



**SOCIAL SERVICES
INSPECTORATE**

**GLEANN ALAINN SPECIAL CARE UNIT IN
THE SOUTHERN HEALTH BOARD**

INSPECTION REPORT ID NUMBER: 54

**Publication Date: 25 Nov 02
SSI Inspection Period: 4
Centre ID Number: 99**

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Introduction

Gleann Alainn Special Care Unit provides for the detention of girls, between the ages of 12-17 years, for their own care and protection. Managed by and located in the Southern Health Board (SHB), it is a regional service that accepts referrals from the SHB, the Mid Western Health Board (MWHB) and the South Eastern Health Board (SEHB).

Gleann Alainn was previously inspected in April 2000 and July 2001. In line with SSI policy of inspecting, on an annual basis, centres where young people are detained, it was inspected for a third time in September 2002. The third inspection was an unannounced inspection. No person connected with the unit had notice of the intention of SSI to inspect. The inspection was carried out by Ann Ryan (lead inspector) and Mike Mc Namara (support inspector).

Methodology

The primary focus of this inspection was to inspect the board's progress in implementing the recommendations of the previous inspection. This is reflected in the format of the report which outlines the recommendations made in 2001 and the action taken by the board to implement these recommendations.

During the inspection the inspectors interviewed the acting manager of the unit, the acting deputy manager, a team co-ordinator and the general manager. Three of the four residents were also interviewed.

Inspectors examined the young peoples' care files and all relevant administrative records. Census forms were completed on the young people and information on staffing provided. Questionnaires were completed by two parents and one social worker.

Acknowledgements

The inspectors would like to thank managers, staff and young people for their co-operation during the inspection.

Summary of Findings

The inspection report of 2001 stated that the unit offered a good service. It found that practices had developed and improved since the first inspection in 2000. The finding of on-going review and development, outlined in the last inspection report, was again reflected in the findings of this inspection. The unit continues to care for young people with challenging needs in a positive and focussed manner. The staff present as professional and caring in their approach to the young people. They enjoy the support of a strong management structure, which has further developed with the introduction of a second deputy manager. There are good internal and external board supports available to the unit and the policies and procedures that inform practice in the unit are the subject of review.

Gleann Alainn employs thirty-one staff members. This includes twelve permanent full time staff, thirteen full time temporary staff and six part time or relief staff. Since the last inspection nine of the permanent staff transferred within the SHB. Five went to work in a new high support unit for boys, two to a residential centre, one to a high support unit for girls and one to the social work department. Two full time staff, one permanent and one temporary, resigned. The new staff were vetted by the taking up of references and garda checks.

The inspectors were informed that the management structure is under review with different options being considered, including the possibility of recruiting a residential services manager for North Lee services. Currently the unit is managed by an acting manager (permanent deputy manager) and two acting deputy managers (permanent child care leaders). Responsibility for administrative tasks and that of staff support and development is divided between the two deputies, each taking responsibility for one of these tasks. The management team are supported in their work by four team co-ordinators. This structure has operated on a pilot basis since June 2001, and was further extended in March 2002. At the time of the last inspection, inspectors were informed that the post of manager would be recruited soon and it was likely that the co-ordinator posts would be recruited on a permanent basis. While the board is commended for their efforts to provide a solid management structure, and to give consideration to what might constitute the most effective structure, inspectors advise that, in the interests of stability and permanency, a decision in relation to the management structure should be made as soon as possible.

Over the last few months the unit has introduced a more formal structure for assessing risk particularly in relation to young people going outside the unit. A simple format is used to assess risk which involves the team on duty identifying the particular risk, the factors contributing to and decreasing the risk, the decision taken and the reason for the decision. The young people are aware of this format and where possible are involved in the discussion of risk and its consequences.

The inspection report of 2001 noted that there had been a considerable reduction in the number of unauthorised absences (from twenty-eight to sixteen). Between July 2001 and July 2002 there were eighteen unauthorised absences from the unit. However, this figure relates to an almost fifty per cent increase in admissions since the previous inspection.

The challenge for management and staff while caring for young people in a secure environment is to provide a balance between security and normalisation, where the need for young people to internalise controls and develop coping mechanisms and skills that will ease their transition back into the community is developed. Decisions have to be made every day about young people; the key is that these decisions are informed ones. Clearly carrying out a risk assessment will not always prevent young people placing themselves at risk, through absconding or other circumstances. However, the inspectors commend the unit for introducing this new procedure in an attempt to ensure that decisions are informed and the risks are managed as far as is possible.

To date the role of monitor has been carried out by the child care manager, who holds line management responsibility for the unit. He visits the unit on a monthly basis and provides reports of these visits. However at the time of inspection the board was about to recruit for two inspectors and establish a registration, inspection and monitoring unit. These posts will have responsibility for monitoring the board's residential units, are outside the residential services management structure, and will report to the child care manager for North Cork Community Services. The board is commended for this initiative.

The inspectors were concerned to learn of the insurance requirements placed on the unit in respect of certain outdoor activities. The inspectors learned that any company providing outdoor activities such as canoeing, horse riding, etc. are now required to indemnify the SHB by name for a minimum limit of €6.4 million. The unit has been unable to source a company willing to meet this requirement as it is far in excess of the standard cover provided.

This has significant implications not just for Gleann Alainn but for all of the board's residential centres. It clearly limits the range of activities available to the young people and as such discriminates against them. It limits the extent to which young people can engage in activities that enhance their self esteem, provide opportunities to develop new skills and interests, and present socially appropriate challenges and accomplishments. This situation is unacceptable. The management committee and board must make all efforts to resolve this issue.

Finally, while some of the recommendations outlined in the previous report still require attention or are being progressed, a considerable number have been acted upon. As outlined throughout the report the inspectors were satisfied that significant progress had been made in relation to recommendations made and commend the staff and management, both internal and external, for their continued efforts to provide good quality service in a challenging and complex area of work.

Summary of recommendations of inspection report 2001 and action taken

The policy and procedure document should state the role of Gleann Alainn and it's regional remit. It should state that Gleann Alainn is a short term unit.

The statement of purpose and function has been updated and formally approved by the Management Committee to state the regional remit of the unit and the fact that it is a short term unit. Inspectors reviewed the length of stay of the four girls in residence at the date of the last inspection and the admission and discharge details of new admissions over the past year to ascertain the extent to which the purpose and function of the unit is reflected in practice.

The total lengths of stay of the four girls resident in the unit at the date of the last inspection was four months, eight months, thirteen months, and fourteen months respectively.

Since July 2001 and September 2002 there have been eleven admissions to the unit, involving eight young people, three of whom had been admitted for a second time within the same time span.

Young Person	Length of Placement	Referral Source	Legal Status of Admission
# 1	4 months	MWHB	High Court Order
# 2	6 months	SHB	Wardship
# 3	8 months to present	SHB	Wardship
# 4 Re-admission	2 months	MWHB	High Court Order
# 5	4 months	SHB	Wardship
# 6	2 months	SHB	Wardship
# 7	5 months	SHB	High Court Order
# 8	3 months	SHB	Wardship
# 9 Re-admission	1 ½ months to present	SHB	Wardship
# 10 Re-admission	1 month to present	SHB	Wardship
# 11	2 ½ months to present	MWHB	High Court Order

Six of the young people were placed by the SHB and two by the MWHB. The length of stay of seven of the admissions was between two months and six months. Three of the current residents were placed between 1-2 ½ months and the fourth for eight months.

The previous inspection report noted developments in practice to ensure girls are not detained longer than necessary and the length of stay of admissions over the past year indicates that this is continuing. Efforts are made to identify step down placements or exit plans at admission stage except where young people are admitted on an emergency basis, as in the case of two of the present referrals. Inspectors, did however, note that re-admissions tend to have been discharged to and re-admitted from a step down unit in the SHB or other high support or residential placements.

The inspectors noted the manner in which one current resident was being eased into her future placement in the SHB's step-down unit (Loughman) by meeting with her new key worker and visits to the centre, including an over night stay. However questions arise regarding whether practice in both centres could be better co-ordinated to ensure, as far as possible, that the transition will be successful. This involves reviewing the two different regimes, the extent to which the practices in both units complement each other and reflect the different functions of both centres.

The acting unit manager should ensure that all staff receive regular formal individual supervision.

A structure has been identified to provide a formal programme of individual supervision. The line manager for the unit continues to provide monthly supervision for the unit manager. The unit manager in turn provides supervision to the two deputies and they supervise the team co-ordinators. The team co-ordinators have responsibility to supervise the child care workers, including the night staff. However this structure for the provision of individual supervision has not yet been sufficiently implemented on a consistent basis. In practice only the unit manager receives formal monthly supervision. Some receive it on a six weekly, others on a two monthly, or less frequent basis. The structure needs to be tightened so that all staff receive supervision on a consistently regular basis, preferably at monthly intervals. The inspectors were informed that a programme of training for managers in providing supervision will commence in November 2002. This is welcomed.

The inspectors were impressed by the other sources of staff support available in the unit. Group supervision is provided by one of the deputy managers on a weekly basis for the three staff teams. The deputy has been in post for about four months and has particular responsibility for staff support and development. Group supervision provides a valuable opportunity to integrate theory and practice and empower staff to find solutions and agree strategies to inform their work with the young people. While group supervision was available to staff during the previous inspection, the value of this work has clearly been acknowledged by assigning one of the two deputies to take specific responsibility for on-going staff support and development.

A staff facilitation/training programme has recently commenced and will take place once per month for the coming five months.

The Department of Health and Children should identify a suitable body to adjudicate on the issue of what other professional qualifications are to be regarded as equivalent to professional child care ones.

It is understood that the Joint Committee on Childcare Workers has considered the question of qualifications and training generally and will be making recommendations in this regard. The Committee's report is expected shortly.

Principal social workers should ensure that a social work service is available to the young people in Gleann Alainn throughout their placement.

All of the young people had an allocated social worker. They meet with the young people at their monthly review meeting and generally visit once in between.

Principal social workers should ensure that care plans are prepared for the young people in Gleann Alainn, preferably prior to admission. They should ensure that care plans are reviewed as per statutory requirements.

Overall responsibility for formulating statutory care plans rests with the social work department. Care plans were available for three of the young people, two of which were devised prior to admission. The third plan was undated. The inspectors were informed that the care plan for the fourth young person, admitted on an emergency basis 1 ½ months previously, was shortly to be devised.

The care plans available on file were in different formats, some more comprehensive than others. The format used for devising two of the care plans required the signature of the social worker only, although one of these was unsigned by the social worker. The third care plan was signed by the Principal Social Worker. One of these plans, which was unsigned, was titled a provisional care plan and was written a month prior to the young person's first admission and six months prior to her readmission to the unit. It made no reference to the young person's placement in Gleann Alainn. As stated there was no date on one of the care plans.

In practice monthly reviews continue to take place, attended by social workers, senior social work managers, centre staff, parents, young people. However records held in the unit make it difficult to track the statutory care plan review system. There were two sets of review minutes for one young person dated eight and nine months after admission. Another young person was reviewed two months after admission and the next statutory review was set for three months later. While there were key worker review reports on file for a third young person, indicating that reviews took place, there were no minutes on file providing details of the reviews. A review was planned for a fourth young person readmitted to the unit 1 ½ months previously.

Last year's inspection report pointed to deficits in care planning and review as opposed to placement planning and review. The situation remains that the requirement in relation to statutory care planning and review is not to an acceptable standard in all cases.

Recommendation

- The relevant health boards should review the format used to devise statutory care plans. They should include evidence that parents and young people are consulted. They should be dated, signed by all, including parents and young people, and updated to reflect changes in circumstance, including re-

admissions to the unit. Minutes of statutory review meetings should be made available to the unit and held on care files.

The management committee should clarify the roles and responsibilities of the young people's social workers in relation to those of care staff.

The inspectors were informed that this issue has been addressed by the child care manager through correspondence with health board managers and that clarity exists in relation to respective roles. The policy document has been amended to clarify roles in relation to placement planning and care planning.

The management committee should, in consultation with colleagues from SEHB and MWHB, clarify who is responsible for providing a psychiatric service to the young people in Gleann Alainn.

Special care units were set up to provide a safe environment for young people whose needs cannot be met in open residential units. Their aim is to provide young people with the help needed to address the issues that led to their detention, and to enable them to return to a community setting as soon as possible. These young people often present with complex difficulties and require a range of interventions. These include the therapeutic relationships they form with staff, the intervention of specialist team members, and access to specialist services outside the unit. Gleann Alainn works hard to support a staff team capable of responding in an informed way to the young people. It also has a clinical psychologist who provides a valuable service to both the staff and young people in four of the board's residential services. This, however, does not make up for the lack of access to other specialist services.

Last year's report found that with the exception of access to psychiatric services, the provision of emotional and specialist support in Gleann Alainn was good. It cautioned that, although inspectors were not made aware of any unmet treatment needs among the young people, from time to time situations may arise that require psychiatric intervention and that clarity was required as to where the responsibility lay for the provision of this service.

The current inspection found that the position in relation to accessing psychiatric services remained less than satisfactory. Unlike last year, difficulty accessing this service was relevant to the care of two residents. The inspectors learned of a litany of difficulties the unit experienced in trying to access psychiatric services for one young person in particular. Eventually, through the intervention of the general manager, an arrangement was made for this young person to be seen by psychiatric services in the SHB, but only through the Accident and Emergency department of a hospital, where, accompanied by staff members, she was eventually seen by the registrar on duty, after awaiting a number of hours.

The difficulty is two-fold. One relates to the age of the young person and the other to the referral source of the young person, that is, what board referred the young person to the unit. Local psychiatry services are of the opinion that services should be made available by catchment area, so that young people referred outside of the SHB should access services within their own board area. This situation is further compounded by a

continuing national difficulty with accessing psychiatric services for young people between 16 and 18. The SHB's objective is to provide a psychiatric service to the young people in Gleann Alainn, irrespective of where they are referred from, and efforts are being made to address this problem. However, in reality, the situation remains unresolved and what is available at present is that of emergency adult psychiatric provision through the Accident and Emergency department of the local hospital.

This situation is unacceptable. It is not the first time the inspectors have come across difficulties in relation to special care units accessing psychiatric services. A review of the steps taken to access psychiatric services for just one young person showed that the services are cumbersome and fragmented. The situation remains that unless a psychiatric service is available to all young people who require it, irrespective of their age or from what board they were referred, the unit alone cannot be effective in meeting the varied and complex needs of all of the young people placed there.

Recommendation

- The SHB should urgently address the provision of psychiatric services to young people in Gleann Alainn, irrespective of their age or placement source.

The management committee should amend the current complaints procedure to ensure that the girls have free access to the complaints forms. It should continue to explore how to introduce an independent element to the complaints procedure.

Free access to complaints forms are now available to all of the young people. In practice these forms are rarely used by the young people. If a young person is unhappy about a situation all efforts are made to resolve the issue at local level. Such complaints are recorded in the log book. As with last year's report the inspectors advise that all complaints are recorded on the complaints forms rather than in the log book, both for monitoring purposes and to convey to the young people that the things they say are always heard and taken seriously. If young people do complete a complaint form it is copied to the child care manager, the young peoples' social workers and solicitors.

The issue of an independent element in the complaints procedure is not yet resolved. In practice young people are informed that they can make a complaint to their social worker, guardian ad litem, and other people external to the unit. As stated, the board is in the process of recruiting two inspection and monitoring officers. The inspectors were informed that the board is considering whether it would be feasible to assign the role of independent complaints officer to these posts.

Recommendation

- The management committee should determine how to introduce an independent element to the complaints procedure.

Managers and staff should reconsider the points system.

The unit no longer operates a points system. This has been replaced by identifying target areas to be addressed in the young people's placement plans. Pocket money is provided as a matter of right.

The manager should ensure that the reason for using physical restraint is accurately recorded on the relevant recording forms.

The use of physical restraint is accurately recorded. However, review of records showed that these forms are not always signed by the unit manager. He is advised to do so. Where physical restraint is used it is generally employed to transport young people away from the group. In practice much use is made of life space interviews as a means of assisting the young people to learn new ways of managing their behaviour. The board has nine Therapeutic Crisis Intervention (TCI) trainers and training is provided for staff within eight weeks of commencing employment. Since the last inspection a new post of TCI co-ordinator was introduced. This person co-ordinates the training programme for TCI and provides a valuable resource to staff in guiding and reviewing its use in particular circumstances. The board is commended for this additional support to staff.

Last year's report considered that, when young people need to be separated from the group, for their own and the protection of others, the unit could use the quiet room, instead of the isolation room which had a forbidding appearance. This has become practice. The isolation room has been used only once in the last year. Single separation is mainly carried out in the quiet room where a bed is made up and the young people can bring some of their own belongings. The visitors room, which is located opposite the quiet room, forms part of the 'quiet' area. It contains a television set and is available to a young person who is separated from the group. One young person was separated in this area during the inspection. She was closely monitored by staff and was accompanied on short breaks out of the unit under the close supervision of staff.

The manager, in consultation with the management committee and staff should formulate an anti bullying policy. The policy should treat this issue as a child protection one.

Work is being carried out on devising a board wide anti-bullying policy. This is still in progress. The inspectors saw a newly written child protection policy, which outlines the measures to be taken in the event of allegations of abuse in specific circumstances. It attempts to provide a child-friendly diagram outlining how an allegation or complaint will be processed including if a young person is bullied. However, this is not a substitute for a policy on bullying that is understood by all and includes education and awareness of bullying and an agreed code of conduct for all, whereby mutual respect is promoted and breaches are responded to seriously.

Recommendation

- The manager, in consultation with the management committee and staff should formulate an anti bullying policy.

The management committee should review the policy on contact lists.

The unit has introduced a practice whereby decisions in relation to contact lists will be made on the basis of a risk assessment at the young peoples' pre-admission meetings. Depending on individual circumstances, particularly in relation to child protection, a decision will be made as to whether the young person's interests are best met by devising a contact or non-contact list. A non-contact list, as advised in last year's report, was introduced on a trial basis in respect of the most recent admission to the unit. This practice will be reviewed and if deemed an effective way of managing contact, will then become part of policy and general practice in the unit, dependant on individual circumstances.

The manager should arrange for the glass panels in the bedroom doors to be altered or replaced in order to ensure privacy. The manager should ensure that staff members respect the young people's privacy by knocking on their bedroom doors before entering.

Blinds have now been placed on the bedroom doors to ensure privacy. They can be adjusted, where necessary, from the outside of the door. The issue of knocking on the girl's bedroom doors before entering was discussed with staff and an assurance given to inspectors that this is standard practice. This was confirmed during interview with the young people.

The policy and practice in relation to searching should be kept under review by the management committee.

A working group has been set up to review practice in relation to searching including looking at practice in other secure units abroad. It remains practice to carry out a full admissions search if the young person has been involved in an unauthorised absence or has returned from home. Inspectors were informed that the young people are not generally searched following trips out with their social workers and the young people confirmed that they are only searched if they have been out of sight of staff while outside the unit. Efforts are made to respond on an individual basis to searching, so that for instance, if a young person is near the end of her placement and on a higher level of trust searching is less frequent. Again this is an area that involves maintaining a balance between the requirements of safety for all, that of proportionality, and respecting the rights and dignity of the young people.

The inspectors await the findings of the working group and any adjustments to policy based on findings.

The general manager should ensure that the young people can shop with cash.

The use of cash rather than order forms was introduced recently. There was an initial problem relating to ensuring that there was sufficient cash available to the unit for purchases. However, this has been resolved by an increase in the allocation to the unit.

Summary of Recommendations

1. The management committee and board must resolve the difficulty in securing insurance cover for outside activities.
2. The relevant health boards should review the format used to devise statutory care plans. They should include evidence that parents and young people are consulted. They should be dated, signed by all, including parents and young people, and updated to reflect changes in circumstance, including re-admissions to the unit. Minutes of statutory review meetings should be made available to the unit and held on care files.
3. The SHB should urgently address the provision of psychiatric services to young people in Gleann Alainn, irrespective of their age or placement source.
4. The management committee should determine how to introduce an independent element to the complaints procedure.
5. The manager, in consultation with the management committee and staff should formulate an anti bullying policy.