	Same age profile as Elm House, but designed for girls only. Opened October 2001.
Cre House, Roscrea	:	Same age profile as Elm House. Girls only, although designed for both genders. Opened December 2001.

There are no plans for further High Support Units within the region.

Two of the High Support Units are located in Clare, one in Limerick, and one in Tipperary North Riding. The four High Support Units provide a service for the entire region.

A mixture of one-year and two-year programmes is felt to be sufficient to enable effective intervention while not creating dependency or allowing the case to drift. As the earliest unit to open, Green Meadow has gone through the discharge process, and two years feels like an appropriate timescale for programmes to staff from that unit.

Provision is 24/7. However, several examples of "shared care" were given, and these were commented on favourably (i.e. the bed is available to the young person for seven nights, but they may return home for three).

In relation to staff and skills mixes

- There are 15 staff to each 5-bed unit.
- The acquisition and maintenance of an effective staffing base has provided the single most difficult issue to deal with over the last two years. Recruitment, development and retention of staff have been extremely challenging.
- Staff are 95% female and there was felt to be a deficit in male role models as a result.
- With many younger, less experienced staff, effort has had to be put in to ensure consistency of approach: there were problems initially as a result of this with particularly challenging young people.
- Staff are mainly CCWs. One-to-one work, through the keywork system, by these is seen as a major part of the therapeutic intervention. There is also a substance misuse guidance worker available to all young people in the units. Mount St Vincent has an internal training resource and a TCI policy.
- There are on-site school and recreation facilities in each of the High Support Units. St Canice's school are reviewing teaching: currently there is one teacher dedicated to each unit, and the plan is to reconfigure these into a team of four teachers with a Principal, working in all four units, dependent on need.
- Links with, for example, Education, psychologists and psychiatrists need improving. Budget is available for a psychology post that will connect to the HSUs, primarily to provide advice and guidance to staff. There is no play therapy, access to sessional art therapy, and access to sexual health therapy. Only Cre House has links to the local community.

Some areas are locked at certain times (e.g. living rooms), and CCTV is in operation.

Staff from the units noted that it can be a problem if therapy means that the child has moved on but the parents have not. This suggests the need for an outreach service, to provide continuity and stability for the young person and support for the family. Increasingly the units are working with families on an outreach basis in a planned and agreed manner with social workers, and as part of the care plan. This work is seen as an appropriate shift of focus from the original statement of purpose of the units.

Referral Process

Admissions to all High Support Units are made through a single Admissions Panel. This Panel consists of a multi-disciplinary team representing the Health Board, Mount St Vincent's and St Canice's School: membership has recently been widened. Social workers send a referral to the Panel and are required to attend the Admissions Panel meeting when their application is being discussed. In the past, a small number of

cases were referred directly by the Courts and placed in High Support Unit: such referrals are more the exception.

The Panel considers:

- Reason for referral.
- Care history and alternative care models/interventions attempted or considered.
- Young person's views.
- Family's views.
- Proposed Care Plan.
- Whether the collective view of the Panel is to recommend High Support.

Thereafter, an appropriate placement is sought. Effectively, it is a two-stage process: Is high support required? Where/what should the placement be? Currently there is one young person on the waiting list. However, there was a feeling that the High Court currently tries to influence the process unduly.

Generally, the units are being used for step-up purposes at present. One young person has been in secure accommodation for around 9 months, and step-down service will be required. Some concern was expressed that Courts will be expecting a step-down service to be in place but it is not available at present. A view was expressed that step-down into High Support should only be for those who need it. A step-down service would have to be of a shorter time-frame to the 1-2 year programmes currently in operation in the High Support units.

Admission Criteria

Admission criteria, in terms of who is included or excluded, are linked solely to age/gender. At first, Green Meadow had three emergency admissions, but such admissions have now been stopped.

Almost all young people admitted to High Support have addiction problems. The units do not take young people with severe learning disabilities or psychiatric disorders. Sexually abusing adolescents can be particularly difficult.

An emphasis has been placed on trying to ensure that young people go to and stay in the unit through the use of structured environments and routines initially, and the quality of relationships and sense of progress thereafter. Where young people abscond, they often go to their home area and then return of their own free-will (i.e. their home community exerts both push and pull influences). Hence, shared care can work well as a reflection of this need for the young person.

Monitoring and Review Arrangements

Inspection reports have said that social work contact for the four units is more frequent than Regulation requires: this was felt by consultees to be essential and something that they learned early on. Close contact of the social worker and unit staff helps to generate ideas, consistency, and support.

Discharge Arrangements

Discharge is generally as per specified end-date (i.e. for one or two year programmes). Young people are only discharged early if there has been failure to engage them. The Admissions Panel is increasingly asking where the young person will be going to at discharge.

The unit managers spoken to commented that the quality of Care Plans is improving: nevertheless, discharge plans are not always clear at the start of the placement.

Extensions have been granted, and tend to be when the young person has become 17, has received approval for a flat with supports, and needs a few more months for arrangements to be finalised. However, it was felt to be a major change to enter independent living from High Support, and there is felt to be a gap for 16-18 year olds in terms of supported lodgings.

4.7 NORTH EASTERN HEALTH BOARD

Definition of High Support - from Group Discussion

Children who will access High Support are typically those whom the mainstream cannot deal with because of difficult behaviour. They have higher levels of need. Interventions should aim to help the child to manage/modify their behaviour.

High Support should provide assessment and therapeutic intervention from a multi-disciplinary team rather than just from CCWs. There should be significant 1:1 interventions between staff and the young person. High support is not secure provision.

Continuum of Provision within the Board

High Support Units : The North Eastern Health Board is one of four Health Boards developing the Castleblaney High Support provision. Castleblaney is located within the area of the North Eastern Health Board. The Ardee unit has been redesignated and is neither a High Support nor a Special Care unit in the eyes of the Board.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Care : Will use Ballydowd, although uncertainty was expressed about the likelihood of gaining admission for anyone from the Board. Some PSWs said that initially they expected Castleblaney to be a Special Care Unit and that this would have actually better suited their needs.

Special Arrangements : Three young people are in special arrangements within the Board as a result of unavailability of high support places.

High Support Step-Down : Ardee Controlled Therapeutic Unit. In the past, children have been cared for in Ardee, on a Detention Order. There was a reluctance to call this a Special Care Unit, hence it was called a Controlled Therapeutic Unit. This unit is being re-designated by the Board as a step-down unit from Castleblaney High Support Unit.

Mainstream residential : There are four official mainstream units in the Board. Three of these are six-bed units (two in Drogheda, 1 in Navan) and one is a three-bed unit. There has been a rise in the number of young people entering residential care, and over the last 5-10 years they seem to be displaying more challenging behaviour (especially aggressive or sexualised behaviour). One

unit has been developed to cater for young people with a lower IQ and has higher staffing levels. 12-15 young people are currently waiting for a placement in mainstream residential care.

Specialist Fostering : None at present, although a proposal for this is being developed. However, there are difficulties in obtaining general foster carers at present also.

Emergency placements : The homeless service is gearing up to become a 24/7 service. Emergency referrals have not been taken in mainstream units for eighteen months and PSWs are now more aware of each unit's statement of purpose.

It was stated during the group discussion that young people currently are staying in residential care for too long and there is an absence of move-on options. Mainstream provision *should* be dealing with higher levels of need than it is currently able to do: there are no psychiatric or psychological services attached to units, and, while a half of a Senior Clinical Psychologist post was recently acquired, the incumbent is now on maternity leave. There is some feeling from social work staff that mainstream units are too quick to exclude young people at present. Staff from mainstream units commented that until recently they had provided a "catch-all" service, to ensure that young people did not become homeless, with a focus on availability of beds rather than case mixes in units.

Consultees from the Board felt that High Support cannot be looked at in isolation. A comment was made that the three or so High Support Unit places that will be available to the Board should not receive inordinate attention, and that it was important to look at thresholds for each level of care. There has not been a comprehensive review of what the overall profile of need is and the appropriate services to match. This in itself means that there is a feeling that more cost effective solutions have been crowded out.

There is a lack of therapeutic input into foster care and mainstream residential care and this needs to be considered also by the Board.

Earlier intervention through family support initiatives should have an impact longer-term. Focus on family support / prevention has only happened in the last two or three years.

One of the representatives of mainstream residential care in the Board also commented that some young people would struggle to cope in *any* group home setting.

Profile of Placements in High Support in Last Twelve Months

Four young people were placed in Ardee, two in Brindley House (in total, three young men and three young women). Ages ranged between 10 and 16. Four were under voluntary care arrangements, and two were on court orders (other than emergency court orders). All were previously in mainstream residential care.

The profile of placements prior to High Support was:

- Two previous placements for three young people.
- Four previous placements for one young person.
- Five previous placements for one young person.
- Twenty-one [sic] previous placements for one young person.

Four had been in care for more than twelve months at the start of their High Support placement. The duration of their High Support placements was:

- One was in High Support for 1<3 months.
- One for 3<6 months.
- One for 6<12 months.
- Three for 12 months +.

Only one young person returned home at the end of High Support and one to mainstream residential. One went into Special Care. One remained in High Support.

In addition, there are four external placements where cases were not solely high support but provisions of care that offered high staffing ratios along with many other features of therapeutic care.

Castleblaney

As Castleblaney is located within the North Eastern Health Board and will service four Boards in total (Midland, North Eastern, North Western and Western), comments within this section are divided into:

- Descriptive details on Castleblaney's function, referral process, admission criteria, monitoring and review arrangements, and discharge arrangements.
- Comments from the NEHB on the same.

Description of Castleblaney

Functionality

Castleblaney High Support Unit is located within the area of the North Eastern Health Board. There are two units on site, one with a target age-range of 12-16, one for 14-17 year olds. Both units are mixed gender, having single rooms with en-suite facilities. However, this is currently under discussion: an experience in a mainstream unit in one of the four Boards is causing some to question whether units should have mixed genders.

Castleblaney is expected to open at the start of August, with phased intake to the end of 2002. Two young people will be taken in during the first week of operation, and two in the second. Two buildings that have been undergoing building work have not yet been handed over and timescales will be dependent on this.

Admissions will be for around three-six months in length. This relatively short length of time is intended to ensure throughput and, as one person put it, to "avoid dumping." Placements will be 24/7.

In relation to staffing issues:

- Staff ratios will be five staff to six children during the day in each of the two units, with three staff at night (two "live" and one sleeping).
- 80% of staff are now in place, with a further recruitment advert about to be launched.
- All staff will be designated as CCWS, will have at least 3 years of experience, and will come from a mix of disciplines (social work, psychology, youth work etc.).
- Castleblaney has a school on-site, and its 2nd phase of construction will add in sports facilities.
- There are two self-contained flats on-site for visits by parents or social workers.
- There will eventually be an in-house psychology service.
- Other specialist supports will have to be bought in: this is likely to be costly but will ensure a rapid response.

Castleblaney is not an assessment unit per se and a range of assessment reports is expected as part of the referral process. Technically it should enable quicker access to, for example, assessments by local NEHB child and adolescent psychiatry services, but this is as yet untested. If the need for a specific assessment arises out of the therapeutic work, Castleblaney will undertake this.

Work with families off-site is limited by distance, particularly as Castleblaney is a four-Board initiative.

Description of Castleblaney Referral Process

Castleblaney will send out a referral pack in response to an initial enquiry (including a verbal referral).

There is a requirement for gatekeeping to be done at Health Board level prior to making a referral to Castleblaney.

The procedures for Castleblaney state the need for a series of reports and assessments. There appears to be no agreement at present about whether all four Health Boards will be required to make referrals according to a set template.

A written, complete Care Plan needs to be submitted, including arrangements for access and review, and a discharge plan.

The multi-Board Admissions Panel will determine who will be admitted. This will meet every four weeks (every two weeks at first) and will comprise the manager of the Regional High Support Services (Castleblaney) and representatives from the four Health Boards. The Admissions Panel should be of sufficient weight and representativeness to identify and act on service deficits.

Prior to admission, a Placement Admissions Meeting will take place, involving the young person, to consider needs, outcomes desired, and timeframes and confirm ongoing contact and discharge arrangements.

The process is intended to take no longer than 25 working days from the point of referral (assuming that the referring Board are prompt in returning a completed referral pack).

There is a feeling that Each Health Board will have no problem in identifying several potential candidates for Castleblaney.

Representatives from Castleblaney have also agreed to join the NEHB's mainstream Admissions and Discharge group. This group was established two years ago, meets monthly, and includes PSWs from each of the CCAs. Effectively, this is similar process to the Castleblaney admission group, but is less rigorous in the information that is required (e.g. no psychiatric or psychological assessments; "look for" a Care Plan whereas this is mandatory for Castleblaney).

Description of Castleblaney Admission Criteria

Criteria for inclusion are:

- Child/young person is aged 12-17 years
- Admissions will be on a planned basis only.
- Has a history of care arrangements that have broken down.
- Clearly demonstrated by the referring agency that the child/young person requires this type of intervention and that this level of supervision is in the child's best interests.
- Has a history of absconding, placing himself/herself at serious risk and it is deemed that their needs can be met within an open facility.
- Gas a history of aggressive, destructive or self-injurious behaviour.
- Has displayed a high lack of self-control or poor social skills
- If the child/young person is deemed likely to cause self-injury or injury to other persons if placed in any standard residential facility or other specialist care arrangement.

Possible exclusions include:

- Children with mild learning difficulties would be considered for admission providing the placement would be in the child's best interest. It would not be considered appropriate to admit a child that was assessed as having a moderate to severe learning disability.
- Children currently diagnosed as suffering from psychiatric disorder would not be considered appropriate for admission.
- If a child/young person is considered to have an addiction problem he/she would only be admitted after having completed a detoxification programme and it is considered that the Centre could offer a care package that would work for the child.

- As per the 1999 Children's Bill, children will not be admitted to the Centre on the foot of a Court Order but will be referred to the Centre via the principal social worker or child care manager.

The Placement Meeting prior to admission is seen as crucial to engaging the young person. This can help to clarify with the young person how long they will be at Castleblaney, why they are going there, and what they will be doing there.

All four Health Boards have expressed concerns that the rigorousness of the exclusion criteria may be too tight. It is important therefore to reflect on how rigid Castleblaney staff themselves see those criteria to be.

- There is recognition that psychiatric illness *is* likely to be present, to a greater or lesser degree, in most cases. If this is not the sole diagnosis, it will not lead to automatic exclusion. Psychiatric nurses are part of the skills mix of the team, so only those with "florid psychiatric illnesses" will be excluded. Similarly, self-harmers will not be automatically excluded, because of the grey area between behaviour and psychosis in such cases.
- The designation of an IQ base of 70 is based on the cognitive ability of the young person to engage in therapy programmes.
- With regard to addiction, the only exclusion is if the young person requires detoxification, as this is a medical issue. If they have undergone detoxification, they are not excluded.

Description of Monitoring and Review Arrangements

Initially a comprehensive intervention package of three months will be offered; and reviewed thereafter every month.

Castleblaney see close contact between the Health Board keyworker and the Castleblaney keyworker as being essential to success.

Description of Discharge Requirements specified by Castleblaney

The onus will be on the Health Board to ensure that discharge plans are in place. The panel will also consider applications for extensions (e.g. if by month five there is a feeling that more time could make a significant impact).

Ardee will become a step-down unit for Castleblaney in the future to "provide a breathing space between high support and mainstream." Castleblaney will manage Ardee. Time at Ardee will be limited to two months maximum.

No post-discharge outreach support is envisaged; although Castleblaney would want to begin to engage with staff from the destination placement some four-five weeks beforehand.

NEHB comments on Castleblaney's

Functionality

Questions were asked about whether assessment would be a part of the function of Castleblaney, or whether a full assessment is expected to have been carried out beforehand. The Board are keen on a mixture of assessment and therapeutic input.

Some Board consultees felt that three-six months was too short to enable an effective therapeutic intervention to take place, particularly where young people have experienced a series of unstable placements. Others noted, conversely, that a longer intervention might damage attachment/bonding with the primary setting from which they have come; and that the Board is not currently as successful as it would like to be in moving young people on from mainstream residential care.

There also appears to be a debate with the unit about the models of intervention to be used, and about what levels of interaction were appropriate from a "duty of care" basis.

Potential Candidates for Admission to the Unit

Most young people referred to Castleblaney are likely to be in mainstream residential care. There are several potential candidates currently in mainstream residential care. As a result of challenging behaviour in mainstream, usually assault, normal staffing levels of two staff per shift have had to be increased to three per shift.

Referral process

There is a debate about whether having exhausted alternative options means that the young person must have *experienced* fostering and mainstream residential care, or whether the appropriateness of these options needs simply to have been explored.

There was a feeling that some young people are currently in detention because of gaps in the continuum of support. On the other hand, some staff said that there is such a long waiting list for Ballydowd that step-down options are not really an issue at present.

In addition, the raising of the age of criminal responsibility under the Children Act 2001 is likely to extend Health Board responsibilities. This might create significant pressure on both mainstream residential units and High Support.

Admission Criteria

There was some understanding of the "exclusions" as regards learning difficulties and psychiatric disorders, given the skills mix in Castleblaney. These exclusions were also seen as logical if a behaviour modification approach is being undertaken. A significant proportion of children currently in care have learning difficulties, and an around four or five have psychiatric problems. In addition, there is a separate need for in-patient psychiatry and services for severe learning difficulties.

However, there were also concerns that the "exclusions" might screen out too many if rigidly applied. In practical terms, there was a feeling that it will be important for the Board to influence who is included/excluded.

Staff from mainstream units noted that residential homes are often in the young person's home area, making it harder to break patterns of behaviour, and that Castleblaney's distance away may in itself help to break cycles (examples given were ease of going to the local pub or friends knocking on the door late at night).

Discharge Arrangements

Although there is a requirement at the start of the placement to specify placement destination, some social work staff felt that the work that Castleblaney undertakes might actually influence the final choice. Some therefore felt it unreasonable to specify a place and date of discharge in advance.

Managers of mainstream residential services within the Board felt that the concept of protected placements needs to be thought through and described the issue as "difficult".

4.8 NORTH WESTERN HEALTH BOARD

Definition of High Support - from Group Discussion

When the four Health Boards met initially to establish Castleblaney, they found they had different interpretations of what "high support" means.

High support should focus on children with complex needs, usually older children, who exhibit extreme behaviours in residential care. There should be an emphasis on therapy rather than punishment.

High support should be the next move on after residential care for those who may be heading towards special care. It should be voluntary and not court-led. It implies more intensive levels of support than mainstream units in terms of therapeutic input and support infrastructures.

It was posed by a participant that in some ways High Support Units provides respite by allowing the donor unit to regroup and stabilise themselves before re-accepting the young person.

Continuum of Provision within the Board

High Support Units	:	The North-Western Health Board is one of four Health Boards involved in developing Castleblaney. The underpinning thinking for the development of this unit was that no single Board would be able to finance the development and fill all its places.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Arrangements	:	Both CCAs have 1 person in a special arrangement that provides wrap-around care. One participant said that these packages occurred historically because of the absence of HSUs (cases, for example, with a history of absconding, violence/aggression, inability to cope with needs in a mainstream residential unit).
Mainstream	:	Sligo/Leitrim CCA has two four-bed units, one direct Health Board provision, the other voluntary. There are currently only five young people in these because of case mix considerations.
	:	Donegal CCA has two units, with two young people in one and five in the other.
Fostering	:	Around 96% of all placements were estimated as being in foster care.

Participants in the meeting on-site noted that the young people coming into care are increasingly more challenging and the Board is struggling to cope with them. With mainstream residential provision being so small, one disruptive person could have a considerable destabilising effect. It might be possible to maintain more in mainstream residential care if residential care workers had better training and experience and there were better links to other professions to provide support (e.g. options to connect to a designated worker or team).

Consultees from the Board were also keen to stress the range of intensive diversionary community-based programmes that are in use within the Board. The extent and effectiveness of such resources can allow a "high support" type approach to be employed in the community. Resources that were noted include:

- *Sligo/Leitrim:* Extern West operates 3 diversion programmes (youth support, Time Out, Janus programme). Good home liaison service. YAPS Youth Action Project. Roscor Co. Fermanagh. Springboard in Sligo. St Anne's Youth Club. Forige YC in Leitrim.
- *Donegal:* Springboard in Rapho. NYP in Dunlow, Ballyshannon. Extern West – Time Out, Janus, Kick Start. Patchy Home School Liaison

Profile of Placements in High Support in Last Twelve Months

There has been no use of High Support by the Board in the past. The Board tried to gain admission to several places but found them to be always full.

Castleblaney

Castleblaney is described under the return for the NEHB, in whose area it is located. Castleblaney is not yet operational.

Two of the twelve places have been designated for use by NWHB.

From some areas of the NWHB, Castleblaney may be around 2 ½ hours travel away.

Potential Candidates for Admission to the Unit

The NWHB have three young people currently who would be candidates for the unit – one in special arrangements, one in residential care whose disruptiveness has limited the capacity of his current home, and one who has been inappropriately detained in Oberstown after a three week assessment.

Referral Process

See NEHB section for detail on the Castleblaney referral process.

Admission Criteria

See NEHB section for detail on those included and excluded according to Castleblaney's admission criteria.

While exclusions do seem consistent with other developments nationally, on participant noted that these tended to exclude those most at need. Another participant

commented that High Support Units can refuse children admission, whereas mainstream residential units cannot.

The absence of provision for emergencies also highlighted the need for a local short-term unit. Comment was also made on the lack of addiction counsellor's nationally for adolescents.

As regards to voluntariness on the part of the young person, this is regarded as a potential deficiency, given that the young people are likely to have significant behavioural difficulties. Castleblaney has to be made attractive.

Review Arrangements

Placements are only intended to be for three months.

Discharge Arrangements

It was seen as critical because of the shortness of placements to have discharge plans in place for when the young person leaves Castleblaney, identifying both the next placement and professional support required.

There may be dilemmas about whether Castleblaney should maintain contact after discharge. The Board may need to consider whether an extra two months would be beneficial.

Involvement may need to be extended, particularly if the young person only becomes engaged towards the end of the three months, even for as much as twelve months.

4.9 SOUTHERN HEALTH BOARD

Definition of High Support - from Group Discussion

The role of High Support is said to remain unclear to both social workers and residential staff, due to the evolving context of both its own development within the Board area and with the recent expansion of Board-managed residential provision.

It performs both a "step-up" function in that it is "the second last resort" for residential care, but also a "step-down" facility from Special Care. A lack of integration between the thresholds and standards of behaviour expected in the Special Care and High Support Unit (Loughmahon) had been noticed in an ISSI report. This was said to have been addressed, although may still present an issue where "step-up" children using the Unit may need firmer thresholds than previously experienced in mainstream provision. Lack of direct management of the overall residential sector until recently has meant that some children entered High Support "by default".

There is clarity that High Support is an open environment (i.e. not secure) and seeks to provide a therapeutic setting based upon the relationships built between staff and residents. All staff are trained in and via TCI approaches.

High Support is seen to be characterised with higher than average staffing ratios, although this has proved problematic:

- No agreed formula for staffing ratios across the residential sector.
- Significant problems of staff recruitment to High Support.

Continuum of Provision in the Board

High Support	:	There are two High Support units within the Board: Ard Doire and Lougmahon. These are described in more detail below.
Special Care	:	Glenn Alainn; a 7-bedded unit for females operated as a Regional resource in collaboration with the South Eastern and Mid-Western Health Boards.
Mainstream residential	:	Prospect Lodge; a 5-bedded open unit for boys.

Until recently (April 2001) Health Board directly-provided residential provision was limited to the above four units.

Additional residential (mainstream) provision was provided by the Good Shepherd and Mercy Orders including:

St Joseph's Mallow	:	originally a mixed unit for adolescents (although younger children have been placed there in the past) but now being re-constructed as two 5-bedded units.
Tree View, Cobh	:	a mixed 10-bedded unit for children aged 8 – 12 years

St Joseph's Passage West	:	a mixed 10-bedded unit for children aged 12 – 16 years
Riverside Tralee	:	a mixed 5 – bedded unit
Woodleigh Tralee	:	a 5-bedded unit
Deenagh House	:	a house homing 5 children from a travellers family
Airne Villa, Killarney	:	a mixed 8-bedded unit for children 8 years + offering emergency placement, assessment and respite

Many of these have now been assimilated into the Board's management structure, and others are in this process, and work is underway to make them into an integrated set of residential provision across the Board's Region.

Additional provision exists for after-care and for semi-independent living

Parkview, Cork	:	a mixed hostel for homeless adolescents in the process of being built
Pathways	:	a hostel for homeless boys aged 14 – 18 years
Riverview	:	sheltered accommodation in 6 self-contained flats for girls under 18 years old
Wellsprings, Cork	:	a purpose built hostel for 5 girls, 16 years plus, seeking semi-independent living
Hearth, Cork	:	independent flats for 5 young single mothers
Besborough	:	single mothers unit for up to 7 with crèche and educational facilities (on the same site as Loughmahon)
Edel House	:	a homeless women's hostel but with 4 beds purchased by the Board for homeless girls 14 years+
Bruach	:	a day training facility used by residents of Riverview and Edel House

Special arrangements have been used in the past, including recently, but not currently in operation. For example an 11 year old with ADHD had a living arrangement with 8 additional workers attached to them. They are now within a mainstream unit, but with five additional workers providing placement supports. Special arrangements are said to work successfully, only on a temporary basis. There is a problem recruiting (invariably) temporary staff to provide special arrangements and also with securing the consistency of their engagement.

In the absence of special arrangements children have been placed out of jurisdiction (e.g. Northern Ireland, Scotland) and currently five children are in detention awaiting a response from Scottish units.

Profile of Placements in High Support in the Last Twelve Months

Two young men (aged 13-14) were placed in Ard Doire, and seven young women (aged 14-16) in Loughmahon. Three were under voluntary care arrangements and six were under other care orders. One young woman had had 2+ high support placements in the period.

Three of the young women had had no placement prior to residential care, two only one placement, one five placements, and one 10+. The two young men had had six and seven placements previously.

Five came to high support from residential special care. Eight were in high support for six-12 months, and one for more than twelve months.

Both young men are still resident in High Support. Four of the young women returned to mainstream residential care, and three went home.

High Support Units Within the Southern Health Board

Ard Doire	:	A 5-bedded unit for males aged 12 – 16 years. Ard Doire has a staffing compliment of 28, with 16 staff in post (9 permanent and 7 part-time). Current occupancy is two children giving a de facto 1:3 ratio.
Loughmahon	:	A 5-bedded unit for females aged 12 – 16 years. Established in February 2000. Staff compliment is 17.5, with 20.5 staff in post (12 permanent and 8.5 part-time). Current occupancy is five children giving de facto 1:3 ratio.

Both units currently address the needs of 12 – 16 years although they want to re-align these to 14 – 17 years. Mainstream units should similarly have their admission criteria revised upwards so that they take those 13 years+.

Psychiatric inputs to children in High Support have to be requested by social workers from area-based child and adolescent mental health services. No protocols exist with the child and adolescent mental health service to provide accelerated access for High Support residents.

Recently a senior psychologist has been appointed to work primarily with Gleann Alainn and Ard Doire, although they are also providing support to Loughmahon.

An educational facility for 24 pupils has been developed in Ard Doire, under the name Ard Alainn, with the intention of providing a service to Gleann Alainn, Ard Doire and for other children in care out of school. To date there have been problems in getting the Department of Education to recognise the status of the school unit. Three teaching staff, a principal on a one-year contract and other sessional teachers currently provide education input for three pupils in the units.

Referral Process

Admission to the High Support Units is overseen by an Admissions Committee comprising a psychologist, the unit manager, and two senior social workers. This oversees admissions to both Special Care and High Support. The Committee meets monthly, although there is no set pro-forma for making referrals and substantiating the needs in applicant cases.

Admission Criteria

Admission criteria for ***Ard Doire*** state:

- That the young person is male and aged between twelve and sixteen years on the date of admission
- That the child absconds, is violent or presents as a serious danger to self or others, but not to a degree that would require placement in a Special Care Unit.
- That the child's level of need and difficulty are judged to be consistently beyond the norm and that he cannot be positively supported within a more open setting at this time.
- Where possible indicators of formal mental illness in terms of distortion of speech, thought or perception exist, that psychiatric assessment has ruled out the same.
- That the child is not a habitual drug user.
- That the child has not been convicted of a serious offence.
- That the child has not been assessed as having a general learning difficulty to a degree that would prevent a constructive intervention at Ard Doire.

Loughmahon's admission criteria states that its client group: "comprises of adolescent female girls aged between 12 and 16 years, who present to being at risk due to emotional or behavioural problems, which cannot be managed in their current care settings. Evidence of other interventions have proved unsuccessful in stabilising the young person's situation… the presence of school refusal, non compliance, inability to settle in a family situation were all seen as appropriate criteria for the admission criteria for the admission of a young person to the unit". The admission criteria also states the following to be *unsuitable*:

- Violent and presenting as a serious threat to self, others or property.
- Having a psychiatric disorder.
- Showing severe conduct disorder or mixed personality disorder.
- Evidence of ongoing drug abuse.
- Having a learning difficulty.
- Having previous or forthcoming convictions.
- Evidence that the young person is currently engaging in self-mutilatory behaviour.

Current children excluded from High Support are those with mental health, learning disability and drug misuse needs, due to absence of staff skills to meet these requirements.

There is no Board provision for residential services to children with learning disability: applications have to be made to the voluntary sector.

Management of the four original Board units is with one Child Care Manager (Two other Child Care Managers have responsibility for the other residential units recently transferred from the religious orders). There is a desire to develop a common management committee for the Special Care Unit and the two High Support Units. There is a further desire to separate out the role and management of those who would undertake Section 17 visits to the establishments.

Both units report closer working with the parents of residents in the recent past. An additional dimension to this will arise when Family Welfare Conferences (FWC) are required by the Children Act prior to admission to Special Care. Consideration of how High Support might contribute to the options arising from a FWC have yet to be formulated.

4.10 SOUTH EASTERN HEALTH BOARD

Definition of High Support - from Group Discussion

The defining characteristic of High Support within the Board area is said to be high staff ratios with an emphasis on planned therapeutic interventions delivered to a plan with the capability of dealing with extremes of behaviour.

The Board's document entitled "Regulating Admissions to the High Support Units within the South Eastern Health Board, 2000" specifically states that High Support units are not: secure centres; emergency reception centres; remand centres; assessment centres; part of the Juvenile Justice system. "They are places to which children are referred for a planned, professional, therapeutic residential care programme."

From the perspective of social work managers there has been an over-concentration on the concept of High Support as a residential service, rather than a (range of) resource(s) which may be used in a preventative capacity as well as a specific form of intervention. Some initiative is currently underway to recruit foster parents that can provide a High Support capacity (in Carlow/Kilkenny) but this is having problems attracting additional in-puts from other disciplines (e.g. psychology, psychiatry, out of hours support to ensure effective levels of service). The favoured approach of social work managers is one which seeks to see High Support as a resource, to be used flexibly with the funding for it following the child. How to deliver this within the present service configuration (and a stated budgetary shortfall for the year) has yet to be devised.

Continuum of Provision within the Board

High Support Units	:	There are four High Support Units located within the Board: Grangemore, Waterford; Ten Acre, Wexford; Kilkreene, Kilkenny; and St Bernard's, Fethard (Sacre Coeur). These are described in more detail below.

Each Community Care Area has access to a range of mainstream residential provision.

Waterford

Bell Lake	:	a short-term 6-bedded unit for boys and girls 7 years of age and above.
St Michael's	:	a mixed 8-bedded unit for those between 11 and 17 years
Dochas	:	a hostel (which is a Regional resource) for 6 girls aged 14 – 18 years

The Area also had reported using a Probation hostel for boys 16 years or more on occasion.

Wexford

Walnut Grove	:	a 6-bedded mixed unit for 11 – 17 year olds offering medium to long-term provision.

A short-term 4-bedded unit is currently in the planning stage.

Carlow/Kilkenny

Crannog	:	a 4-bedded mixed unit for those aged 10 years or more on admission with an original short-term remit but now extended to medium-term care.
Avondale	:	a similar unit to Crannog

An after-care 3-bedded apartment is also available on the Crannog site.

South Tipperary

St Bernard's High Support site has two medium-term units of mixed residents aged ten years and over. In addition Avila unit provides three places for children aged 10 years or more who are disabled and have been involved in the child protection notification system.

No Special Care facility exists within the Board area, although there is a (informal) reciprocal arrangement with the Southern Board (for access to Gleann Alainn for girls) and with the Mid-Western Board (for access to a boys special care unit, yet to be opened.) These two Boards have used the High Support facilities provided by the South Eastern Board.

Special arrangements are or have been in place at one time in all Community Care Areas.

Waterford	:	Grangemore has a special arrangement called Cool gowar for a female subject to a court direction.
Wexford	:	Mount Prospect is a special arrangement for four children aged 5 yrs and 7 years (sibs) and 12 years and 16 years.
Carlow/Kilkenny	:	Uses Blessington Community Children's Centre for four children from the area and Fresh Start in Cobh for one child.

All areas report using placements out of jurisdiction on occasion, especially for children with learning disabilities and behaviour problems.

The Health Board also funds a regional resource, the Holy Families Centre for 20 children of school age with moderate learning disability.

Each of the directly provided Units has a Management Advisory Committee which acts as a support mechanism to the Unit Manager. This usually comprises, along with the Unit Manager, representatives from Child Care Managers, Programme Managers, Senior Social Worker, Child Care Specialists (e.g. Psychologist, Consultant). In St Bernard's this function is discharged by the organisation's regular management team meeting.

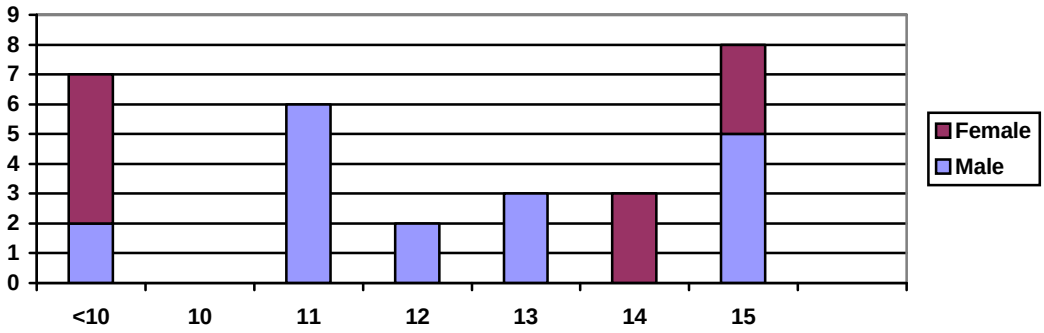
While a degree of operational integration may exist between the High Support Units and other, mainstream, residential provision, the level of strategic integration of the sector is poor. No post-holder has Board-wide responsibility for the strategic development of residential care and responsibility for this within Community Care Areas is unclear. An overall review of residential services within the Board is proposed for the autumn 2002.

Profile of Placements in High Support in Last Twelve Months

29 young people were admitted:

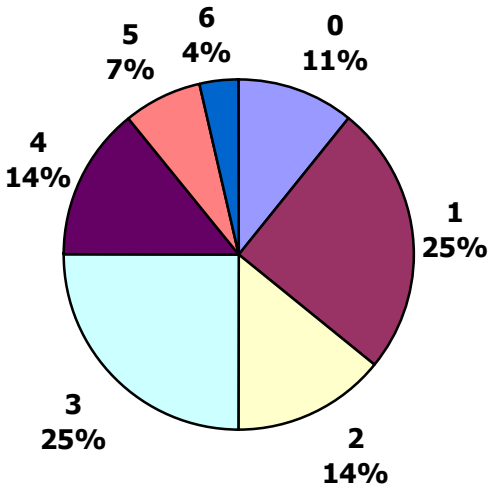
- 9 to St Bernard's
- 7 to Kilcreene.
- 6 to Ten Acre.
- 6 to Grangemouth.
- 1 to the Community Children Centre.

There was a significant proportion in the under 10 category, and an uneven gender distribution. No one was above 15 years of age on admission.

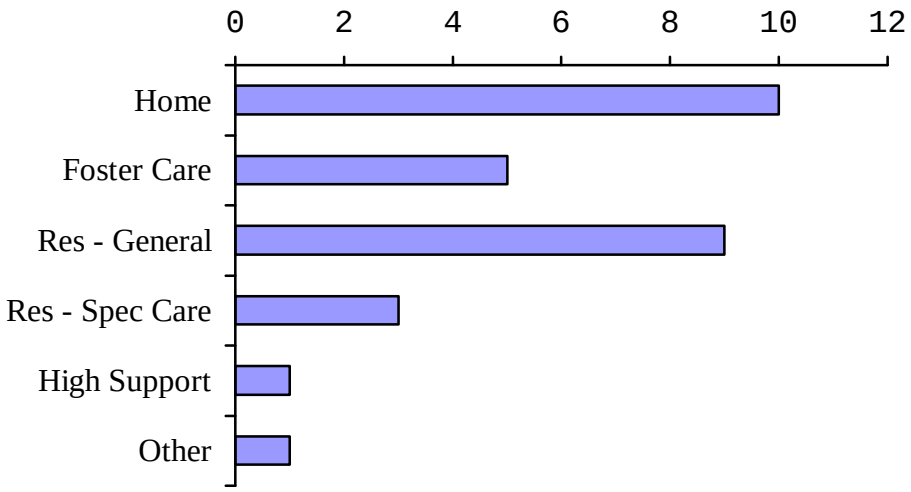


17 were under voluntary arrangements, 1 under an Emergency Care Order, and 11 under other care orders.

50% had two or fewer placement moves prior to entering High Support:



More went into High Support from home than from any other category. None came from custody/detention.



14 of the 22 who were reported to have been in care prior to their High Support placement had been in care for twelve months or more.

10 were in High Support for 6<12 months and 17 for 12 months+.

Of the 16 whose next placement type was reported, 7 went home, 2 went to foster care, 3 went to mainstream residential, one to residential special care, 2 to custody/detention, and one was deceased.

High Support Units within the South Eastern Health Board

The Regional deployment of High Support has been a deliberate policy of the Board and although this may place children away from their home environment, contacts with families are said to be good.

The South Eastern Health Board have four High Support Units, located in each of the Community Care Areas it covers, providing a regional remit for differing types of need

Grangemore, Waterford	:	a 5 bedded unit for girls aged 12 – 17 years providing a therapeutic intervention individually tailored with an education unit on the premises over a 12 month period.
Ten Acre, Wexford	:	a 5 bedded mixed unit for those aged between 8 – 12 years on admission. This provides a structured regime based on cognitive behavioural approaches, including what was described as "reality therapy", for one to two years.
Kilkreene, Kilkenny	:	a 5-bedded unit for boys aged 12 – 17 years abuse using a psychotherapeutic approach over an 18 month period.
St Bernard's, Fethard	:	a 4-bedded mixed unit for those under 12 years on admission operating a therapeutic community Miliev along the lines of the Cotswold/Mulberry approach lasting for up to four years.

Staffing ratios are reported to be between 1:1 to 1:3 at present. With one exception (Ten Acre) staffing levels are to compliment, although there is a shortage of permanent staff which is supplemented by part-time staff.

Each Unit has an educational facility on the premises and direct input from a psychologist, psychotherapist, family therapist or similar. Contributions into the Units from other disciplines were reported on occasion to be problematic. This was most frequently stated with respect to child and adolescent psychiatric input. Referral to child psychiatry was on the usual referral/waiting list basis, with no protocols for accelerated access. No in-patient child and adolescent provision is available within the Board area.

Regional deployment of the High Support Units has also meant that for the three directly provided services line management of the units has been integrated into the overall management structures within the Community Care Areas, rather than have a specific High Support board of management. (Interestingly the High Support Managers report directly to the Area General Manager rather than a Programme Manager, Principal Social Work or Child Care Manager.) The one commissioned unit (St Bernard's) manages High Support through its overall Board of Management.

Referral Process

Each Unit has an Admissions Committee at which social workers seeking a placement present their applicant cases. These applications are by way of a pro-forma separately developed by each unit which reflects not only the social worker's analysis of the needs in the case but also those of allied disciplines that have been involved.

The Admissions Committee typically involves the Unit Manager, Unit Psychologist, Child Care Manager, Principal Social Worker and the Board Head of the Child Care Development Unit. The latter post-holder sits on all Admissions Committees and is the only common member to these fora.

Admission Criteria

Admission criteria for Ten Acre, Wexford, are stated as: "A child or young person will have demonstrated extended impairment in functioning due to severe emotional difficulties in the following five areas:

- *Living arrangements:* The child demonstrated emotional and behavioural difficulties, which is impacting on their current placement. As well as a history of adjustment difficulties resulting in numerous placements.
- *Social relationships:* The child demonstrated severe difficulties with interpersonal relationships, social skills, play, use of leisure time, and has a poorly developed value system.
- *Directions/self-control:* The child demonstrates difficulty with attention for long periods of time to permit completion of appropriate tasks, impulsivity, poor-decision-making and insight.
- *Self-care:* The child presents with poor personal hygiene, eating habits and sleeping habits.
- *Educational records:* The child refuses to go to school, poor attendance, and weak academic performance and/or has behavioural difficulties during the school period."

No unplanned or emergency admission to the unit is possible.

"Admission Criteria" for the other High Support Units actually focus on the referral procedure.

Two overriding principles have been pursued by Admission Committees with respect to the High Support Units:

- The avoidance of "emergency" placements into High Support.
- The avoidance of admitting children with no previous experience of living away from parents.

The impression gained was that, apart from consideration of admission to a High Support Unit, the Committees will offer advice to social workers on alternative provision or responses to children's needs that might be pursued.

Step-up and step-down arrangements have been most fully developed between the High Support Units and the mainstream residential services. Examples were provided of integrated pre-admission and post-admission services and supports being provided to young people coming to and exiting High Support to other residential services.

"Step-up" and "step-down" arrangements on a regular basis from Special Care were not described.

Monitoring and Review Arrangements

Relationships with caseholding social workers were reported to be strained due to overall pressures on caseloads leading to discontinuity in their involvement with Unit processes and procedures (e.g. reviews).

Discharge Arrangements

Post-admission support from High Support was also described where children leave the Unit to return to their own homes. Overall, however, problems were identified in moving children on from High Support, in part related to the Units' relationships with caseholding social workers and their commitment to finding move-on placements.

The transferability of approaches used and gains made in the High Support context is an issue. Learning lessons from High Support to mainstream has not been a particular feature of the past experience. The exception to this is St Bernard's where the mainstream units sharing the site of the High Support Unit have been examining the implications of recent practice for the future operations of all the Units.

4.11 WESTERN HEALTH BOARD

Definition of High Support - from Group Discussion

High Support would deal with young people that mainstream residential units could not cope with: but the capability of those units themselves might vary over time according to levels of staff skills and support. The young people concerned involve a disproportionate amount of time and stress.

High Support was defined as providing on-site open residential facilities, with a high level of multi-agency service inputs and higher staff ratios than a mainstream setting. Focus would be on therapy as well as offending. High Support Units would not exclude children for behavioural difficulties. They would also provide respite.

"High support" was defined not just in terms of a specific building and unit, but in terms of the provision of intensive wrap-around support in any setting, including mainstream residential care and home. However, it can be particularly difficult to gain the involvement of other Agencies where a child is in the care of the Health Board.

Thus, the High Support Unit to be used, Castleblaney, was seen as only one small part of the necessary approach. It will provide another tool, but without absolving Health Boards from their wider responsibilities. One person commented that it is "irrelevant" and another that there were no false hopes about how much impact it would make.

CCMs as a group they felt that it would be a "waste of time" to develop High Support in isolation – there was a need to develop wrap-around services in all settings. The CCMs decided that they needed to organise a meeting to plan an integrated residential strategy. Deficits in current provision were felt to be known, and a full strategy might take three-five years to implement. Such a strategy would need to consider whether existing mainstream units could be developed to provide "higher support."

Continuum of Provision within the Board

High Support Units	:	The Western Health Board is one of four Health Boards involved in the development of Castleblaney. In addition, Barr Aille, Galway, has provided either high support or secure care alternately.

The following approximately summarises the profile of placements in non-High Support provision within the Board.

Special Care	:	Have used Oberstown.
Individualised Community Programmes	:	The Edge Project, Co. Mayo provides individualised programmes in community with child and family as an alternative to secure care. In addition, the Youth Advocacy Programme (YAP) has been established for

		Co. Galway and Co. Roscommon and will be operational from October.
Special Arrangements	:	The Board has an "Out of Control" fund. One property in Galway had been used for several young people and adapted as secure/open according to needs: (Barr Aille) this has since been discontinued. Currently a secure house "special arrangement" is being developed in Co. Mayo for one female adolescent.
Mainstream Residential	:	24 beds in four- units, plus Rice House Homeless Hostel and Westside for emergency reception into care. Only two of the units are Health Board units. This is a decline from 40 beds a couple of years ago.
Specialist Foster Care	:	This is lacking at present and needs to be developed.

Participants stated that there is not enough residential provision and it is not of the right mix. Current residential units have mixed staff skill and access to multi-disciplinary supports. The training and support needs for residential homes need to be addressed, and a restructure needs to be undertaken.

Profile of Placements in High Support in Last Twelve Months

There has been little usage of High Support in the past. One house was converted to provide either High Support or secure care (Barr Aille, Galway) and two young women (aged 14 and 16) have been accommodated there in the last twelve months as "high support".

Both young people had had five placements prior to entering high support, had been in care for more than twelve months, and their last placement type prior to entry was mainstream residential.

One stayed in high support for 1<3 months, and one for 6<12 months. Both returned to mainstream residential care.

Castleblaney

Castleblaney is described under the return for the NEHB, in whose area it is located. Castleblaney is not yet operational. With four Health Boards to access the unit and twelve places, the average number of places per Board will be three.

Potential Candidates for Admission to the Unit

Several likely candidates for Castleblaney were identified: some appear to be step-down (from Oberstown, Mountjoy, Michael's); some may be effectively on-and-off the street. All three CCAs could identify potential candidates, and Galway in particular could have as many as ten.

Referral Process

See comments under NEHB on the referral process for Castleblaney.

Some staff wondered whether it might be useful to have a Family Welfare Conference within the Board before making a referral.

Admission Criteria

See comments under NEHB on those included/excluded from admission to Castleblaney.

A concern was expressed that the strictness of exclusion criteria might mean that Castleblaney would simply replicate what was already available at home. Several of the potential candidates initially identified may be excluded from admission Castleblaney. Immediacy of response was also regarded as a significant issue, both because Castleblaney is not taking emergency referrals and because of the length of the admissions process. Indeed, one person estimated that the absence of emergency provision might mean that the unit would only be dealing with ¼ of those with more complex needs.

There were already doubts about whether older children with a history of absconding were likely to stay in Castleblaney; and, because of its distance, it could increase the danger to themselves if they hitched, went to Dublin, or even stole a car to drive home. As one person put it, "kids who go to Castleblaney are already highly motivated if they consent to going" whereas those with a history of absconding may be less so. On the other hand, there was a potential benefit for Galway in particular in the distance to Castleblaney, as at present it can be too tempting for friends of young people in care to entice them back to the street: it could help to break this cycle.

Monitoring and Review Arrangements

There was some uncertainty about whether the social worker from the home Board would maintain contact with the unit, or whether this might be the responsibility of "Children Act" staff within the Board. If it is a field social worker, there might be resource implications (although it could be argued that they would have a reduced day-to-day workload associated with the same young person).

Discharge Arrangements

Doubts were expressed about the ability to complete therapeutic input within three months. Resources would be required to provide follow-up treatment. In Mayo, the Edge Project might work with the young person and their family.

There are issues relating to whether or not the "donor" unit would want the young person to return, and a dilemma about whether the Board can afford to protect an empty bed for three months.

4.12 SUMMARY

The evolution of High Support since the last "Laxton Review" (November 2000) has taken place against a context of increasing complexity:

- High Support Units increasingly provide a diverse range of provision with respect to the purposes of the regimes, the age ranges served, the duration of stay and the therapeutic models employed.
- The passage of the Children Act 2001 has now clarified the position with respect to the role and usage of Special Care Units and High Support needs to be re-considered as to its relationship with those services and the infrastructure to be introduced to access and regulate them.
- High Support-type "arrangements" may be found in a variety of settings with a variety of approaches employed. Because these arrangements are frequently deployed in places other than designated "Units" they are low visibility. The ability of any of the relevant organisations (commissioning, providing, regulating) to have a comprehensive overview of High Support-type arrangements at present is exceedingly problematic. Similarly the quality assurance of so-called "special arrangements" can be variable.
- The evidence gathered from the Boards would suggest that the continued evolution of High Support has not taken place against a backdrop of a comprehensive three year child care planning strategy as recommended by Laxton to ensure that High Support is, "at the hub of co-ordinating the placement of young people in and out of Special Care and alternative care arrangements". Developments such as the Regional Childcare Framework in ERHA may begin to address this.
- Similarly the evidence gathered would suggest that frequently there is poor integration between those with responsibility for the strategic management of High Support and those with responsibility for the strategic management of "mainstream" residential care. Indeed, in some instances, these roles do not exist in all Board areas.

5. HIGH SUPPORT AND THE FUTURE

5.1 HIGH SUPPORT IN DESIGNATED RESIDENTIAL UNITS

Despite its relatively brief heritage, High Support as a concept has evolved into a number of different strands and approaches across the country. As can be seen from the review evidence, different regions of the country configure residential High Support in very different ways:

- Regionally configured "short-term" intervention – characterised by the arrangements in the four Northern and Western Boards.
- Regionally configured "medium-term" intervention – characterised by the arrangements in the Eastern Region
- Locally configured community-based residential units – characterised by the arrangements in the South East, South and Mid West Boards.

The requirement in the medium-term, if residential High Support is to retain a conceptual coherence, is to ensure that they are delivered and evaluated to a common set of agreed verifiable standards. We recommend, therefore, that the National Standards for Children's Residential Centres should apply fully to High Support Centres; and that the Department of Health and Children, in collaboration with all relevant parties, develop an addendum to the National Standards addressing the criteria of standards that are of particular relevance to High Support in designated residential units (including staffing, placement and admission, emotional and specialist support, managing behaviour and discharge).

With respect to eligibility criteria for residential High Support there are a number of the original defining characteristics which still have a pertinence today:

- Provides short to medium term intensive care
- A non-secure environment which focuses on stabilising an extreme situation
- Provides a high staffing ratio so that therapeutic relationships may form
- Maintaining links with family
- Throughcare and Aftercare
- Access to education provision
- Access to therapy services

Each of these characteristics needs to be re-evaluated in the light of changes to policy, legislation and practice.

Provides Short to Medium-Term Intensive Care

The present development of High Support Units has led to a wide variety of purposes or models being pursued. These can be characterised as the following:

- Assessment model.
- Trauma treatment model.
- Therapeutic community model.
- Alternative Special Care model.

With respect to High Support residential units, we recommend that Boards should continue to determine, on the basis of their own local needs analysis, which model(s) or approach(es) best suit their needs.

Similarly, with regard to the age and gender mix of service users requiring residential High Support services, Boards are best placed to know the patterns of local need and demand that exists. As such we make no recommendations as to a minimum age at which residential High Support should apply.

With respect to the delivery of residential High Support, consideration needs to be given to the implications arising from the reconfiguration of Detention Schools and Special Care brought about by the passage of the Children Act 2001. The legislation restricts the use of restrictive forms of residential care for those who offend to a minimum age of 12 years (the revised age of criminal responsibility) and its duration to a maximum of three years. For Special Care Orders, while not restricted to a specific age, the anticipated average duration will be six months. Given the emphasis of the legislation on applying the least restrictive options and seeking to normalise services wherever possible, some comparability in the parameters of the usage of residential High Support should be considered.

We recommend, therefore, that where High Support services are to be delivered in a designated residential Unit, the guideline should be that the presumptive minimum duration of intervention is three months and the presumptive maximum 12 months. There may be circumstances where an episode of care in a dedicated High Support Unit should be extended, but this should be verified by a review process, which should evaluate the continuing need for such intervention and document the reasons.

The introduction of a presumptive maximum duration of intervention within High Support is to emphasise that the decision to implement this option should be needs-led rather than service-driven. By requiring a routine re-evaluation of the need for such services (by way of a structured review process) at a point established at the outset of the intervention, the intention is to ensure:

- That case managers (i.e. children and family social workers and their managers within Health Boards) actively seek alternative services to High Support to meet the changing needs of children and young people, where appropriate.
- That High Support service providers regularly and robustly re-evaluate the need for their services: continuing to provide them where needed; and advocating alternative services that should be available on behalf of young people where the needs for a High Support service have in fact been met.

This recommendation seeks to re-emphasise the role of residential High Support as intensive and focused with the aim of reconstituting the child or young person into normalised mainstream services as needs require. We recommend that this structure of indicative timescales be reviewed after two years with the overall review recommendations contained later in this report.

A Non-Secure Environment which Focuses on Stabilising an Extreme Situation

The passage of the Children Act 2001 has served to clarify that the only secure residential settings that will be permitted in the future will be Special Care Units for

children subject to Special Care Orders and Detention Schools for those subject to a Children Detention Order. As a consequence High Support, both as a unit of provision and as a methodology, must operate in an open environment, with the consent of the young person and with the therapeutic relationship provided by the staff as the main means of delivering a "secure" setting for their care. In our interviews with High Support users and providers this message was clearly understood.

Earlier ISSI inspection reports have demonstrated that regimes which have been practised in High Support Units (TCI, the locking of doors at particular times, the use of C.C.T.V.), do need to be monitored, recorded and reviewed both internally and by inspection processes. This is particularly important if the concept of High Support, as a methodology to be applied outside of traditional residential settings, is to be developed.

We have been asked to specifically consider whether High Support should be reserved, as with Special Care, for children and young people subject to formal court orders (either full or interim). Given that High Support seeks to respond to stabilising extreme situations that children and young people find themselves in via an open, albeit intensive, environment we do not feel that this pre-condition is necessary or appropriate, particularly if High Support as a methodology is to be promoted.

This latter recommendation has important implications for the use of High Support by the High Court under its residual jurisdiction to secure the welfare of children and young people. Prior to the passage of the Children Act 2001 this power was a significant driver of the development of Special Care, High Support Units and "special arrangements". Given that in the future High Support, as a residential provision or a methodology, will be a non-secure regime, it would be inappropriate and contradictory for Courts to order children to be "detained" in such facilities or by such services. The Special Residential Services Board should lead effective communication of this message.

Provides a High Staffing Ratio so that Therapeutic Relationships May Form

The high staff ratio is a key characteristic of High Support in its role of responding to extreme situations in which children and young people find themselves. Currently the recommended staffing levels for High Support is three members of staff to one child. We recommend that this remains the guideline ratio for residential High Support.

We have noted, however, some particular problems and difficulties in recruiting, retaining and sustaining appropriate staff for High Support at present, not least of which is the overall pressure on the labour market for residential child care posts. If residential High Support is to provide an effective service dealing with children in extreme situations there must be a core group of staff that are competent in its delivery. The SRSB and Health Boards should together establish these competencies. Health Boards should ensure that there is a training and development strategy in place to enable staff working in High Support settings to gain the required competencies in the most efficient manner deliverable.

Maintaining Links with Family

A key feature of High Support as originally scoped, and subsequently developed in ISSI inspections, has been the emphasis placed on maintaining family links while the child or young person is in receipt of services. While originally the concern was to avoid the "drift" of children in residential care, the passage of the Children Act 2001 gives further opportunity to revisit this issue.

Prior to the implementation of the application for a Special Care Order under the new legislation it will be mandatory to convene a Family Welfare Conference (FWC) to determine if alternative resolution of the child's situation can be advanced. One of those alternative solutions, of course, may be High Support. To avoid the anomaly in the future whereby certain children enter High Support placements via an FWC route while others may not, we recommend that Boards consider how the opportunity for families to more fully explore alternative solutions to High Support may be built into admission procedures. Some Boards may wish to fully implement an FWC process into situations where a "step-up" from mainstream service into High Support is being considered. Other Boards, however, may wish to modify existing admissions processes to ensure the maximum contribution of parents and carers to the deliberations.

Where residential High Support placement is the agreed outcome from an admission process (FWC or otherwise), the procedure should identify:

- The objectives of the service to be provided.
- The contribution of the parents and family to attaining these objectives.
- The duration of the placement.

For all High Support residential placements a review process should be established by Boards to enable evaluation of the matters established at the point of admission. This will usually be:

- Where the originally scoped High Support placement is to end and a subsequent provision of alternative care is required.
- Where an extension to the original High Support placement is being sought beyond the duration agreed at the point of admission (e.g. residential High Support is sought beyond the 12 month duration originally planned).

Where the admission process involved the use of a FWC, this should be reconvened to constitute the review function. In other circumstances Boards should consider the existing review processes they employ and, in particular, evaluate whether the contribution of parents and carers to the process is currently maximised.

Responsibility and accountability for admission and review processes attached to the use of residential High Support should continue to be firmly located within the Boards' remit under these recommendations. Transparency and accountability for the admission and review process, however, is vital, particularly if confidence in the appropriate use of High Support is to be maintained and the avoidance of children and young people "drifting" in care is to be assured.

To this end we recommend that the following be associated with admission and review processes to residential High Support operated by the Board.

- Wherever possible, admission and review processes should be independently chaired i.e. by a person who does not have line management responsibility for the case or the residential resource.
- Admission and review decisions (positive or negative) should be evidenced and documented. Each Board should establish eligibility and admission criteria to the units they control or commission.
- Admission and review decisions and processes should be subject to the inspection standards used by ISSI.

Documentation of admission and review decisions against defined standards should enable more efficient monitoring of the use of such provision. Independent chairs should be given responsibility for monitoring the use of High Support provision by the Board and communicating the resultant trends analysis as requested by the SRSB, Department of Health and Children and ISSI.

Through Care and After Care

The original Laxton Report (2000) identified the importance of scoping High Support Packages of care within the context of through care and after care. Emphasis was to be given to planning for services on exit from the High Support Unit from the very point of admission. In practice this has not always been easy to achieve, as numerous comments from the consultation exercise with users and providers testified. The recommendation made here with respect to admission and review processes around residential High Support should serve to re-emphasise the importance of medium-term, post residential High Support, placement planning.

Effective through care and after care also depends, however, upon a broader strategic approach being in place within Boards to:

- Integrate residential High Support alongside other treatment and support modalities available in mainstream services;
- Develop community-based networks of after care provision.

Both issues illustrate the growing significance of Boards having a “strategic vision” for children and young people’s services across a range of provision. To that end it is vital that any repositioning of High Support is done in a way that is strategically integrated with both residential and community-based services. We return to this issue in the penultimate recommendation of our report.

Access to Education Provision

A key characteristic of the original concept of High Support Units as originally proposed was for education on the premises to be made available to residents. While in the main this objective has been pursued, it has not been without its difficulties, particularly in securing continuity of calibre staff with the skills and abilities to deal with children and young people who feel in crisis. We recommend that residential High Support Units should continue to provide education on the premises for residents. A commitment to accessing learning services should be a hallmark of High

Support provision, and education should be a routine element in any High Support package. We further recommend that a review of educational services in residential High Support should be undertaken.

Access to Therapy Services

Again, a key characteristic of the original concept of High Support was that it should facilitate access to appropriate therapy services. This was in recognition that:

- Children likely to require High Support services usually have a range of allied needs (physical health, mental health etc.)
- High Support units per se could not be a substitute for medical, clinical or other therapeutic services that more appropriately should meet that need.

In practice, the recognition of the broader, often complex, needs of children and young people on the threshold of High Support has led to:

- The exclusion of significant numbers of conditions and states that require some therapeutic input.
- The engagement of certain therapeutic practitioners (most notably psychologists) to assist staff develop practices to deal with aspects of behaviours that may result from these allied need areas and/or signpost the young person to more appropriate therapeutic services.

We recommend that access to therapy services should be the hallmark of residential High Support. In order to secure this, we propose that all Boards providing residential support ensure that there is sufficient dedicated capacity from the relevant disciplines to provide the therapeutic input required.

5.2 HIGH SUPPORT AND "SPECIAL ARRANGEMENTS"

In gathering the evidence for this review we have noted, in all Board settings, a growth of High Support-type "special arrangements" for certain children and young people who have particular problematic needs which cannot be accommodated within mainstream provision. These arrangements are frequently deployed in places other than designated "Units" and as a consequence are of low visibility and problematic to oversee and evaluate. At present there is a degree of inconsistency within and across Boards as to the notification of the "special arrangements" as High Support interventions. Thus, we recommend that a review of the definition, development and operation of "special arrangements" should be undertaken.

We have noted in the review that with respect to "special arrangements" there are particular difficulties with staffing, especially the use of agency staff, which gives rise to:

- Discontinuities in the care provided to children due to the variety of care givers that may be involved.
- Detachment of these staff from the care group of High Support caregivers currently based within dedicated units.

Staff working in High Support settings currently characterised as "special arrangements" should be subject to the same requirements as to competencies, training and development as staff colleagues in designated High Support Units. Where High Support residential provision is provided on a local basis, the staff providing such services should be seen as an integrated adjunct to the total composition of High Support resourcing. This would have implications for recruitment, training and deployment strategies, and the management arrangements that should apply.

5.3 HIGH SUPPORT AS A METHODOLOGY

As we have noted, High Support is an evolving concept which has both changed from its original conception and continues to develop. Its most recent manifestation can be seen within some Board areas that wish to re-conceptualise High Support from its designation as a specific form of residential care to one that acknowledges it as a methodology of child care that can be practised in a variety of settings. That methodology may be implemented:

- In a designated (High Support) Residential Unit.
- In a mainstream residential setting where a particular child or children requires the methodology.
- In the community where the child is placed with professional foster carers.
- In the community where the child requires additional support to enable parental care and control to be maintained.

Conceptualising High Support as a methodology, to be deployed in different settings for children who may experience a variety of extreme situations, has the merit of reflecting the de facto use of such services today. As such High Support is not merely the penultimate placement within a linear model of ever increasing intensity (and security) of placement, rather, as a methodology, High Support can be used flexibly to meet the extensive needs of children and young people as they arise, wherever they reside.

Conceptualising High Support as a methodology, rather than solely a particular set of resources, maximises the potential for flexible applications:

- Deployment of High Support type methods in the community for a duration shorter than the minimum three months scoped for residential provision to act as a preventive service. Formal (i.e. three month + residential) High Support services only coming into play if this was unsuccessful.
- Deployment of High Support methodologies in the community for a child placed on a waiting list for a residential High Support Unit.
- The use of a community-based package of High Support to provide an effective "step down" from intensive forms of residential therapeutic service.

In order to overview and quality assure the use of such a methodology, however, there is a need to ensure that it is delivered within an accountability framework and subject to the necessary safeguards of inspection and review.

We recommend that the use of High Support as a methodology in places other than residential units will require guidance relating to:

- The eligibility criteria for the application of the High Support methodology.
- The core characteristics to be associated with the High Support methodology.
- The applicability of the indicative timescales as to the duration of intervention using the High Support methodology.
- The applicability of "admission" and "review" processes previously scoped for residential forms of High Support.

In addition, three particular issues will require guidance: staffing, access to education provision, and access to therapy services.

Staffing

If High Support as a methodology is to be developed within a Board area there must be a core group of staff that are competent in its delivery both residentially and peripatetically. While currently there are examples of High Support as a methodology emanating from staff originally based in High Support residential units following through with their caregiving into the child's subsequent "step down" placement (both while continuing to live in care or as an after-care plan), this is placing a strain on staffing of the units.

To progress the use of High Support as a methodology, each Board would need to examine the likely level of need and the staffing requirements. Where High Support residential provision is provided on a local basis, staff providing the High Support methodology in the community need to be seen as an integrated adjunct to the total composition of High Support resourcing. Where High residential provision is provided on a regional basis, community-based High Support staff should be affiliated to those residential units that most frequently act as the local "step down" facility.

Access to Education Provision

The development of High Support as a methodology has consequences for educationalists as much as it does for social care workers. In particular, consideration needs to be given to:

- The extent to which the skills of educationalists operating in High Support Units can be accessed by other children with High support needs that are not resident in that Unit.
- The extent to which the skills of educationalists to meet the needs of children with High Support needs can be accessed in community-based schools and other local arrangements for providing learning.

Evidence of both non-resident children accessing High Support Unit education provision and High Support teachers operating in schools within local communities was provided to us during the consultation. At present, it is fair to say, this is an embryonic development. The notion of developing a pool of skilled staff to meet the education needs of children requiring the High Support methodology regardless of its setting, along the lines outlined for social care workers, requires further exploration. This will require not only consideration by the tripartite group but also the

engagement of the Department of Education and Science. This issue should be included in our recommended review of educational services in residential High Support units.

Access to Therapy Services

Expansion of the application of High Support as a methodology requires specific consideration to be given to access to therapeutic services. The proposal made earlier for Boards to ensure that they have adequate dedicated capacity from relevant disciplines to provide the therapeutic inputs required to children and young people with High Support needs would require an audit and evaluation of both the demand from those seeking a residential service and those receiving the services of a High Support methodology. Levels of dedicated services from a variety of disciplines need to reflect both sources of referral.

5.4 HIGH SUPPORT IN CONTEXT

All of the above seeks to assist Health Boards, the Department of Health and Children, the ISSI, and the Special Residential Services Board to develop a clearer understanding of the role, remit and usage of High Support for the future. The evolving development of this provision, and its extension into an applied methodology, require decisions about the usage and application of High Support to be transparent, accountable and quality assured as to effectiveness. These requirements should apply irrespective of whether High Support is used as a "step-down" or "step-up" provision, residentially-based or community-oriented. The proposals thus far, however, have focused specifically upon High Support and not the context within which these resources and methodologies operate.

Arguably, the greatest weakness in the development of High Support over the past three years has been the absence of a systematic approach to have these resources firmly located in a strategic framework which provides a coherent range of resources locally available to meet the needs of vulnerable children. We recommend that any repositioning of the use of High Support takes place in a way that is strategically integrated with an adequate range of children's services – both residential and community-based. In the absence of such integration, High Support will not be a core element of a co-ordinated placement strategy, but a driver for imbalance and disequilibrium.

We recommend that the Special Residential Services Board advise the Department of Health and Children that each Health Board should review the adequacy of their current models of care and intervention with vulnerable children and develop a strategic plan to ensure a fully integrated local system. The development of that strategic plan should be assisted by the recent submission from Boards of allied plans for youth homelessness and fostering services. The strategic plans should detail Boards' medium-term (i.e. three-year) intentions and be developed against a common template and timescale.

Finally, given the rapid evolution of High Support despite its short heritage, we recommend that the development and operation of High Support should be subject to a review in two years time.

6. SUMMARY OF RECOMMENDATIONS

6.1 HIGH SUPPORT IN DESIGNATED RESIDENTIAL UNITS

1) We recommend that the National Standards for Children's Residential Centres should apply fully to High Support Centres; and that the Department of Health and Children, in collaboration with all relevant parties, develop an addendum to the National Standards addressing the criteria of standards that are of particular relevance to High Support in designated residential units (including staffing, placement and admission, emotional and specialist support, managing behaviour and discharge).

2) We recommend that where High Support services are to be delivered in a designated residential Unit, the guideline should be that the presumptive minimum duration of intervention is three months and the presumptive maximum 12 months. We also recommend that the structure of indicative timescales should be reviewed after two years within the overall review recommendation contained within the final recommendation of this report.

3) We recommend, as earlier ISSI inspection reports have demonstrated, that regimes which have been practised in High Support Units (TCI, the locking of doors at particular times, the use of C.C.T.V.) should be monitored, recorded and reviewed both internally and by inspection processes.

4) We do not feel that High Support should be reserved, as with Special Care, for children and young people subject to formal court orders (either full or interim). As High Support seeks to respond to stabilising extreme situations that children and young people find themselves in an open, albeit intensive, environment we do not feel this pre-condition is necessary or appropriate. Given that in the future High Support, as a residential provision or a methodology, will be a non-secure regime, it would be inappropriate and contradictory for Courts to order children to be "detained" in such facilities or by such services. The Special Residential Services Board should lead effective communication of this message.

5) We recommend that the current staffing level guideline of three members of staff to one child remains the guideline ratio for residential High Support.

6) We recommend that the SRSB and Health Boards should together establish staff competencies required for staff to provide an effective service in dealing with children in extreme situations. Health Boards should ensure that there is a training and development strategy in place to enable staff working in High Support settings to gain the required competencies in the most efficient manner deliverable.

7) We recommend that Boards consider how the opportunity for families to more fully explore alternative solutions to High Support may be built into admission procedures to avoid the anomaly in the future whereby certain children enter High support placements via an FWC route while others may not. Some Boards may wish to fully implement an FWC process into situations where a "step-up" from mainstream service into High Support is being considered. Other Boards,

however, may wish to modify existing admissions processes to ensure the maximum contribution of parents and carers to the deliberations.

8) We recommend that where residential High Support placement is the agreed outcome from an admission process (FWC or otherwise), the procedure should identify:

- The objectives of the service to be provided.
- The contribution of the parents and family to attaining these objectives.
- The duration of the placement.

9) We recommend that for all High Support residential placements a review process should be established by Boards to enable evaluation of the matters established at the point of admission. This will usually be:

a. Where the originally scoped High Support placement is to end and a subsequent provision of alternative care is required.

b. Where an extension to the original High Support placement is being sought beyond the duration agreed at the point of admission (e.g. residential High Support is sought beyond the 12 month duration originally planned).

10) Where the admission process involved the use of a FWC, this should be reconvened to constitute the review function. In other circumstances Boards should consider the existing review processes they employ and, in particular, evaluate whether the contribution of parents and carers to the process is currently maximised.

11) We recommend that responsibility and accountability for admission and review processes attached to the use of residential High Support should continue to be firmly located within the Boards' remit under these recommendations. To this end we recommend that the following be associated with admission and review processes to residential High Support operated by the Board.

a. Wherever possible, admission and review processes should be independently chaired i.e. by a person who does not have line management responsibility for the case or the residential resource.

b. Admission and review decisions (positive or negative) should be evidenced and documented. Each Board should establish eligibility and admission criteria to the units they control or commission.

c. Admission and review decisions and processes should be subject to the inspection standards used by ISSI.

12) We recommend that residential High Support Units should continue to provide education on the premises for residents. We further recommend that a review of educational services in residential High Support should be undertaken.

13) We recommend that access to therapy services should be the hallmark of residential High Support. In order to secure this, we propose that all Boards

providing residential support ensure that there is sufficient dedicated capacity from the relevant disciplines to provide the therapeutic input required. Of particular relevance are:

- Children likely to require High Support services usually have a range of allied needs (physical health, mental health etc.)
- High Support units per se could not be a substitute for medical, clinical or other therapeutic services that more appropriately should meet that need.
- The exclusion of significant numbers of conditions and states that require some therapeutic input.

6.2 HIGH SUPPORT AND "SPECIAL ARRANGEMENTS"

14) We recommend that a review of the definition, development and operation of "special arrangements" should be undertaken.

15) We recommend that staff working in High Support settings currently characterised as "special arrangements" should be subject to the same requirements as to competencies, training and development as staff colleagues in designated High Support Units.

6.3 HIGH SUPPORT AS A METHODOLOGY

16) We recommend that the use of High Support as a methodology in places other than residential units will require guidance relating to:

    a. The eligibility criteria for the application of the High Support methodology.

    b. The core characteristics to be associated with the High Support methodology.

    c. The applicability of the indicative timescales as to the duration of intervention using the High Support methodology.

    d. The applicability of "admission" and "review" processes previously scoped for residential forms of High Support.

17) If High Support as a methodology is to be developed within a Board area, we recommend that each Board examines the likely level of need and the staffing requirements. Where High Support residential provision is provided on a local basis, staff providing the High Support methodology in the community need to be seen as an integrated adjunct to the total composition of High Support resourcing. Where High residential provision is provided on a regional basis, community-based High Support staff should be affiliated to those residential units that most frequently act as the local "step down" facility.

18) The development of High Support as a methodology has consequences for educationalists as much as it does for social care workers. In particular, we recommend that consideration needs to be given to:

a. The extent to which the skills of educationalists operating in High Support Units can be accessed by other children with High support needs that are not resident in that Unit.

b. The extent to which the skills of educationalists to meet the needs of children with High Support needs can be accessed in community-based schools and other local arrangements for providing learning.

19) Expansion of the application of High Support as a methodology requires specific consideration to be given to access to therapeutic services. The proposal made earlier for Boards to ensure that they have adequate dedicated capacity from relevant disciplines to provide the therapeutic inputs required to children and young people with High Support needs would require an audit and evaluation of both the demand from those seeking a residential service and those receiving the services of a High Support methodology. Levels of dedicated services from a variety of disciplines need to reflect both sources of referral.

6.4 HIGH SUPPORT IN CONTEXT

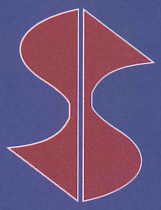
20) We recommend that any repositioning of the use of High Support takes place in a way that is strategically integrated with an adequate range of children's services- both residential and community-based. In the absence of such integration, High Support will not be a core element of a co-ordinated placement strategy, but a driver for imbalance and disequilibrium.

21) We recommend that the Special Residential Services Board advise the Department of Health and Children that each Health Board should review the adequacy of their current models of care and intervention with vulnerable children and develop a strategic plan to ensure a fully integrated local system. The development of that strategic plan should be assisted by the recent submission from Boards of allied plans for youth homelessness and fostering services. The strategic plans should detail Boards' medium-term (i.e. three-year) intentions and be developed against a common template and timescale.

22) We recommend that the development and operation of High Support should be subject to a review in two years time.

The Special Residential Services Board

An Bord Seirbhísí Cónaithe Speisialta



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