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“**A** hundred years from now it will not matter what my bank account was; the sort of house I lived in; or the kind of car I drove. **B**ut the world may be different, because I was important in the life of a child.”

Anonymous

EXECUTIVE SUMMARY

In December 2002, the Prime Minister of Jamaica, the most Honourable P.J. Patterson, Q.C., P.C., M.P, mandated that a review of all Children's Homes and Places of Safety in the island. To this end, the Honourable Minister of Health, the Honourable John Junor, convened a Review Committee in January 2003, to carry the examination.

Methodology

Early in the exercise, we recognized that, given the depth of the subject matter and public interest in the review, the inputs of interested parties and public interest groups should be sought. The result is a range of interview with the public; the convening of focus group sessions; visits to homes and places of safety; interviews with staff in the head office of the Ministry of Health and other relevant institutions; interviews with past and present workers of the state.

A list of Recommendations is at *Appendix I*

Terms of Reference

The terms of reference were as follows:

- Assess the procedures for intake evaluation and placement of children in care and make recommendations for improvement
- Determine the support systems necessary to address behavioural problems exhibited by children in care

- Ascertain the functionality of the children homes in Jamaica, determined by factors such as staff-child ratio, level of education accessed, environmental conditions and prepare for final separation from care
- Evaluate the effectiveness of the monitoring procedures that will ensure that standards of care and children’s complaints are addressed
- Review the structure proposed for the CDA to determine the congruence between structure and desired improvements in care
- Determine any other steps to be undertaken by the State to ensure the safety and well being of children in its care.

The Review Committee comprised:

- | | | |
|----|--------------------------------------|---|
| 1. | Mrs. Sadie Keating Dip. | (Public Sector Mgt.) M.Sc. Retired
Civil Servant |
| 2. | Dr. Pauline Milbourn | Paediatrician, Child Psychologist |
| 3. | Her Hon. Mrs. Rosemary Neale –Irving | Resident Magistrate and Judge
Family Court |
| 4. | Ms. Maureen Webber | B.A. (Hon) M.A. (Urban and
Regional Planning) |

The Review Committee was ably assisted by Miss Samantha Blair – Research Assistant, Mrs. Sharon Atkinson – Research Assistant / Administrative Assistant, Miss Claudian Dennis – Secretary. We must also acknowledge the assistance of the staff of Development Options, which provided administrative support, especially in the early days of the assignment.

Status of Children - A Contextual Framework

The population of Jamaica is 2.6 M as at the year 2000. In the Island, the population is a youthful one with approximately 41% under 19 years of age. Childcare and protection covers the age group 0 – 18 years. Children account for almost half or 49% of the number of poor persons.

The UNICEF Master Plan of Operation, for the year 2000 – 2006, identifies inadequate safety nets for children, which is manifested in inadequate care and protection standards in institutions; inadequate protection and counselling services; limited support to children with special needs. An inadequacy in legal/judicial systems also exists in the laws protecting children, lack of knowledge of child rights and weak coverage of services within the Family Court

As at March 2003, there were 2,402 children who are wards of the State. Of this number, 668 are in places of safety and 1,734 in children's homes. There are 12 places of safety and 45 children's homes. Visits were made to 15 homes and 43 homes were contacted via telephone.

The programme of childcare and protection is managed by the Child Development Agency, which is an Executive Agency under the Ministry of Health

CHAPTER 1 INTAKE AND EVALUATION

1.1 Preliminary

The Juveniles Act is the principal piece of legislation governing juveniles in the Jamaican Jurisdiction. It was enacted over fifty (50) years ago, on the 1st July 1951, to reflect a gentler age when the juvenile court was a “baby Court”.

Since then many revolutionary changes have occurred. Nationally, our political status has changed and this has transformed our concept of ourselves. Globally, information technology has made available to us an infinite expanse of knowledge. The World Wide Web (www), Television (TV) Telephone or other electronic media transmits news from almost all parts of the world, almost instantaneously. Furthermore, geo-politically the balance of power has changed and this has greatly affected the geographical importance Jamaica once occupied. Few persons worldwide have been left unaffected.

These factors have impacted socially, culturally and economically on all the population, but particularly on our juveniles. It is to be noted that 60 % of our population is under 30 years of age. The cumulative effect of these and other factors such as the consequences of drug addiction, trafficking/dealing in narcotic drugs, the “bling bling” culture and the violence, which underpins both, exert enormous influence on the young and vulnerable. Sadly, the moral and stabilizing social base, which institutions like the church/religion and the family would normally wield, are simultaneously being weakened. Concurrently, immigration of parents in pursuit of financial and educational goals, ostensibly for the family welfare, has in the mean while left children to nurture themselves and their smaller siblings.

It should therefore be of no surprise that the infrastructure upon which the Juvenile Act was established, can no longer meet the legal or social realities of today's Jamaica.

The Legislators of the Juveniles Act could not have envisaged the seemingly endless number of juveniles presenting themselves daily to be accommodated and maintained in institutions and ultimately being placed before the Court.

Accordingly, basic requirements as the preparation of a Social Enquiry Report, which the Act states should be presented to the Court in respect of each juvenile before an Order can be made, can rarely be completed within the maximum period of three months. juveniles are therefore being kept in institutions for periods in excess of three months, thereby flouting the provisions of the law and extending the stay of juveniles in the institution. This arises primarily because of what the 1999 report, "*Faces of Residential Care in Jamaica*", said was the Children's Officers high caseload of approximately 130 families - triple what is judged to be manageable. The position is considerably worse today.

Due to the frustration arising from their prolonged stay in the institution, and/or the appalling conditions they experience, juveniles abscond with regularity from the places of safety, singly and in groups. The administrative machinery involved in locating them and returning them to the places of safety and ultimately before the Court, is seen by some as futile. Nor did the Juveniles Act envisage that juveniles would be committing such serious offences on other juveniles as well as on adults.

Although the offences are of a serious nature, some of the perpetrators cannot even be charged because either:

- i. they are incapable of forming a criminal intent; or
- ii. the evidential burden of proof that is to be discharged, for sexual offences cannot be adduced, because the victim is of tender age and can neither give sworn or un-sworn evidence. Usually, forensic evidence is not available.

Further, even after a juvenile is charged and pleads guilty, or is tried and convicted, the sentencing options available under the Juveniles Act are not commensurate with the serious nature of the offences committed. Such sentences as can be imposed have therefore no deterrent effect.

Juveniles in institutions are traditionally accommodated according to age. This practice has continued despite the change in circumstances. The places of safety continue to accommodate from ages 8-18 a diverse collection of juveniles.

These consist of:

- i. those with acute behavioural problems or aberrant conduct;
- ii. those charged with criminal offences (including murder); and
- iii. those deemed to be in need of care and protection. (Falling within this category, would be e.g. a juvenile whose parents or guardians died tragically (in a motor vehicle accident/victim of gun crime) and there is no readily identifiable relative or Foster parent willing or able to care for him within their home.

It is totally undesirable and inimical, particularly to juveniles (falling in category iii above) to be so exposed. These juveniles are already emotionally traumatised, vulnerable and already at risk, therefore are more deserving of care and protection.

It is therefore a legal, social and economic imperative that immediate consideration be given to overhauling/dismantling the structure established under the Juveniles Act to reflect today's reality .It is not sufficient to merely incorporate the existing provisions of the Juveniles Act into the Child Care and Protection Act.

Recommendations:

New provisions are now called for, which would include the following:

- 1) Extend the sentencing options to reflect the serious types of offences being committed by juveniles.
- 2) Introduce Community Service Orders.
- 3) Impose an adult sentence on the juvenile who commits a serious offence and is of an unruly or depraved character.
- 4) Increase the penalties, particularly as it relates to Child Abuse.
- 5) Where applicable, the juvenile should be referred to the Drug Court for rehabilitation.
- 6) Introduce new provisions whereby a Fit Person Order or a Supervision Order may be varied to substitute for another Order as the changed circumstances warrant.
- 7) Amend the rules of evidence to admit the unsworn evidence of a victim, in sexual cases, notwithstanding being of tender age, without the need for corroboration. Safeguards, in the form of psychological tests, can be applied.

- 8) Increase the quantum of the Contribution Order payable by a parent or guardian who has the ability to pay. Payment should not be restricted to the imposition of a Fit Person Order or a Correctional Order. All parents or guardians, who are able to pay for the support of their children whilst in care, should contribute. Their contribution should be regarded as part of their role as a parent.
- 9) Empower the Social Worker/Children's Officer to send a juvenile for assessment where the assessment team so directs; the juvenile can be placed with a therapeutic foster parent for a temporary period of three months. The juvenile would not need to be sent to an institution, nor go before the courts as a prerequisite for payments to be made to the foster parents, as is now the case. The proposal would reap the triple benefit of reducing not only the numbers coming before the courts but those being placed in an institution and most importantly, be of benefit to the juvenile.

1.2 Intake and Evaluation of Juveniles

Places of Safety (POS)

A Place of Safety is defined as:

“Any place appointed by the Minister to be a Place of Safety for purposes of the Juveniles Act or any hospital or other suitable place the occupier of which is willing temporarily to receive the juvenile”.

Juveniles enter a Place of Safety either because they are:

- i. deemed to be in need of Care and Protection,
- ii. uncontrollable,
- iii. charged with a criminal offence.

Boys charged with, convicted of, or awaiting sentence for a criminal offence, are remanded in the Remand Centre, if bail is denied or where no suitable surety is available. There is no similar institution for girls.

1.3 Children's Homes

Children's Homes are established for the accommodation and maintenance of children for period up to 18 years. The Place of Safety is intended to accommodate the juvenile on a temporary basis. Children's Homes may be provided by voluntary organizations or by the government and administered by the Children's Services/Child Development Agency. A valid licence has to be granted by the responsible Minister before a Children's Home can be established or maintained. The licence may contain such terms and conditions as the responsible Minister, now the Minister of Health, at his discretion, thinks fit.

Accordingly, where there has been any contravention of any of the provisions of the Juveniles Act or the terms of the licence, the Minister may cancel, suspend or refuse to renew the licence. He may also apply to the Court for an Order to remove a child from the Children's Home.

The Licensee of a Children's Home is under a duty to ensure that the Home is properly administered so that every child in the Home receives, at all times, careful and humane treatment, suitable education and proper care and attention.

The accommodation provided should not or be likely to endanger the welfare of the juvenile.

1.4 Juveniles in Need of Care and Protection

Pursuant to Section 12 of the Juveniles Act a Police Constable, Children's Officer or a Probation & After Care Officer, may take initially to a Place of Safety, and to a juvenile Court as soon as practical thereafter, any juvenile in respect of whom any offence mentioned in the First Schedule of the Juveniles Act has been committed.

The generic nature of the offences, coming within the ambit of the First Schedule, includes acts where the juvenile is ill-treated, wilfully assaulted, neglected, abandoned or exposed to, or subjected to unnecessary suffering or injury to his or her physical or mental health.

The Minister of Justice is empowered, where it is necessary or expedient, to appoint any person to bring any juvenile before a juvenile Court. A person recommended by a welfare organization may also be appointed by the Minister to bring a juvenile in need of care and protection before a juvenile Court.

The vast majority of wards in the institutions consist of several cohorts of juveniles in Need of Care and Protection.

The cohorts include:

1.4(a) Abandoned Babies

Babies are abandoned in a variety of places:

- i. in Hospitals, often by their teen-age mothers
- ii. at Police Stations, usually by a mother who is mentally retarded and is nomadic

- iii. at a street corner, where the juvenile is physically or/and mentally challenged and the parent can no longer either physically financially or emotionally continue to support him or her.

In one reported case an infant, hours old, was discovered in a pit latrine when a member of the community heard its cries. In another reported case a mother left her baby with a “kindly looking lady” at a bus stop on the pretext that she was going to answer a call of nature. She did not however return.

The numbers falling within this category is undoubtedly affected by the fact that juveniles at 16 years can consent to sexual intercourse. However, pregnancy produced thereby becomes the responsibility of their parents or ultimately the State. Rights and responsibilities are not in accord.

(b) Juveniles Abused by their Parents, Guardians or Siblings

Examples include:

Neglect

A single parent father, frustrated that his only son left their home immediately after the father left for work, chained the child to a tree in their yard. This drastic measure was intended to prevent the child from straying into the community and to protect him/her from mixing with bad company. Although the majority of the juvenile who suffer from neglect come from the lower socio-economic strata, they are not confined to this category. Children of “intellectual” parentage, had to be removed from their parents and hospitalised, as they were diagnosed as suffering from severe malnutrition. The parent’s ideology prevented the consumption of basic nutrients and stopped the children from associating with other children. When found occupying a “hut” in the hills of St. Andrew the children were frightened of other people. Generally

however, poverty, ignorance and cultural inhibitions result in varying forms of neglect of juveniles.

Physical Abuse

Severe beating with electric cable; branding in the face with hot iron; and immersing hands in hot water are examples of punishment inflicted to change undesirable behaviour or conduct such as stealing; telling lies or showing extreme aggression towards younger siblings.

Sexual Abuse

These are predominantly girls, but more boys are becoming victims.

The perpetrators are often fathers, stepfathers or men who stand in loco parentis* to the juvenile. In an extreme case, the abuse took place when the child was less than one year old. An attempt at vaginal penetration by an adult male, resulted in the necessity for reconstructive surgery on the child's genitalia.

Sexual activity is generally introduced to a juvenile between the ages of 10-12 years old. The National Knowledge Attitude Behaviour and Practice survey (2000), found that 40% of children between ages 10 -18 are sexually active. When sexual abuse is perpetrated by a parent figure, it is usually under the cover of strict secrecy. Even where the mothers/step-mothers becomes aware, some remain in fearful denial in order to retain the financial support and presence of the perpetrator, giving him the licence to continue his illegal behaviour. They also sometimes send the victim out of the household so that the next female child can be initiated.

By the time some of these juveniles enter the institutions their sexual appetite is well established. In order to find sexual release, they often become sexual

In place of the parents

predators by initiating younger victims when they cannot find willing bedfellows.

(c) Homeless Juveniles

Parents and guardians sometimes present themselves to the authorities seeking accommodation in a place of safety for their children. The request is sometimes for a specified period until permanent arrangements can be made e.g. until the conclusion of job prospects presently pending. However, where a large number of children are involved, and support from their respective fathers is not forthcoming, the period contemplated for the juvenile to remain in the place of safety is often until the expiry of the Fit Person Order at age 18 years.

Documented reports reveal that juveniles often present themselves for admission into the institution. They recognize the futility of relying on their parents or guardians to supply them, on any consistent basis, with food, accommodation, basic educational opportunities (i.e. lunch money, bus fare to attend school and school uniform and books etc.) Living on the streets is not seen as presenting a creditable alternative as it exposes them to other problems.

A desire to have a permanent place of abode, regular meals and access to educational facilities (where residence in a Children's Home automatically confers credit for the payment of examination fees), the opportunity to become literate and acquire a life skill, is definitely seen as being a superior alternative. A participant in one of the Focus Group session with wards of the state identified these factors as distinct advantages.

(d) Uncontrollable Juveniles

The second highest number of juveniles admitted into a place of safety fall within this category. Pursuant to Section 15 of the Juveniles Act a parent or guardian can bring his/her child before a juvenile Court on proof that he/she is unable to control him/her.

The number of juveniles falling in this category is increasing especially amongst females. Uncontrollable behaviour takes the form of truancy from school; absenting themselves from home for weeks and sometimes months at a time; forming sexual relations with adult men; drug addiction; dealing in marijuana/cocaine; and associating with men of dubious character. These men are often called upon to intimidate the juveniles' parents because the parents object to the liaison.

(e) Death of Parents/Guardians

There are times when terminally ill patients arrange, through medical social workers, to have juveniles admitted to homes, upon their deaths, where there are no other family member willing to care for these juveniles. There are also cases where parents/guardians die by accident and the affected juveniles have no other means of support.

(f) Juveniles Who Commit Criminal Offences

The third category of juveniles admitted to a place of safety is in respect of juvenile girls who are charged with criminal offences. The type of offences involved include:

- i. Murder – *(where of the 1,139 murders committed in 2001, 29 of those arrested were juveniles; and of 1,045 murders committed in 2002, 44 of those arrested were juveniles)**

- ii. Wounding – wounding with intent, felonious wounding, aggravated assault (*between 1999 and 2002, 1,939 juveniles were arrested for assault and wounding*)*
- iii. Indecent assault - carnal abuse (*2,051 young girls were raped between 2000 and 2002*)*
- iv. Larceny
- v. Robbery with aggravation.

(Data provided by the Constabulary Communication Network*)*

The types of offences being committed by juvenile girls now require that proper security fence/walls be erected to ensure not only the safety of the juveniles but to prevent undesirable members of the community from entering the institutions. The erection of a wall will prevent or reduce the frequency with which juveniles abscond. Superintendents can then be held accountable for each juvenile in their care. In the absence of a security fence, the payment of a security guard for the provision of security seems futile.

Recommendations:

- 10) There should be a physical separation of
 - a. Juveniles in need of care and protection
 - b. Those deemed to be uncontrollable
 - c. Those who have committed criminal offences
- 11) A team of professionals (paediatrician, psychiatrists, psychologists, mental health officers, social workers, psycho-educational specialists) in each of the four health regions should be identified to carry out the evaluations. The team should also include persons from the public and private sector.

1.5 Intake Procedures

There was a great disparity in the record keeping capabilities of the institutions visited. Having regard to the different ways in which a juvenile comes into care, the recording procedure on intake varies and different types of instruments are presently in use. Limited accurate information is understandably unavailable in respect of an abandoned infant or physically and mentally challenged juvenile. Where however, a juvenile is able to disclose basic information about himself, this should be documented. The Police should also complete the J2* instrument in respect of each juvenile taken to a place of safety. The data collected is essential for administrative and other action to be taken namely:

- a) for the Children's Officer to contact the juvenile's parents or guardians to inform them of the juveniles whereabouts and to commence preliminary investigations in the preparation of the Social Enquiry Report;
- b) for logistical arrangements to be made to transport the juvenile to and from Court on the specified Court date.

The J2 instruments are not available at the police stations. Accordingly, compliance with this procedure is compromised.

The A-Z Manual is a booklet developed by the Ministry of Health as a guide to the assessment and intake of juveniles. The procedure set out in the A-Z Manual is not being adhered to. Nor is the 24 hour emergency telephone number utilized as it should to effect placement. This facility needs to be restored and the procedure be widely disseminated amongst new police recruits as a routine part of their training, particularly those who deal

* Copy of a proposed J2 Form is at Appendix X.

with juveniles. Refresher courses should also include a compulsory segment on juveniles i.e. procedure for intake when a juvenile is charged with a criminal offence and the level of sensitivity which is required to reduce emotional trauma when considering separating young children from their parents or guardians.

On intake, as detailed information as possible is to be obtained about the juvenile regarding his physical, mental and educational status. This is to facilitate early assessment and evaluation by a multi-disciplinary cadre of professionals consisting of:

- Child psychologist
- Doctor
- Social Worker
- Psychiatrist
- Children's Officer

The Children's Officer, in the preparation of the Social Enquiry Report, can also be the source for providing additional information. Ideally, each institution should have its own team. However, given the resource constraints, it is recommended that the team operate on a regional basis (Cornwall, Middlesex and Surrey). They will visit each Place of Safety at set intervals bi-monthly or at monthly intervals (as resources permit) and at other times as the need arises, in relation to juveniles deemed as having severe behavioural problems.

The assessment should have regard to the juvenile's:

- health needs and the promotion thereof
- care and welfare promotion
- physical and emotional needs and occupational targets for acquisition of life skill

- leisure needs
- need to maintain contacts with his family members (whether biologically derived or at common law) and social groups.
- religious needs.
- any particular interests shown or exceptional talent.

On the basis of the above criteria a programme of placements or plan will be developed in relation to each juvenile in care.

The Children's Officer will monitor each juvenile to ensure that the objective of each juveniles placement plan is being met or implemented. This should be documented in his individual file, which will accompany him to where ever he is transferred to. The juvenile's views on the overall plan or aspects of it should be sought, if his maturity and level of understanding is sufficient to have his own views.

The placement plan should include preparation for leaving the institution and to ensure his/her adequate survival after release from care.

The Assessment Team, child psychologists etc. will visit the children's home at 6 monthly intervals to monitor each juvenile's placement plan.

The Children's Officer in conjunction with the Superintendent of each Home will ensure that the personal file of each juvenile is regularly up-dated e.g. and available for inspection by the Assessment Team. The team will review each juvenile's placement plan and determine whether any changes are necessary.

Where the juvenile has sufficient understanding s/he should be present at the review to participate in any decision determining changes to the plan in accordance with the

Convention on the Rights of the Child. Where a juvenile has attained any set targets, or achieved any goals, these should be recorded on his file and communicated to the Assessment Team.

Particular emphasis should be placed on the juvenile's:

- family, if known, and his history of achievement
- self esteem
- values and attitudes
- understanding his sexuality and
- benefits of maintaining relationships.

Recommendations:

- 12) The procedures relating to the intake of juveniles should be developed and documented within the Ministry of Justice (Family Court) and the Ministry of Health, from the point of entry to the childcare system to the placement in Places of Safety and Children's Homes.
- 13) The number of wards in the institution (Places of Safety and Children's Homes) should be drastically reduced to manageable proportions to achieve a ratio of 10:1 caregiver. This ratio will facilitate the provision of a higher standard of care for each ward approximating internationally acceptable standards for juveniles in care. Accordingly, the available resources can be more efficiently applied.
- 14) Community based care as compared to institutionalisation as a treatment modality should be pursued.
- 15) An aggressive, unrelenting, public education campaign promoting family values and attitudes should be conducted nationwide. This should incorporate the Ministry of Education; corporate Jamaica; the Churches the Family Courts; the

Trade Unions, NGO; the Universities, Community Colleges and Service clubs should be urged/required to become involved in the programme.

- 16) Tax or other incentives could be offered to corporate Jamaica for its participation. Focus should be directed at the rural poor and to the inner city communities from which most of the wards of the institutions come.
- 17) There should be recruitment of more foster parents to foster the juveniles presently in care and those potentially in need of care.
- 18) The Children (Adoption of) Act should be reconstructed to facilitate more adoptions of juveniles in care particularly when they are small and can be moulded.
- 19) There should be cost effective interventions to families by providing financial assistance in the home.
- 20) An Assessment team should visit the institutions to monitor the welfare of the juvenile. When juveniles are utilised as a source of labour when a commercial venture is undertaken in the institution for its viability, not only should the juveniles acquire a skill, but also his/her welfare should be the paramount consideration.

CHAPTER 2 THE SUPPORT SYSTEMS NECESSARY TO ADDRESS BEHAVIOURAL PROBLEMS EXHIBITED BY CHILDREN IN CARE

2.1 Overview

In recent times there has been a frightening increase in criminal activities in Jamaica. Also, the increasing number of serious crimes committed by juveniles in Jamaica has focused our attention on the behaviours of our children. It has been well recognized that difficulties in childhood can lead to adult antisocial behaviours and this knowledge has led to a need to look at the behavioural difficulties some of our children manifest.

2.2 Research Studies

- i) The 1999 report, “**Faces of Residential care in Jamaica**”, indicated among other things that children were admitted to institutions because of :
 - Carers unable to cope & child beyond parental control (55%)
 - Physical, sexual abuse & neglect (35.5%)
 - Unavailability of parents (20.3 %)
 - Delinquent behaviour problems (9.9%)

At the time of the study 10.7% of these children were aged five years or younger and 59.9% were between 12 – 17 years old.

- ii) Local research by Dr Maureen Samms- Vaughan “**Cognition, Educational Attainment & Behaviour in a cohort of Jamaican children**” March 2001, has shed light on the frequency with which many behaviours occur in our child and adolescent population. The study examined several factors in the lives of more than 1700 children at early adolescence and reported that our children experience more internalising (sad, withdrawn etc) than externalising (steals, fights etc) behaviours.

Table 1

INTERNALISING BEHAVIOURS	EXTERNALISING BEHAVIOURS
Withdrawn	Steals
Secretive	Runs away
Refuses to communicate	Truants
Anxiety	Fights
Depression	Is mean
Feelings of being worthless, unloved, guilty	Destructive
Somatic complaints eg. dizzy, tired, headaches with no known cause	Threatens

- iii) Dr Sandra Chambers in her 2002 report on “**Depression in Wards of the State in Kingston and St Andrew**” looked at 309 children, ages 10 – 18 years. These children were resident in four Places of Safety and four Children Homes. The primary reasons for their placement in these institutions were :

- behaviour problems 37%
- care and protection issues 36%
- physical abuse 7.4%
- criminal offences 5%
- sexual reasons 4% (incest, statutory rape and pregnancy)

This paper set out to find the prevalence of Depression in this group of children (38.8%) and noted that it was much higher than that of the normal population (5% in adolescents in the USA). The report also noted that children admitted to institutions because of behaviour problems had the highest levels of depression.

Findings from the 2003 Review Team

The Children Homes / Places of Safety (POS) Review team sent out specially designed questionnaires to all the fifty-seven institutions in which children were resident. Thirty-nine completed questionnaires (75%) were returned and the results compared with the 1999 study.

It is interesting to note that the gender breakdown for both studies is exactly the same. However, there was a marked increase in the percentage of behaviour problems noted; **9.9% in 1999 and 38% in 2003**. While the 1999 study did not give details as to the kinds of behaviours that their group manifested, the 2003 group showed definitely more externalising (aggressive, stubborn) than internalising (depressed) behaviours. This is in direct contrast to the large cross section of children (living at home with their families) in Dr Samms Vaughan's study who had more internalising behaviours. Dr Chambers' 2002 study showed the same percentage of behaviour problems as did the 2003 data.

There was also a marked increase in the medical conditions identified in the children in the 2003 study (44% in comparison to 21% in the 1999 study); asthma being the condition that was most prevalent.

Table 2

Analysis of Questionnaires & comparison with the 1999 & 2002 reports

	1999 “FACES OF RESIDENTIAL CARE”	2002 “DEPRESSION IN WARDS OF THE STATE”	2003 REVIEW OF CHILDREN HOMES & PLACES OF SAFETY
Gender	63% males 37% females	53% males 47% females	63.2% males 36.8% females
Behavioural problems	9.9%	36.6%	37.5%
Types of behaviour		Drug use – 11.7% Depressed – 38.8% Suicidal – 20%	Aggressive - 44% Stubborn - 36% Depressed -10% Suicidal -10%
Medical condition	21%		44%
Asthma	3.7%		20%
Sickle cell disease	0.9%		3%
HIV/AIDS	1.2%		-
Other	42.6%		26.7%

2.3 Behaviours of concern to Review Team

Bed-wetting

In virtually all the homes visited, concern was expressed about children who wet their beds at night. Invariably they were assigned to specific areas in the dormitories, their beds were unmade at the time of the Review Team's visits and we were told that the sheets were being laundered. The stench of urine was obvious in the areas of the dormitories assigned to "bed-wetters".

Not learning in school

We were informed that just about all the children in the Children Homes/POS were not learning and could not fit into the regular school system. However, they must have been enrolled in some educational institution before they came into care and so had been at some stage part of the established school system. The schoolrooms we saw were neat and well tended with many activity charts and pictures on the walls. However, these charts seemed more appropriate for preschool children and we saw no evidence of remedial training taking place for all these children who were said to be so far behind their peers.

In spite of being told on more than one occasion that the Homes/POS had children who were at GSAT and CXC levels, nothing was seen to suggest that such curricula were being pursued by any of the children.

Suicidal attempts and suicidal thinking

At two Places of Safety (POS), the Superintendents articulated great concern about children who tried to hurt themselves or spoke openly about wanting to kill themselves. They indicated that these teenagers presented significant management challenges and had to be referred to healthcare facilities. Children spoke of witnessing on several different occasions, attempts at suicide by hanging. They talked about their efforts to untie sheets and scarves to assist their peers from hurting themselves, their feelings of anxiety and helplessness and the off-hand manner in which the “staff” responded to their pleas for help. “So why you didn’t just leave him/her?”.

At one POS, a quire book, in which records of visits to healthcare facilities were kept, provided confirmatory evidence of suicidal children being referred for mental health evaluations. One Place of Safety reported the death earlier this year of a teenager who was diagnosed with diabetes. There were written reports to indicate that the child had received medical attention on several occasions but there were also verbal reports that spoke to the child’s adamant refusal to adhere to the recommended diabetic diet or follow the advice of the care-giving staff. We wonder if this child was depressed and determined to end her life.

In Dr Samms Vaughan’s study of “normal” children, 13.8% admitted to suicidal thoughts and their overall behaviour was different to that of their non-suicidal thinking peers. The children with suicidal thinking reported more internalising and externalising behaviours than their peers.

In Dr Chambers' study 9% of children admitted to suicidal thoughts and 11% had attempted suicide.

Run away behaviour

During the team's visit to a Place of Safety we saw several holes in the fence that the children were reported to have cut to facilitate their escape. We also saw the damage inflicted by children on the doors and windows of dormitories and heard of the several risk taking behaviours in which they indulged in a desperate attempt to be "free". At another Place of Safety the holding area in which runaway children are held following their return to the institution looked dark, unhealthy, overcrowded and unacceptable for the purpose. The boys in this area appeared sub nourished, dishevelled and said they were hungry in spite of just having had lunch. They begged for money to buy "biscuits" from the tuck shop. They were held in this area during the daytime and were not involved in any stimulating or educational activities. At night they slept in an assigned dormitory.

Use of alcohol and other drugs

The reported wild and out-of-control behaviours that some of the children displayed strongly suggested drug use. No clear history or evidence of this was obtained.

In Dr Samms Vaughan's study, 12.6% of children admitted to using drugs. More boys than girls in this study used drugs and alcohol. Drug use was associated with externalising behaviours and attention problems. Children who used drugs made much lower scores on school achievement tests than drug free children.

In Dr Chambers' study 11.7% of the children living in institutions admitted to ever having used drugs.

Sexual behaviours between Children / between Children and Caregivers

There are reports of same gender sexual behaviour between children in the Children Homes & Places of Safety. It was reported that “bullies” or gangs of older children sexually prey upon vulnerable children. As a rule, same gender sexual behaviour was reported to be unacceptable to the children and this was openly discussed with members of the Review Team. One child spoke of being raped by caregivers in an institution and other children have been identified who have been sexually abused by care-giving staff.

During the focus group for Physicians, one of the Paediatricians spoke of a young child who was resident in one of the Children Homes. This child on admission to Hospital was noted to have obvious sexualised behaviour. What was significant about this particular child was that on previous admissions to hospital and before placement in the institution, no such behaviour had been demonstrated.

Antisocial behaviours: Aggressive / oppositional / defiant behaviours

Several of the institutions visited aired their concerns about the children’s oppositional and defiant behaviours. There was talk of the children being disobedient and disrespectful; cursing House Mothers and other in-house staff. The Superintendent at one of the institutions indicated that he had never before experienced the defiance and out-of-control behaviour that is now rampant in the home. He dated the onset of the behavioural changes to the end of last year (2002) and associated it with the presence of construction workers in the home. He added that one construction worker was fired because of alleged sexual involvement with the children.

Recommendations:

{Children who are presently in care}

- 21) Every child at present in a Place of Safety or Children's Home should have a complete physical / psychological / educational evaluation. This should include
- i) detailed information about the child's family
 - ii) detailed history of the child's birth, development and immunisation status
 - iii) medical history, especially previous illnesses (especially Asthma, Sickle cell disease) and hospitalisations
 - iv) medical examination with laboratory tests as ordered by a Physician
 - v) psychiatric evaluation
 - vi) school history
 - vii) psycho-educational evaluation if warranted

The Children's Issues Coalition (CHIC) has volunteered to assist in carrying out a detailed study of all children in Homes and Places of Safety¹

¹ Letter from Professor Elsa Leo-Rhynie 4/3/03 – a written submission to the Review Team).

- 22) An individual care plan should be developed for each child. The Children's Officer, Superintendent of the Home and the child's parents / family should be actively involved in the creation of this plan.
- I. Clear and achievable goals should be identified and monitored*
 - II. Quarterly meetings should be held. They should include family members, the identified child's Children's Officer, the Superintendent of the Home and the Regional Children's Officer Supervisor. The child should also participate in these meetings*
 - III. An estimated date of discharge should be identified*
 - IV. During the period of institutionalisation, every effort should be made for child and family to keep in touch*
 - V. The family should be prepared for the return of the child home.*
 - VI. An in-house medical record should be created for each child and updated when the child attends a medical facility*
 - VII. Repeated assessments should be done at appropriate intervals.*

2.4 Focus group for the children

Twenty children, ten boys and ten girls, ages 10 – 18 years were brought together in a focus group. The children were randomly selected from ten children's homes and places of safety. They were very neatly groomed for the occasion; some arrayed in their "Sunday best". They were initially suspicious, reluctant to engage in conversation and unclear as to the purpose of our meeting. When placed in small groups most of the children gradually warmed up and share with us but one child elected to remain silent for the entire meeting.

These children had been wards of the state for periods varying from one year to fourteen years. Four of the children had been admitted because they had been victims of Child Abuse and Neglect, two because of disruptive and aggressive behaviour problems and the rest because their parents were unable to care for them.

The common threads that ran through their conversations were

- a longing to return home, “I miss my people”
- the misbehaviours of other children eg. lying, stealing, fighting, not listening to caregivers
- the beatings given by Housemothers and “Aunties” and
- fear of the future.

Several positive ones balanced these negative responses. Some children spoke of the availability of three square meals each day, the opportunities to go to school, to the pool on Saturdays and Church on Sundays and the loving and guidance they received from the Housemothers.

Only six of these children had regular contact with family members or other significant persons in their lives. Two of the children had parents who had died and one was now actively mourning the death of his Father, who had died many years previously. Another boy’s Mother was seriously disabled and even though she wanted to reach out to him, he was repulsed by her physical condition and refused to see her. There was also a child whose family members told him they were migrating to the USA and he responded to the news by becoming increasingly disruptive and oppositional in the institution.

A couple of these children had been seen in Child Guidance Clinics but there was evidence that their issues remained unresolved and that their involvement in therapy needed to be long term.

2.5 New innovations

Early Identification of Children and Families At Risk.

Early identification of children and families at risk can take place in antenatal clinics, especially high-risk antenatal clinics, well baby clinics and in basic schools. Young women, especially pregnant teenagers, women with chronic illnesses such as diabetes and hypertension, women with several children and others need support and careful monitoring during pregnancy and after delivery. The children need to be checked for developmental delays and the caregivers guided with parenting information. Families in which the child abuse and neglect has been diagnosed, are also at high risk and the siblings of the abused child should be monitored as they are also at risk for abuse.

Avoid placing children in institutions.

Every effort should be made to avoid placing children in institutions. Part of a child's healthy development involves learning about the history of their family, carrying on family traditions and identifying with their parents or other family members. Much of the value of the family's customs and records may be permanently lost by separating parents and child and lead to adolescents who are constantly mourning for and searching for clues about their past.

If parents cannot afford to care for their children, the State should seriously consider the financial support of families at risk in order to keep children and their parents together. This process would have to be carefully monitored. Ideally the parent(s) should be assisted in some income generating activity so that they could become self-sufficient.

Other family members should automatically take over the role of parent if and when their relatives are unable to care for their children. If they are not able, foster care is the next best option. Only when these options fail should institutional placement be considered.

Trained foster parents

The Children Officers in each parish should identify and train a core of available foster parents. These persons could be called on at short notice to provide short to medium term care for children eg abused children who need a safe home. A core of specially trained “therapeutic” foster parents should also exist in each parish. They should have the skills to manage challenging children eg. children with significant behaviour problems.

Regional teams.

A team of professionals (Paediatrician, Psychiatrist, Psychologist, Mental Health Officer, Social worker, Psycho/Education specialist etc.) should be identified in each of the four health regions to carry out evaluations on identified children, especially children who are being considered for placement in institutions. The team should include available persons from the public and private sectors and preferably should be resident in the particular region. The Regional Children’s Officers should coordinate these teams.

Selection of staff

The selection of staff suitable for employment in Places of Safety and Children's Homes needs to be reviewed.

- *Police clearance should be sought to ensure that these persons do not have a history of abusing or harming children.*
- *Qualifications for the jobs need to be reviewed*
- *Job descriptions need to be clear and*
- *An adequate Monitoring system with clear written guidelines for the supervision of institutional staff should be readily available*

Children who have to be admitted to institutions

- Each child must be evaluated before being placed in an institution
- This evaluation should be carried out speedily, say over a two-week period.
- Following the evaluation a decision based on factual evidence should be made as to an appropriate institution for placement.

Functions of Children Homes & Places of Safety

- Each home should have access to a Social worker who is responsible for the counselling of identified children and who decides in conjunction with the Superintendent, which children should be referred out of the institution for mental health treatment.
- Each home should have an intensive **Physical activity program** which could be developed in collaboration with staff from the G.C. Foster College
- Each child should have the basic requirements of a bed and a locker in which to store their possessions
- Every effort should be made to keep child and family in touch

- It is essential to continue the child’s education. The individual care plan would have identified the educational needs of the child and the institution should follow through with the recommendations.
- Skills training in association with HEART/ NTA, should be available to children in the institutions.

At risk children/ families in the community

- Promotion of a “*Parents, your children are your responsibility*” campaign to ensure that both mothers, fathers, families and the community understand that they are totally responsible for their children
- A National Parenting Campaign targeting community leaders as well as parents and teenagers should be launched
- A National Family Planning Campaign promoting “*Sexual Abstinence*” and targeting teenagers should be launched
- Promotion of a “*If you must have sex, make it safe sex*” campaign
- Improvement of the physical facilities of Children Homes and Places of Safety to replicate the model of the small group home setting used at the SOS Villages.
- Develop a program to identify early on, for example in the pre-school years, children who are at risk. These children need to be evaluated and channelled early on into appropriate intervention programs.

CHAPTER 3 CHILDREN WITH DISABILITIES

3.1 *Overview*

In conducting this review there are two things that are startling. The first, which the quantitative data indicates, is that there are a significantly higher proportion of children and adolescents with disabilities in children's homes/places of safety than there is outside the walls of these 'homes'. The second, which, is not as easily captured in numbers, is the substandard provisions made to meet the developmental and living conditions in which the majority of children and adolescents with some level of developmental and/or physical disability 'exist' in these homes. Children, who for the most part are not able to effectively communicate their needs, live in unacceptable environments.

Children with moderate to profound developmental/physical disabilities are placed in a system that is already unable to respond to the emotional and physical needs of non-disabled children, let alone the complex challenges of children with special needs. The system is currently not positioned to provide opportunities to ensure that the ability of each child is maximized. The system is unable to define their development, medical and emotional needs; there are no minimum care standards to ensure that where there is some understanding of their needs, these needs are met.

3.2 The Data

Survey was conducted by a member of the Review Team using the data on file and discussions with 70% of the Children's homes. Fifty-seven (57) homes indicate that 69% have children with some level of developmental and/or physical disability. We can extrapolate and conclude that two-thirds of the fifty-seven homes have children with some level of development disability. Twelve percent (12%) of the homes are operated solely for children with a developmental and/or physical disability and another fifteen percent (15%) have an average of 35% children with a developmental and/or physical disability.

The 1999 report established that an estimated 30% of the children in homes have a form of disability; the majority of these have a developmental disability. It is important to note that while reference is made to 'disability' the primary grouping of disability which has been observed at the homes visited and what a sample of the children's files indicate is that of 'development disability'. Several of the children in the homes also display Physical Disabilities. Development Disability is mental retardation that is manifested before the person is an adult. It is likely to continue indefinitely and depending on the degree, ranging from mild (high-functioning) to profound (multiple-involved) there are limitations in self-care, understanding and using language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

All indications from fieldwork and data collection are that this assumption is understated. Based on a detailed review of data from the Ministry of Health (MOH) and visits and telephone interviews to select homes, of the 1,575 children living in the forty (40) private homes, an estimated 37% of these children have a disability. From the field survey

conducted as a part of this review, at least 14, of a sample of 39 children, had some level of developmental and/or physical disability.

Sixty-five percent (65%) of the children with developmental and/or physical disability live in homes run exclusively for disabled children. Twenty-five percent of the children with a disability residing in homes range from the ages of 18 – 40.

(There is one instance of an autistic ‘child’ living in the Golden Age Home).

Despite the reality that the percentage of children with disabilities in Children’s homes is three times² greater than that occurring in the disabled population in private households, the MOH has no established standards for the care and development of children with disability living in homes and places of safety. No member of the Children Services Division (CSD) team has had any acceptable level of training on the care and support needs of persons with developmental and/or physical disabilities.

While not stated, what is often implied by the action of all the stakeholders, with the exception of the children, is that given their [the children’s] “condition” they are being well taken care off. An officer of the CSD on visiting Home A stated in her report “... *continues to operate at a relatively high level despite the limitations of the children they cater to.....*”

² In the 1991 Census (2002 Not yet available), 14% of the disabled population in private households was within the age cohort 0 – 19. It should however be noted that when you compare the categories of disability observed in Children’s Homes/POS with the national census there are only 1.5% in comparable categories in private households.

3.3 Children with Developmental Disabilities

Some 90% of the homes that are dedicated solely to and/or have a significant number of children with developmental and/or physical disabilities are operated by non-government organizations. The process of licensing is similar to that for homes with non-disabled children, with the exception of minor physical requirements such as ‘wheel-chair’ access. There is no system in place: no standards or basic guidelines and minimum requirements for the care and development of children with developmental/physical disabilities. Visits to homes, review of files, focus groups held during this review support this and below are a summary of some core concerns.

3.4 Education & Development Programmes

For children with developmental/physical disabilities, education and development programmes which seek to build their cognitive and self-help skills are critical, they are fundamental to the level of independence that each child must achieve. Despite this, there are no requirements for the education of these children. Children with developmental/physical disabilities will have a range of educational needs. At one end of the spectrum, for those with profound developmental and/or physical disabilities, the focus would have to be on occupational and physical therapy and a structured stimulation programme. At the other end of the spectrum, those with mild developmental/physical disabilities can be mainstreamed into an existing school.

In the absence of standards however, practices differ.

Case 1:

A home with some 40 children with moderate to profound developmental/physical disabilities was asked about their education programme for the children and the response was ‘the children cannot learn we just take care of them’. There are no individual development plans, nor is there a generic development plan for all the children in this home.

A visit to this home confirmed that less than 1% of the children were in a structured education programme and this despite the fact that the School of Hope³ has an extension ‘classroom’ located on the premises of the home. In speaking with the Senior Tutor of the extension classroom she explained that she had to insist that children from the home were sent to class. At the time of our visit, March 2003, only four (4) of the twenty-two (22) children were from this home, others were bussed in from other homes.

Case 2:

In this home, some 40% of the children have mild to severe developmental and physical disabilities. Those with mild - moderate developmental/physical disabilities attend a school on-site, these appear to do fairly well and work to standards established by the School of Hope. There is a makeshift stimulation programme for those with severe and profound developmental/physical disabilities. The programme varies based on the input of ‘volunteers’ and partially trained aides. There are sporadic notes on each child’s file. The last entries on files viewed varied from January 2003 to December 2001. There is a minimum level of ongoing monitoring to track the progress of each child and to determine the appropriateness of the stimulation ‘programme’.

³ The School of Hope has a primary campus located in the August Town area. In addition to this centre, it operates several satellite schools islandwide, with quite a few of them located on the premises of homes with large numbers of children with mental retardation.

Case 3:

In another home, where there is a mix of moderate and severely disabled children, 23% of the children are in a formal learning environment, they attend appropriate off-site schools. Copies of their current school records were available. A further 20% clearly receive interactive therapy in a special centre; however, the regularity of supervised therapy could not be established from the records. The children with severe developmental/physical disability appear to receive ongoing basic physical therapy. There are adequate computerized critical data for all 50 children.

Case 4:

In this home, where there are seventy-seven children with moderate to profound levels of developmental and physical disabilities fifteen (15) are in school some on-site and some off-site. The claim is that each child, not in school, has therapy daily at a physical therapy facility on site. Upon inspection the facility, adequately equipped, and an estimated 200 sq. ft., is appropriate as a 'model' but is inadequate with its staff of two aides to guarantee daily 30 minute sessions for each of the other fifty children.

Preliminary calculations confirm that the facility can have a maximum throughput of 18 children daily. The best-case scenario therefore is that each child has two 30 minutes sessions weekly. When the files of three children were reviewed, there was no indication from the entries over the previous three weeks that any of these three (3) children had seen a therapist daily.

However, it must be noted that this facility offers the 'best' support for children with development disabilities.

The above case summary reviews support the finding of our survey of the records of thirty-nine children from 70% of the homes. Of the children surveyed, 56% were disabled. From among those children, 40% had an Individual Education Plan (IEP). An IEP can be a complex multi-page document or a simple two-page document. It sets out critical targets for a child with a developmental disability; the targets are usually around increasing gross motor, fine motor and cognitive skills as well as developing an increased level of self-care. The IEP is critical guide in charting and tracking the course for a child with a developmental disability.

With the exception of one home, Case 4, there is no overall development programme for the children with developmental/physical disabilities, in particular those who are not in a structured education programme.

3.5 Staffing

Children with developmental/physical disabilities require greater levels of support and constant stimulation and therefore a higher level of staff child ratio. No guidelines for staff/child ratios appear to exist for the entire system and certainly there are none that recognizes the need for a different level of care for children with developmental/physical disabilities. In one home, Case 2, with 33 children with severe to profound disabilities there are three-day time care givers, with fewer at night. In one home, Case 2, the resource responsible for overseeing 33 children with a range of developmental/physical disabilities has had no formal training.

The home in Case 4, considered to be a model home, the ratio of caregivers appears to be appropriate. When visiting the home, however, one was struck by the ‘short’ manner in which a few caregivers interacted with the children. The Superintendent of the home indicated that her caregivers are constantly trained by a senior personnel, however the

level of training of this resource is inadequate given the complex developmental and emotional issues of the children and adolescents in the home.

In Case 3, a home solely for children with developmental and/or physical disabilities the Superintendent has had no significant formal short or long term training in the administration of a home for children with developmental/physical disabilities. The staff members there have been exposed to short-term training ranging from 1 – 5 days with the last of these some 15 months ago.

3.6 Finance

The stipend paid to a home for a child with a disability is the same as that for a non-disabled child. The MOH must recognize the significant additional cost to care for children with a developmental and/or physical disability, especially for those with moderate to profound disabilities.

- The cost of education anywhere in the private or public system is greater than that for a disabled child.
- Children, a result of their disabilities, have to be transported by the Homes to their schools.
- For Children who are in formal school system on-site occupational and physical therapy is a required part of their care, this specialized therapy is costly.
- There is a need for greater supervision. Fewer children to each caregiver, means increased cost.
- Only a small percentage of the children with a development and/or physical disability will be toilet trained. As a result the Home will need to spend more on “disposable” underwear” for the children well pass traditional age.

Despite the above there is no indication that the MOH has given any consideration to the potential of a difference in cost and subsequently reviewed their current allocation. It is unlikely that all children will need the same level of financial support as their needs differ. Each home in 2002 received J\$1,090⁴ per week per child. As an indication of costs, in a children's home with non-disabled children which provided a multiple of services, education and vocational training, their financial data indicated that the cost per child in 2002 stood at J\$2,040.00.

3.7 *Diagnosis and Assessment Systems*

Visits to homes and a review of records have revealed there is no system to diagnose the disability of each incoming child with a disability. Labels vary and are generic, mentally retarded, being the primary catchall label. Of a sample of twenty-five records of children with a developmental/physical disability 20% of the diagnoses were done by an appropriate professional. Other 'diagnoses' were done by the home or caseworker based on observations and past experiences. Only one home, Case 3, has a clear record of each child with a diagnosis for each of the fifty children currently in their care. Based on their data and the level of detail it is likely that some of these diagnoses were done by an appropriate professional.

On the basis of the review of the records less than 2% of the children with developmental/physical disabilities have been assessed. There is no system and or a requirement for assessing the cognitive levels of each child. In the absence of a 'reasonable' assessment it is difficult to determine the developmental programme for

⁴ In 2003 each Home/POS now receive J\$1,200 per week per child.

each child. The children who are currently enrolled in a School of Hope programme is likely to have been assessed to determine the grade they would be placed in.

Homes will at times refer children who are ‘slow’ for assessment that may indicate that there is a level of disability, usually undiagnosed. This appears to occur in homes where the population is primarily non-disabled.

3.8 Monitoring done by the Children Services Division

Overall, the level of monitoring for the entire children’s homes and places of safety is inadequate. Increased vigilance for homes with children with developmental and/or physical disabilities is necessary. Historically levels of abuse have been higher in these homes than in homes for non-disabled children, one of the reasons that prompted the closure of several such homes in both the USA and UK.

The ‘monitoring’ of the homes with children with development disabilities is similar to that for the entire system. There appear to be two methods:

- i. A ‘long-form’, which seeks to determine the current number of residents and children, number in school, health, with a paragraph on comments and recommendations. The form is signed by the visiting Children Services Division (CSD) officer but not signed off by the supervisor of the homes. The system is pointless since there are no established standards against which to monitor and assess the home. There are no standards set regarding the ratio of caregivers to children, which will vary for a child with a moderate to a child with a severe disability.
- ii. Reviews, which, from the records, appear to be prompted by complaints. The visiting CSD officer prepares reports, which are short (no more than 1 ½ page), they are qualitative, there is no standard format, and there is no indication of a

sign-off by the operators of the home, there is no system which establishes whether or not recommended actions have been taken.

Neither of these systems is adequate to ensure the care and protection of any child in any home. This is addressed in another section of the report. The Standards for Quality Care in Children's Home & Places of Safety does not take cognisance of the need to establish specific standards for the supervision of children with disabilities.

3.9 Summary

There is a proportionately higher number of children with a developmental and/or physical disability in homes than occurring in the wider population. The MOH has perhaps not taken stock of the implications this has for the way they approve, monitor and finance the care of children with special needs. There are no standards established to guide the care and development of these special children. Care for these children is lopsided with one home, Case 4, clearly making an effort to embrace better practices and others demonstrating clear neglect. The MOH is without the necessary expertise in-house to be in a position to establish the necessary level of care required and to subsequently assess if homes are meeting these standards.

The percentage of children with developmental/physical disabilities in homes is unacceptably high. This is in part a result of an absence of a system and network to provide the necessary support to families with children who have a developmental and/or physical disability.

Recommendations:

- 23) A long-term strategy must be implemented to minimize the entry of children into Children's Homes and Places of Safety. This strategy will require collaboration with the Ministry of Labour & Social Security and the Ministry of Education, Youth and Culture. The Community in which children with developmental and/or physical development and their families live and work also has a critical role to play.
- 24) Alternative strategies must be explored, which should include financial support to family units willing to care for their disabled child at home; Build a community environment, providing information on opportunities, working with relevant Ministries to create opportunities for these families.
- 25) Provide through its clinics 'special needs extension workers' to support families and do a level of monitoring of disabled children at home. The Health clinics should provide scheduled community based-services for evaluation, development programme review in addition to health care needs.
- 26) The Ministry of Health, with the Ministry of Education, Youth & Culture, should explore the provision of 'respite care' and special day care facilities where parents can leave their child with a disability for brief periods to allow them the opportunity to work and nurture any other child who may be in the household

Short Term

- 27) Establish standards for homes that have been established for children with disabilities. There should be a time frame for compliance for existing homes.

- 28) Establish the actual cost of care and support for children depending on the level of disability, then enter into a clear agreement with each home regarding the level of Government funding or support, it will receive and what is expected from the home to keep their accreditation.

CHAPTER 4 FUNCTIONALITY OF HOMES

4.1 Background

In addition to extensive focus group meetings and visits to Children's Homes and Places of Safety the team developed three survey instruments, see *Appendices IX* to collect information on

- I. Homes and Places of Safety
- II. Children
- III. Employees

Each home was asked to complete and return their instruments. The survey instruments were designed to allow for a level of comparison between some critical variables.

4.2 General Information on Homes

This section contains a summary of the data collected during March-April 2003 using Survey Instrument in *Appendix IX*. The data from the survey is complemented with information gleaned in the review of Children Services Department (CSD) files/records and visits to thirteen homes and a review of their records.

Data presented by the Ministry of Health states as at March 2003, there are 57 children's homes/places of safety in Jamaica. This number includes twelve (12) places of safety and forty-five (45) homes. Four (4) of the places of safety are privately run and eight (8) are operated by the State. There are forty (40) private children's homes and five (5) operated

by the State. There are an estimated 2,402 children in children's homes and places of safety.

Forty-two (42) of these homes completed survey instruments sent out to them during this Review. Of these forty-two (42), thirty-three (33) are children's homes and eight (8) are places of safety. One home in this sample was opened in 1,880 and the newest home was opened in 2002.

4.3 Governance of Homes

Just fewer than eighty-six percent (85%) of the homes indicated have been inspected by the Public Health Inspector and the Fire Department. The responses indicate that the Public Health Inspector visited the homes on at least one occasion over the period 1998 to 2003. Responses indicate that the Fire Department made their last visits between 2001 and 2003 to these homes. However, in the fifteen (15) homes visited by the Committee, while there was some indication of visits by the Fire Department through until 2002, there was no indication that any of these fifteen (15) had an inspection from the Public Health Department since January 2002.

Ninety-five percent (95.2%) of the homes indicate that between the years 2001 and 2003 the Children's Services Division had inspected them. There is nothing to substantiate this. We reviewed the records of twenty-two (22) homes at the CSD and discovered Inspectorate Reports for less than 30% of the homes. Of the fifteen homes visited by the Team, nine (9) could not recall an official inspection by the CSD in the past three (3) years.

There is no indication that the CSD has established a roster for conducting audits and reviewing homes to ensure that they are consistent with licensing agreement. In addition to the CSD Inspectorate Report the CSD does conduct sporadic checks at homes and the Officer may prepare a one-two page qualitative report, several of these are in response to a particular complaint.

There appears to be no system for tracking the recommendations for improvements and/or changes requested from the Fire Department & the CSD itself.

Fifteen (15) of the homes comprising 36% of the total have quarterly Board meetings. Six (6), just over fourteen percent (14.3%), of the homes have monthly Board meetings. There is one private home which receives 80% of its funding from the government and no doubt as a result of this the government has a 'place' on its Board. Despite this the Ministry of Health (MOH) does not attend these Board Meetings.

The importance of participating in Board Meetings and or reviewing Minutes of these meetings cannot be overstated. On visiting a home where there had been several complaints, the minutes for an eighteen (18) month period pointed to ongoing concerns and an action to have someone removed based on 'suspected' behaviour'. The 'someone' was the adult male child of the then Superintendent of the Home.

Recommendation:

- 29) That the Ministry of Health develops policies and guidelines which will enhance the process by which adequate governance of homes is monitored

4.4 Care and Support Staff

The number of Care and Support staff varies significantly primarily as a result of the size and numbers of children in each home. There is no consistent relationship to establish whether a standard ratio of caregiver to children has been established.

One home employs up to 91 persons on the care staff, of which 56 are full time workers, at the other end of the spectrum one has 2 persons employed on a full-time basis. The home employ an average of 7 full-time support staff, although the number for each home varies significantly, with one home having up to 36 support workers and three homes having three (3) support workers.

On average, a home has 2.7 part-time care employees. Thirty-three (33%) of the part-time care staff work up to approximately 32 hours per week and 14% work up to 40 hours per week. On average, there are 2.1 part-time support employees at each home. They work an average of 36.5 hours per week.

4.5 Ratio of Staff to Children

The ratio of staff to children varies significantly from home to home. When averaged, there is one staff member to six children during the day in each home. The average ratio of staff to children during the evening is one staff member to ten children, below are additional specifics:

- The average ratio of staff to children during the day on weekends is 1:10
- The average ratio of staff to children is 1:13 during the evenings on the weekend.
- The average ratio of staff to children during the week, at night is 1:15
- The average ratio of staff to children at night on the weekends is 1:15

Recommendation:

30) That the ratio of staff to children be standardized as follows: Children with disabilities - 1:3 Normal Children - 1:10

4.6 Educational Facilities

A select number of the homes have on-site education facilities. These range from an extensive school with all the required grades and an average class size of 13 to a Home with 10 children, with a mix of ages, in one classroom. In the home with the most extensive school system we were advised that the children do not go on to secondary school since their academic performance remains below required levels!

Of those surveyed, 28.6% of the homes do not employ full time teachers, this is consistent with the number that do not operate on-site schools. For those homes operating schools there was an average of three (3) teachers to each home. For those operating schools 66% do not have part time teachers, while 14% of the homes hire one part-time teacher in total.

4.7 Budget and Financing

Just over thirty-three percent (33.3%) of the homes are unaware of what the costs were to run their homes for the past financial year. This is more likely to be the case with Government owned and operated homes. Forty percent (40%) of the homes questioned did not present figures estimating the total cost of running their home for the past financial year.

The current mechanism for providing funding to the private homes is that they submit the list of their current complement of children and they receive an allocation based on the numbers in their care at the time; disbursements are done monthly. There are no minimum requirements and/or guidelines for expenditure. In one home, 60% is spent on salaries and 25% on food for the children.

The larger number of private homes depends significantly on fund raising, locally and overseas, some through income generating projects. It is unclear if the Government is aware of the percentage these homes mobilize from these sources.

In the private homes there are no standards for financial record keeping, despite the fact that these homes receive Government allocations. The quality of financial records varies significantly. In one home there are detailed financials prepared using appropriate off-the-shelf software. As a result, this home is clear on the cost of operating, and by extension, the cost of care, development and protection of each child. In another home however, there are no financial records; the home operates much like an informal sector business.

The Team reviewed the financial records of 70% of the homes/places of safety that we visited.

Recommendation:

31) That financial standards and procedures for private homes be developed.

4.8 Profile of the Children in Homes

Overview

A survey was conducted of a sample of 42 children from the forty-two homes responding to the survey instruments. It must be noted that with an unscientific sample of less than 2% of the children in homes the results of this survey are not necessarily conclusive, where possible we supplemented the data with that from other records to support or question the extent to which we can extrapolate.

The average age of the in this survey is 9.9 years. Below is a summary of the data from the Survey.

- Approximately 63.2% of the Children are males and 36.8% are females.
- 35.7% of these children have some category of disability*. Of this group:
 - 21.4% are hearing impaired,
 - 14.3% are visually impaired and
 - 50% are speech impaired,
 - 71% have learning disabilities,

*35.7% is the result of the survey instrument to which 42 Children's Homes and Places of Safety, had submitted responses.

- 57.1% have physical disabilities and the majority of these cases are considered to be severe while
- 42.9% with mental retardation

It is important to note that none of these groups are mutually exclusive. Therefore a child with mental retardation is likely to have some level of physical disability and also have speech impairment.

- 38.4% of the children have a range of medical conditions, with the primary one being asthmatic, 40% are asthmatic.
- Several have behavioural problems. A significant number of those with behavioural problems are found to be aggressive. 56.7% of the sample is found to be withdrawn, suicidal or stubborn as a stated behavioural problem.

4.9 Admission to Homes

This section summarizes how children were admitted and the reasons they were “turned over” to the Government for care and protection. With 60% of the caregivers indicating that they were unable to cope underscores the need for parenting and community support in childcare.

- About 60% of the children are admitted to the children’s homes after getting a Fit Person Order from the courts, establishing the need for removal from their former residence.
 - The majority of the referrals were made by a Children’s Officer (40.5%) or the police (28.2%) while some 18% were from the children services division
 - Fifteen percent (15%) are admitted through referral by a parent or caregiver

- Fifty (50%) have been abandoned or neglected
- Fifteen (15%) of the children were being sexually abused before entry into the homes
- Ten (10%) were orphans
- Sixty percent (60%) of the children had caregiver that were unable to cope with them. Of these:
 - 30.4% of them were noted as a child beyond parental control and
 - 25% were delinquent or guilty of criminal activity another
 - 40% were overwhelmed with the challenge of caring for a child with significant disabilities

4.10 Formal Education / Occupational Therapy

The results of the survey indicate that eighty nine percent (89%) of the children are receiving formal education, training or occupational therapy.

(a) Non-Disabled Children

Visits to homes and review of records indicate that non-disabled children are for the most part mainstreamed into traditional primary and secondary schools. The challenge these children face is less one of access to school and more one of the quality of education they are receiving and the appropriate support once back in homes to undertake after school assignments and ongoing studying

From the survey:

- ◆ 38.9% are receiving full time education at the homes
- ◆ 11.1% are receiving part-time education at the homes

- ◆ 28.6% are receiving full time education elsewhere while none has reported part-time education elsewhere
- ◆ 22.9% receive vocational training at the homes but none reported receiving vocational training elsewhere.
- ◆ 17.1% are part of a structured recreational programme

(b) Children with Disabilities

Overall, for children with disabilities less than 10% island-wide are in a structured off-site education programme, and the majority of these children reside in one home. The problem of placing children with development disabilities in a structure learning environment is more a reflection of the inadequate allocation of resources to meet the needs of educating children with mental retardation and other disabilities.

For children with severe and profound development disabilities the ‘content’ and/or stimulation exercises are in all but one case woefully inadequate. There is little urgency about the need to have ‘aggressive’ and sustained therapy to ensure maximum independence for a child with a development disability. From the survey five percent (5%) are in receipt of some degree of occupational therapy

There is also a lack of therapeutic care, in the home, for children with behaviour problems. Thirty-six percent (36%) reported that they have referred such children to therapeutic care elsewhere, but this did not indicate any sustained therapeutic programme.

4.11 Separation from Care

The State has no written guidelines for Separation from Care Procedures. Homes visited have a range of practices none of which, including one with a relatively formal system, have written guidelines.

In the focus group with a random sample of children from homes they spoke to the level of uncertainty about their life once they leave the *home* “.....*the home should prepare us better into the real world. There should also be a programme for us once we reach 18 years old...*”. In our meeting with one former ward he indicated that he received little guidance on what to expect and what options existed prior to his leaving at the age of 18.

Neither the homes nor the Ministry conduct any structured tracer studies/follow-up of all or a sample of leavers to determine how they are adjusting once outside the home. There is need to review the impact of life in a home on the children’s ability to socialize.

Two of the thirteen (13) Homes visited by the Team offer a semblance of a separation from care programme, one has an apprenticeship programme on site and has developed a series of useful manuals to support the areas of skills training. Another home has converted two rooms into – ‘half-way facilities’ for children who at age 18 may have secured employment. The facility provides the necessary transition for the young adult, however this can only accommodate two (2) persons at any given time.

For homes with children with a disability there is no policy regarding ‘separation from care’ it is generally accepted that a child with a disability will live in the home until s/he passes. The reality as expressed by the Supervisors is that there are no external options for children with severe disabilities. The children may learn life skills, however, there is no environment in which they can function in assisted living homes. One home, with

significant external funding, has established a series of group homes where they house persons with severe mental retardation who range in age from 18 – 35.

Recommendations:

- 32) The Ministry of Health should develop written policies and guidelines for separation from care
- 33) Tracer studies to determine how children are coping after separation.

4.12 Employee Information

A total of 248 employees from forty-two (42) children's homes and places of safety were asked to respond to questionnaires the break-out of those responding is set out below:

- 5.7% are nurses or nurse aides.
- 11.3% are duty officers and
- 10.9% are cooks.
- 9.2% are teachers or instructors while
- 7% are housemothers, the director, superintendent or the social worker respectively.

The average age of the employee is 42.2 years; the majority of the employees are females, accounting for 67%, while 33% are males.

(a) Education/Training

- The majority of the employees have completed primary level education.
- Just over 50% have completed secondary level education and 15% have completed tertiary level education.
- 20.6 percent have reported completed other levels of education, such as vocational and other special courses or skills training.
- All have reported receiving job related training while 77% have participated in special training, in- house training or external training.
- Most have reported attending their last training sessions between 2002 and 2003. The major areas of training that were participated in were conflict resolution and behaviour change as well as stress management and coping with all types of abuse.
- 107 indicated that they desired additional training

(b) Years of Service and Evaluation

- 29.45 of the workers have been employed for 11 years or more while
- 18.5% for 8-10 years
- 23.8% have been employed for 2-4 years,
- 16% for one year or less
- 39.5% of the employees stated that they have not been evaluated,
- 48.8% were last evaluated in 2002.
- 6.9% were evaluated in 2001 and 2.8% in 2003.
- 4% were evaluated in 2000.

(c) Job Description, Average Work Week & Compensation

- 65.3% have reported having a job description while 14% have no particular job description
- 74.2% are contracted to work for 40 hours per week.
- 34.7% do not work outside of their contracted hours per week while the amount of additional hours worked by the others vary significantly
- The average employee's salary is approximately \$15885.52 per month.

4.13 Physical Environment

Team Members did physical assessments when they visited the homes/places of safety. The conditions of the homes visited varied. The Team visited a total of fifteen (15) homes; of these 10% are in need of minor repairs; 40% are in need of moderate repairs; 35% in need of significant repairs.

Case 1: For this home, which is a privately run facility, the main building needs to be re-roofed. The building is infested with termites, the trap doors to the ceiling are missing but upon investigation, there is a visibly high level of rot and deterioration. There are no hurricane straps on the building. On this visit, rodent infestation was noticeable, as 'droppings' were seen in certain areas of the main building.

The sleeping accommodations are inadequate with a 15 x 15 room sleeps 8 girls on bunk beds. There are centralized cupboards for storing clothing for children. Although the shelves are labelled, there was general disarray in the cupboards, very little sense of individuality. There are caregivers who live in the dorms; however they are assigned individual rooms and a bathroom and in all cases the lighter and more airy rooms. The

accommodations for the Superintendent differs significantly as she occupies a 1400 sq. ft. unit. The main building was constructed in the 1930's and the supervisor's quarters in 1967-8.

On our visit we found that the indoor bathrooms were locked; children are expected to use outside facilities, two traditional pit toilets. The initial explanation that they were locked because the children make a mess of them in the day was not logical as at the time of our visit all the children were out at school. Indications are that these bathrooms are open for use early in the mornings and late at nights, the latter to allow the children to brush their teeth.

Fire extinguishers had not been checked in 15 months. There are inadequate fire extinguishers in a building where the primary building material is wood. The extinguisher in the kitchen had the pin removed and the one in the general/recreational room was inappropriately placed, and access would be difficult, in the event of an emergency.

There is an external play area for the children, however all the equipment are unusable and unsafe. During our visit we commented on this and the Superintendent noted that a child had fallen and broken his elbow while in the play area.

In the midst of this unacceptable environment there are plans to submit a request to Jamaica Social Investment Fund (JSIF), to construct accommodations to host persons, members of the parent church, who visit the home from time to time to do 'good works'.

Case 2: This privately run place of safety, originally a single-family dwelling unit has seen a series of 'add-ons' in an effort to increase physical space for the children. Funding for some of the renovation was received from the Jamaica Social Investment Fund.

Thirty-five children live at this place of safety (POS); the internal recreation area is a dark 12 x 15 room with seating for a maximum of 8 children. Dining facilities are equally cramped; you are left to conclude that the children eat in shifts.

There is clearly a sustained water problem, in a home with fifteen percent of the children with moderate to profound development disabilities; this increases the problems that irregular water supply usually presents. At our visit there was an eighteen year old lying in her faeces. There is an outside tank but we were advised that there are problems with the tank. It is interesting to note that the National Water Commission for the Region in which this place of safety is located has 'adopted' the Home.

As a result of the series of add-ons, it was clear to see how the places of safety could be a firetrap, yet one of the three extinguishers was not functional; there have been no fire drills. The caregivers had no knowledge of how to use the fire extinguishers. The bathrooms, built from JSIF funding, are inadequate and not easily accessed for children with disabilities. There is a school on-site for the non-disabled children; the classroom was not conducive for learning. The places of safety has playground equipment, donated by the NWC Region, which was in fair condition.

Case 3: This home for children with development disabilities run by a non-government organization, is in an unacceptable condition. It has clearly deteriorated; a result in part of limited funding but also an absence of experience in the operation and management of a Home for children with disabilities.

The home is a two-storey unit, inappropriate for children with disabilities; it presents risks and challenges for the children with development disabilities.

The only Inspectorate Report on file for this Home notes in 1998 that *'there was no offensive odour present'*. In a brief October 2001 report the CSD again commended the Home for its *"relatively high level despite the limitation of the children they cater to"*. It

is unclear the yardstick for measuring quality, however on both our visits there was an 'offensive odour' at the home. As this is now, May 2003, some fourteen (14) months after the CSD's last recorded inspection it could be that things deteriorated during that period, or that level's of expectation and standards by the CSD are low.

The October 2001 Inspectorate Report ended with a note that the Superintendent had satisfied the Jamaica Fire Brigade requests. However, in a correspondence of January 2002 the Fire Prevention Department of the Fire Brigade wrote indicating that following its inspection of the property concluded that that *'the premises is not being operated in conformity with Standard Fire Prevention Practices'* and gave a list of things which needed to be done. The Director of CSD forwarded this correspondence to the Home and concluded in his letter with the following *"I appreciate that you might not be able to undertake all at one time and I suggest that they be prioritised and phased over time"*.

The compounded implication of a fire in a two storey home; children with disabilities; no regular fire drills; inadequate staff to move the children quickly to safety, appears to be lost.

The rooms are sparse, with the explanation that *'these children will destroy the toys which are donated'*. There are no adequate storage areas for clothing for each child and there is no indication that each child has her/his 'wardrobe'. Clothing is grouped by age and gender and not by the name of the child.

Recommendations:

- 34) The Child development Agency should establish a time-table to carry out inspections of the physical facilities of all homes

- 35) Establish minimum standards for physical facilities such as number of bathrooms based on occupancy; special design of buildings to facilitate children with disabilities; allocation of sleeping space and minimum outdoor and indoor recreational facilities

CHAPTER 5 MONITORING OF ACTIVITIES

5.1 Overview

It is necessary here to restate the difference between Places of Safety (POS) and Children's Homes. Places of Safety are intended for short-term stay (approximately two months) and are the interim accommodation before the Courts issue a Fit Persons Order. Children's Homes are intended for long-term stay to which wards are assigned, segmented by age, gender and space availability. As at March 2003, there were 2,402 children in institutions. Of the fifty-seven (57) institutions, twelve are Places of Safety (POS) and 45 are Children's Homes.

5.2 Current Inspection Mechanisms

It was found that Places of Safety are operating as Children's Homes due to:

- Delays in processing wards at the Family Court level
- Overcrowding in the homes
- The sheer volume of children to be processed

The above situation calls for a process of monitoring which will ensure that no ward is allowed to fall through the cracks of the institutional care system.

Inspection is at present carried out by one Deputy Director Inspector who is assigned to the Head Office of the Child Development Agency (CDA). Assistance is provided through the utilisation of the services of the Social Workers who are located in the Regions and who are required to visit wards in the Institutions as the need arises.

5.3 Methods of Inspection

The methods of inspecting are as follows:

- At least one announced/unannounced visit per year. With one person in the organization and 53 institutions to inspect, only one annual visit is possible;
- Regular telephone contact with institutions;
- Discussions with Board members when necessary;
- Perusal of annual work plans;
- Staff meeting with Superintendents and Assistant Superintendents.

At each annual inspection an Inspectorate Report is prepared, which is a checklist with information on the physical conditions, number of children in the home, collective data on the individual child etc.

5.4 Policy Analysis

True monitoring activities were never really carried out in the now defunct Children Services Division (CSD). The monitoring function is a subset of policy analysis by which broad policies are developed, strategies or performance indicators are identified and, in

the case of a service delivery organization such as the CSD, standards are developed. No such documentation exists.

A document was presented entitled “Standards for Quality Care in Children’s homes and Places of safety”, which lacked depth and, is at best, operational guidelines. There is no evidence that these guidelines were being used.

In order to promote effective monitoring, as a means of policy analysis, operating standards should be placed against which efficiency and effectiveness will be determined.

For example, there should be standards for:

- a) Management and administration
- b) Service delivery, and
- c) Quality of care

In this information age, there are many workable models to aid development of these standards. Of course, cultural norms must be taken into consideration in order to ensure the best fit for our local needs.

Recommendations:

- 36) Establish operating standards be established against which performance may be monitored
- 37) There should be annual revision of these performance standards to meet changing needs

5.5 External Monitoring

Apart from the internal monitoring which is necessary to maintain efficiency and effectiveness in any organisation, a national service driven organisation requires an oversight body to ensure that the needs of wards of the State are met. To this end, it is proposed that a Board of Visitors be established which will be responsible for:

- Making announced/unannounced visits to institutions at regular intervals;
- Ensuring that remedial action is taken based on the outcome of those visits.

Each institution should have a strategic plan for service delivery and those plans should be developed annually in collaboration with the Child Development Agency. The plans would contain the following:

- Institutional objectives
- Standards of care
- Guidelines to operations
- Performance indicators
- Desired inputs
- Desired outputs
- Final outcomes

The above should be used as performance measurement tools.

Recommendations:

- 38) A Board of Visitors should be established which will report to the responsible Minister of Health on the performance of each place of safety and children's homes
- 39) Annual strategic plans should be prepared for each place of safety and children's home.

5.6 Children's Opinions/Complaints

Article 12 – United Nation Convention on the Rights of the Child

1. "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

2."For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law."

At present, there is no institutional arrangement to facilitate the airing of opinions and complaints of the wards of the State. It may be argued that there are Home Superintendents and other caregivers who are willing to listen. During the Review we found that children appeared nervous and suspicious when asked questions. This

prompted the scheduling of a Focus Group Session for children outside of the Home environment. There was greater enthusiasm to speak out, but one day was not enough to establish the degree of freedom that we desired. The outcome of this session has already been discussed in Chapter 2

As the Review progressed, and presumably, as the ‘network’ established the presence of the Committee, children began to send requests for interviews. Such a practice should be encouraged and there should be inculcated a general awareness of the right to complain.

Recommendation:

- 40) Responsibility for hearing opinions/complaints of wards of the State be vested in the recommended Board of Visitors.

CHAPTER 6 CHILD DEVELOPMENT AGENCY

6.1 Overview

The Child Development Agency (CDA) came into being on the 1st April 2003. It was established under the provisions of the Executive Agencies Act and incorporates the:

- Children's Services Division, MOH;
- Adoption Board;
- Child Support Unit, MOH.

The intent is to give greater autonomy in the management and delivery of services to the children of Jamaica.

The Mission Statement is as follows:

“To develop, implement, co-ordinate and regulate national policies and programmes that promote the welfare of all children, meet Government's obligation to international standards for children, and assist in making children capable of maximising their potential.”

Specimens of the of the Organisation Structure for Head Office and the regions are shown in **Appendix VII & VIII** The Regional Structure to facilitate operations throughout the island will remain essentially the same with the difference being a compacting to four instead of six regions and the assignment of key personnel now in the Head Office to Head these Regions.

At the Head Office level there is an improvement in the support functions through the provision of research and development, corporate planning and data entry personnel. However, the technical personnel, who are needed to steer the intake and assessment activities, need to be included. Greater emphasis needs to be placed on the linkage between the Family Court and the CDA through the strengthening of the Social Workers cadre and the provision of psychiatrists and psychologists who will work along with the Family Court to move wards swiftly through Places of Safety.

The tracking of wards through the use of computer-based systems should also begin at the intake level to ensure that the needs of the wards are met efficiently and that none falls through the cracks and be forgotten. The needs of the wards currently in the system should also be addressed through a planned programme for immediate assessment with a view to:

- Returning them to their homes
- Adoption
- Identifying foster parents

Institutionalisation should be the last resort.

Recommendation:

- 41) The organisation structure of the Child Development Agency (CDA) should be reviewed to reflect staffing which will meet the direct needs of wards of the State.

6.2 Monitoring at the Head Office Level

While the monitoring function is mentioned in the Region, there is no provision for monitoring at the Head Office level. The importance of managing and implementing the monitoring process in Places of Safety and Children's Homes cannot be overemphasised. There must be monitoring at the internal as well as the external levels in order to ensure conformity with standards and guidelines; and thus improved the quality of service given to wards of the State.

Recommendation:

- 42) A monitoring structure and staffing should be introduced into the organisation structure of Head Office of the CDA

6.3 Expanded Activities

The mission statement of the CDA points to “develop, implement, co-ordinate and regulate national policies and programs that promote the welfare of all children”. The organization structure as presented, does not reflect the institutional arrangements, which are required to meet this mandate. Care should be taken to ensure that not only the needs of children in institutional care are met. Provision should be made for all groups of children eg. Street children etc.

Recommendation:

- 43) The organizational structure of the Child Development Agency should be reviewed to reflect the needs of *all Jamaican children*

6.4 Training

For the CDA to be successful in its drive to improve the level of care in institutions, it must begin to change the organisational culture that now exists. This puts the focus on training and reorientation of suitable staff with at least a basic knowledge of childcare and development. The training provision of the new structure does not allow for the development and execution of a viable training programme.

Recommendation:

- 44) The training apparatus of the CDA should be strengthened.

6.5 Computerised Database

Data from the Children's Services Division (CSD) revealed that, as at March 2003, there were 1,734 wards in Children's Homes and 668 in Places of Safety.

It is not possible to do an effective monitoring of operations of Institutions with the manual system, which now exists.

The August 2000 KPMG Report entitled "Modernisation of the Children's Services Division" recommended greater use of technology in the management of information on

children. We reiterate that steps be taken to develop an information system which will capture data on all aspects of operations of institutions. The monitoring activities would therefore be greatly enhanced.

Recommendations:

- 45) A Management information system be developed which will be able to record and retrieve data relating to case files for each ward of the State and operational activities of each institution.

CHAPTER 7 PUBLIC RESPONSE

7.1 Focus Group Sessions

Early in the Review it was recognised that given the depth of the subject matter, inputs should be invited from the public and interested parties. Consequently, advertisements were placed in the voice and print media requesting that comments be sent to the Review Team. There were also requests made to individuals and public interests groups.

Based on the excellent response, it was decided to schedule Focus Group Session in order to garner all available comments and recommendations. The Sessions convened were with:

- Social Workers
- Superintendents of Homes and the Police
- Physicians
- Non-Governmental Organisations (NGOs)
- Randomly selected wards of the State

The feedback received was useful and informative and served to cement some of the recommendations of the Review Team. It is proposed that these group sessions be introduced in the CDA as a means of community outreach to include parents, foster parents, adoptive parents, civic groups, churches and other interested parties.

The results of the sessions with the wards of the state have already been dealt with in Chapter 2 of this report. Please find in *Appendices II to V* the outputs of the session for the other groups. At *Appendix VI* is a list of persons/public interest groups who contacted the Review Committee.

Recommendations:

- 46) That the CDA introduces a programme of community outreach through Focus Groups / Town Hall Meetings with groups interested in the welfare of children in their communities.

7.2 Written Submissions

A number of written submissions were received and this served to reinforce the notion that, given the medium, interest groups are willing to speak out. As is the case with other material submitted to the Review Team, anonymity will be maintained but we consider it important that the points raised be published.

Set out below is a list of issues raised. We are indeed grateful to the public for contributing so substantially to this exercise.

- Government is to be congratulated for the courage to offer review
- Congratulations to the Team for the approach to the review and best wishes
- The rights of the parents to know the movement of children between homes, hospitals etc.
- Physical abuse to Wards
 - Beatings – unnecessary restraint eg. knees in chest etc. girls being hit on the breast and pubic area
 - Solitary confinement
 - Kneeling on sharp objects
- Unruly behaviour of wards eg. breaking down fences and open sexual activities
- Untrained staff in homes and places of safety

- Poor handling of newborns
- Sexual abuse to wards
- Inappropriate use of financial donations
- Misuse of food and gifts to homes and places of safety
- Suggestion regarding leisure time activities
- Need for increased paediatric and psychiatric personnel
- Need for increased monitoring
- Verbal abuse to wards
- Wards do not benefit from commercial activities
- Poor child to caregiver ratio
- Lack of proper supervision of wards
- Experiences of past superintendents of homes

CHAPTER 8 CONCLUSION

Physician's Focus Group - *“There is no quick-fix”*

The recommendations contained in this Report point to five (5) main categories, namely:

1. Improvement in the intake and evaluation process, from the Family Court to the Ministry of Health. Less emphasis should be placed on institutionalisation
2. Introduction of a process whereby the physical, educational and psychological needs of the children are met, both for those considered normal children and those with disabilities
3. Improvements in accommodations and all amenities in the homes
4. Rationalization, training and development of caregivers
5. Improvements in organizational structures and standards in order to strengthen the monitoring of activities in homes

A common thread running through all the recommendations is the need to immediately begin improvements in the homes and places of safety. The Ministry of Health should now develop a plan of action geared at meeting the immediate needs of homes and places of safety, medium and long term, and to set verifiable objectives and standards against which outcomes will be measured. The UNICEF Report (1999) and the KPMG Report “Modernisation of the Children’s Services Division”, should be factored into the implementation plan.

List Of Recommendations

- 1) Extend the sentencing options to reflect the serious types of offences being committed by juveniles. 12
- 2) Introduce Community Service Orders. 12
- 3) Impose an adult sentence on the juvenile who commits a serious offence and is of an unruly or depraved character. 12
- 4) Increase the penalties, particularly as it relates to Child Abuse. 12
- 5) Where applicable, the juvenile should be referred to the Drug Court for rehabilitation. 12
- 6) Introduce new provisions whereby a Fit Person Order or a Supervision Order may be varied to substitute for another order as the changed circumstances warrant. 12
- 7) Amend the rules of evidence to admit the unsworn evidence of a victim, in sexual cases, notwithstanding being of tender age, without the need for corroboration. Safeguards, in the form of psychological tests, can be applied. 12
- 8) Increase the quantum of the Contribution Order payable by a parent or guardian who has the ability to pay. Payment should not be restricted to the imposition of a Fit Person Order or a Correctional Order. All parents or guardians, who are able to pay for the support of their children whilst in care, should contribute. Their contribution should be regarded as part of their role as a parent. 13
- 9) Empower the Social Worker/Children's Officer to send a juvenile for assessment where the assessment team so directs; the juvenile can be placed with a therapeutic foster parent for a temporary period of three months. The juvenile would not need to be sent to an institution, nor go before the courts as a prerequisite for payments to be made to the foster parents, as is now the case. The proposal would reap the triple benefit of reducing not only the numbers coming before the courts but those being placed in an institution and most importantly, be of benefit to the juvenile. 13
- 10) There should be a physical separation of
 - a. Juveniles in need of care and protection
 - b. Those deemed to be uncontrollable
 - c. Those who have committed criminal offences20
- 11) A team of professionals (paediatrician, psychiatrists, psychologists, mental health officers, social workers, psycho-educational specialists) in each of the four health regions should be identified to carry out the evaluations. The team should also include persons from the public and private 21
- 12) The procedures relating to the intake of juveniles should be developed and documented within the Ministry of Justice (Family Court) and the Ministry of Health, from the point of entry

- to the childcare system to the placement in Places of Safety and Children's Homes. 24
- 13) The number of wards in the institution (Places of Safety and Children's Homes) should be drastically reduced to manageable proportions to achieve a ratio of 10:1 caregiver. This ratio will facilitate the provision of a higher standard of care for each ward approximating internationally acceptable standards for juveniles in care. Accordingly, the available resources can be more efficiently applied. 24
- 14) Community based care as compared to institutionalisation as a treatment modality should be pursued. 24
- 15) An aggressive, unrelenting, public education campaign promoting family values and attitudes should be conducted nationwide. This should incorporate the Ministry of Education; corporate Jamaica; the Churches the Family Courts; the Trade Unions, NGO; the Universities, Community Colleges and Service clubs should be urged/required to become involved in the programme. 24
- 16) Tax or other incentives could be offered to corporate Jamaica for its participation. Focus should be directed at the rural poor and to the inner city communities from which most of the wards of the institutions come. 25
- 17) There should be recruitment of more foster parents to foster the juveniles presently in care and those potentially in need of care. 25
- 18) The Children (Adoption of) Act should be reconstructed to facilitate more adoptions of juveniles in care particularly when they are small and can be moulded. 25
- 19) There should be cost effective interventions to families by providing financial assistance in the home. 25
- 20) An Assessment team should visit the institutions to monitor the welfare of the juvenile. When juveniles are utilised as a source of labour when a commercial venture is undertaken in the institution for its viability, not only should the juveniles acquire a skill, but also his/her welfare should be the paramount consideration. 25
- 21) Every child at present in a Place of Safety or Children's Home should have a complete physical / psychological / educational evaluation. This should include
- viii) detailed information about the child's family
 - ix) detailed history of the child's birth, development and immunisation status
 - x) medical history, especially previous illnesses (especially Asthma, Sickle cell disease) and hospitalisations
 - xi) medical examination with laboratory tests as ordered by a Physician
 - xii) psychiatric evaluation

- xiii) school history
- xiv) psycho-educational evaluation if warranted

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22) An individual care plan should be developed for each child. The Children’s Officer, Superintendent of the Home and the child’s parents / family should be actively involved in the creation of this plan.

- *Clear and achievable goals should be identified and monitored*
- *Quarterly meetings should be held. They should include family members, the identified child’s Children’s Officer, the Superintendent of the Home and the Regional Children’s Officer Supervisor. The child should also participate in these meetings*
- *An estimated date of discharge should be identified*
- *During the period of institutionalisation, every effort should be made for child and family to keep in touch*
- *The family should be prepared for the return of the child home.*
- *An in-house medical record should be created for each child and updated when the child attends a medical facility*
- *Repeated assessments should be done at appropriate intervals.*

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23) A long-term strategy must be implemented to minimize the entry of children into Children’s Homes and Places of Safety. This strategy will require collaboration with the Ministry of Labour & Social Security and the Ministry of Education, Youth and Culture. The Community in which children with developmental and/or physical development and their families live and work also has a critical role to play.

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24) Alternative strategies must be explored, which should include financial support to family units willing to care for their disabled child at home; Build a community environment, providing information on opportunities, working with relevant Ministries to create opportunities for these families.

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25) Provide through its clinics ‘special needs extension workers’ to support families and do a level of monitoring of disabled children at home. The Health clinics should provide scheduled community based-services for evaluation, development programme review in addition to health care needs.

52

26) The Ministry of Health, with the Ministry of Education, Youth & Culture, should explore the

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provision of ‘respite care’ and special day care facilities where parents can leave their child with a disability for brief periods to allow them the opportunity to work and nurture any other child who may be in the household.	52
27) Establish standards for homes that have been established for children with disabilities. There should be a time frame for compliance for existing homes.	53
28) Establish the actual cost of care and support for children depending on the level of disability, then enter into a clear agreement with each home regarding the level of Government funding or support, it will receive and what is expected from the home to keep their accreditation.	53
29) That the Ministry of Health develops policies and guidelines which will enhance the process by which adequate governance of homes is monitored	56
30) That the ratio of staff to children be standardized as follows:	
I. Children with disabilities - 1:3	
II. Normal Children - 1:10	58
31) That financial standards and procedures for private homes be developed.	60
32) The Ministry of Health should develop written policies and guidelines for separation from care	65
33) Implement tracer studies to determine how children are coping after separation	65
34) The Child development Agency should establish a time-table to carry out inspections of the physical facilities of all homes	71
35) Establish minimum standards for physical facilities such as number of bathrooms based on occupancy; special design of buildings to facilitate children with disabilities; allocation of sleeping space and minimum outdoor and indoor recreational facilities	71
36) Establish operating standards be established against which performance may be monitored	74
37) There should be annual revision of these performance standards to meet changing needs	74
38) A Board of Visitors should be established which will report to the responsible Minister of Health on the performance of each place of safety and children’s homes	76
39) Annual strategic plans should be prepared for each place of safety and children’s home.	76
40) Responsibility for hearing opinions/complaints of wards of the State be vested in the recommended Board of Visitors.	77
41) The organisation structure of the Child Development Agency (CDA) should be reviewed to reflect staffing which will meet the direct needs of wards of the State	79
42) A monitoring structure and staffing should be introduced into the organisation structure of Head Office of the CDA	80
43) The organizational structure of the Child Development Agency should be reviewed to reflect the needs of <i>all Jamaican children</i>	81
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- 44) The training apparatus of the CDA should be strengthened 81
- 45) A Management information system be developed which will be able to record and retrieve data relating to case files for each ward of the State and operational activities of each institution 82
- 46) That the CDA introduces a programme of community outreach through Focus Groups/
Town Hall Meetings with groups interested in the welfare of children in their communities. 84

FOCUS GROUP MEETING WITH SOCIAL WORKERS

Procedure for Intake and Evaluation

Problems Identified

- Parents are unaware of where their children are located after they are removed from their homes.
Breakdown in communication between relevant personnel.
- Machinery not in place for evaluation, by a psychologist or a physician, when the child is removed from their homes or brought in to the authorities.
- Physician's exam done much later than preferred and sometimes done only when it is deemed necessary.
- Some assessments are done only if ordered by the courts.
- How can it be determined when and under what circumstances a child should be assessed?
Cases such as
 - rape victims
 - abandoned
 - brought in by parent
 - brought in by police
- Children being sent to homes that may not be ideally equipped to deal with their specific needs.
- Children Officers don't have the power to place a child where they think they would be most suited, other than Place of Safety and the courts.

Possible Solutions

- Assessments to be done, if possible, before the child is removed from their home or at a place specifically designed to assess and evaluate the child before they are placed in a place of safety.
- Reorganizing the different homes, and installing a support system, with relevant professionals.
- A psychologist assigned to each region to assess children on a regular basis.
- Assessment of each child's educational level and mental ability.
(health, education, psychological and social development)
- Possible place for assessment based on the type of problem the child might have, for example, behavioural problems or rape victims. Decisions can then be made to determine the best action for the child (whether foster care or counselling)
- Officer should be able to place child in a temporary home without going through the courts.

DEVELOPMENT AND BEHAVIOURAL PROBLEMS

Problems Identified

- Increased number of children coming to court with these types of problems (ages ranging from 11-16 years). One possible reason is from early sexual activities.
- Laws not firm enough. Removal of abuser from the home/location and not the child.
- Improperly trained staff to deal with children who have been sexually abused.
- Checks should ensure that staff are not abused victims themselves and are not reliving this abuse.
- Locating source of bad behaviour i.e. physical, mental, social or developmental problems are not a priority.
- Media involvement affecting both child and parent; confidentiality breached.
- Police unaware of laws to protect children

- Parental monetary contribution to care for child too little.
- Improper placement of children with disabilities.
- Not enough facilities for children with disabilities as they grow older and are not able to take care of themselves.
- Teenagers having babies, who are not fully developed themselves.
- Inadequate number of halfway homes to prepare children who are turning 18.
- Inadequate preparation for independent living.

Possible Solutions

- Design specific programs in children homes to deal with children with problems and also for residential homes.
- Properly trained staff and staff who have not had any personal abuse experience.
- Training for foster parents.
- Withholding child and parents' names from the media.
- Pamphlets in simple English explaining the Rights of the Child.
- Video to inform the public on how to handle children with problems
- Persons encouraged to attend Parenting Skills classes.
- Placing children according to their level of disability and not because they are disabled.
- Day care for children with disability.
- Increased funding for foster parents.
- Renewed family planning campaigns.
- Returning students to formal education.
- Appointment of a Public Officer to provide assistance to the children as well as the parent.

FUNCTIONALITY OF CHILDREN'S HOMES

Problems Identified

- Inadequate number of homes to accommodate growing number of children being placed in homes.
- Ratio of staff to children undesirable
- Some homes in need of refurbishing and to be properly equipped.
- Parents not involved with their children within the homes.
- Teenagers turning 18 inadequately prepared for leaving the homes.

Possible Solutions

- Improve the number of homes to minimize overcrowding and allow children to get more attention.
- Fewer children would allow for more staff to give more productive care.
- Encourage family involvement and decrease length of stay.
- Smaller homes/group homes
- Creating independent living components to each home.

MONITORING PROCEDURES

Problems Identified

- Ratio of caregivers to children inadequate
- Gender needs are not properly addressed through the existing standards as well as those addressing age.
- Inspections and monitoring very minimal
- Standards set are not specific to development needs of each child.
- Licensing too vague, without much emphasis given to basic standards.
- No check listing to maintain level of standard care.
- No internal auditor to work with the external auditor.
- No medium for children to direct any complaints they may have.

Possible Solutions

- Increased number of trained staff.
- More homes to accommodate more children
- More inspections and check listing to maintain a high standard.
- Internal auditing to ease external auditing and accommodating accountability
- More features and standards set for licensing.
- Medium created to allow children to voice their concerns without fear of reprisal.

FOCUS GROUP MEETING WITH PHYSICIANS

Intake Evaluation

- There is no consistency in evaluating children for intake
- The POS is a temporary holding place on entering the system, while the Home is a permanent place of residence
- A child should be brought before the Courts within two weeks of entry in the POS

Sexual abuse of younger children by older children, such as oral sex, is practiced in Homes and POS.

Assessment

- Assessment period should be timelier. Fast processing aids in having the children settled quickly.
- Evaluation should include health (general examination of hearing, vision, testing for infections), nutritional status and education (psycho-educational assessment). Appropriate referrals would be made immediately after.
- Assessment process should begin as soon as the legal process begins
- Behavioural assessment can be done at the child's last school

There is no continuity of care. When a child enters the Home, there is little or no information on the child. The underlined problems are therefore, not easily seen.

The movement of children from Home to Home is also another problem, as well as, children missing appointments due to one or more factors. This also impedes in the continuity of care.

A form to be completed by the Superintendent of Home is needed. This would include basic information, such as: name, address, age, parent/guardian, details surrounding birth of child, school, contact number, other relatives, pet name(s), gender, and landmarks to home/school.

Certain matters have to be kept confidential. Infirmities like allergies and sickle cell need to be known.

We should look at other places to see what they have, eg. Britain, re: intake process (including intake forms).

There are probably now more children in the Home and Places of Safety with HIV.

There should be a sampling of a few of the Children's Homes to find out how many children are in contact with their relatives. Family members have said that they are discouraged in making contact with children. Homes have said that relatives do misbehave when they visit the children in Homes.

We need to evaluate the current needs to plan for the future better.

Screening instruments exist: if a child has hurt other children, if a child shows anxiety (eg. nail-biting), aggression, sleeping in class, suicidal, psychosis screening, odd perceptions, and general personality screeners using psychological instruments. Ask the child's teacher or person in the Home who knows the child best to give information.

Support necessary to address behavioural/developmental problems.

STAFF:

- The process of education for caregivers must be an ongoing one.
- Once this process is in place, persons must become better qualified to run Homes.
- This process can begin now. Caregivers can become certified (in-service training) while they are in the Homes/POS.
- Qualified persons are reluctant to take these jobs as the current positions are underpaid.
- Self-esteem of staff needs to be boosted. This will impact on their care for the children.

- Monitoring of staff is necessary.
- Staff need to be rotated to give the children a chance to be exposed to other persons.

A Social Worker needs to be assigned to each Home, on a long-term basis, or there needs to be a regional group of professionals for the Homes.

The majority of caregivers show an attitude of apathy, which is a cause of the children being distant.

Children with special needs are generally not wanted. The Catholic Church has a different level of care. They view this as their calling; hence the children are treated differently.

Overcrowding in Homes/POS and lack of training, impacts on the care of the children.

Places of Safety sometimes acts as a Children's Home, as persons are there for over a year.

Should Homes be closed? – Points Raised

Restructure the physical location/facility

- A number of children come daily before the Courts but not being moved fast enough out of the POS. The inflow is increasing while the outflow is stationary.
- Sometimes the residential Home is better than the POS
- There is no correctional institute to place girls once they have committed an offence.
- There is the practice of passing on the buck in society by parents, eg. mentally ill.
- Persons must be held responsible for the actions

RECOMMENDATION:

- Intensive rehabilitation programme for children in Homes/POS to teach discipline, social graces, responsibility
- Separate children with criminal offenses from children who need care and protection
- Parents are primarily responsible for their children. Reduce the number of children being born to low-income mothers.
- Need after-school activities – dancing, physical education, and exercise. Volunteers can be recruited to teach children these activities.
- Parenting should be made a national responsibility. There is no quick fix. A national focus on parenting is of absolute necessity. Parenting is a community responsibility.
- The alternative to being in care – located in the community.
- Foster Care Programme needs to be revised to make it more structured. The incentive is small. There needs to be identification and training of foster parents. A marketing campaign can be used to invite persons to foster children.
- The processes for adoption need to be reviewed. (Under the CDA, this process should be revised) – The process needs to be based on our reality.
- Volunteers could care for a percentage of children in Homes. However these people would have to be trained.
- There needs to be social activities in all Homes, eg. Girls’ Guides, Boys’ Scout, Cadets, this can lead to the learning of social skills and discipline.
- The practice of young or troubled children butchering animals need to be addressed.
- The birth rate is generally steady in Jamaica. Approximately 25% of teenagers are giving birth.
- The ability to learn by skills training can be extended by linking with various industries.
- Programmes such as work-studies and apprenticeship can be established for skills training.
- Training is needed in the use of physical disciplinary measures. There are other alternatives to beating, and these should be stressed.
- Funding for Children’s Homes must become a priority of the government, with compulsory contributions from the parent(s).

- Children who require continuous medication need special Homes, where the caregivers monitor their intake of prescribed medication.
- S.O.S. Village is a good system, utilizing small group homes with mother and father. Training is key.
- Attempted suicides and suicidal thoughts are exceptionally high in Homes

FOCUS GROUP MEETING WITH POLICE AND SUPERINTENDENTS OF HOMES

Intake Assessment of Homes/Places of Safety

There needs to be assessment of children at time of admission to Home:

RECOMMENDATIONS:

- Government to appointment professional(s) to see child on admission –physician as a start
- Begin evaluation “normal” kids earlier, i.e. in Basic Schools – must be ongoing. This is a prevention (Research project to identify “high-risk” children
- Have Assessment Centres in all regions
- There must be separation of children – depresses/abandoned from abused/offenders in Homes
- There should be a Neighbourhood watch for children
- Family support – in areas – how to assist parents and children with behavioural problems
- Parent groups in community / church centres
- Community leaders (including “dons”) to be involved and “buy into” parent group programme

ON ADMISSION

- RECOMMENDATIONS:
 - Core of professionals should examine children: Psychologists, Paediatricians, Educational Psychologists, HIV/STDs testing, Asthma/Seizures – Medication
 - It would be good to have professionals in the regions who actually live in that region
 - Identify “high-risk” children early
- Concern re caregivers being exposed to HIV/AIDS – no transfer of information is being done

- Parents are sometimes young, ignorant, and irresponsible. Hence, there is the need for the community to be involved
- Medical facilities uncaring – do not facilitate the rearing of a child
- There are physicians in the community who are willing to see the children
- Need for creativity on part of Superintendents to engage Community resource persons
- Need for RECORDS – each child needs a file. Files lost in transfer: File – Headquarters – back to Home before being sent to new Home
- Loss of educational access when placed in Place of Safety
- Foster Care – need to assess, train, monitor foster parents
- Need money

Behavioural/Developmental Problems

- Wide extent of the problem
- Interventions in home, community and school
- RECOMMENDATIONS:
 - Prevention begins in the home, family and community
 - Involvement of school
 - There needs to be a serious educational national campaign on Family Planning
 - Staff training – course for residential carers. This must be continuous, ongoing training
 - Children’s Officers should live 6 months in a Home
 - Superintendents should have tertiary education, but the wisdom of experienced workers must not be ignored
 - There must be an in-house Guidance Counsellor/Social Worker and easy access to professionals in the area
- Problems manifest themselves within a few days of admittance to Homes, e.g., not wanting to bathe
- Little support presently available for parents. An option, therefore, is to use community resources. One recommendation is to have Children’s Officers in-house to assist with parenting training

- Caregivers should give hope to children by boosting sense of self.
- Caregivers are untrained, ignorant of child development.
- Children are depressed, suicidal. The situation is very scary.

Children with Disabilities

- Children with disabilities (special children) are sometimes not moved to suitable Homes
- There are hardly any places for special children to go once they have reached the age of 18 (most of them will never be fostered)
- Resources are a constraint; a great deal of time is spent on raising funds instead of doing administrative work
- RECOMMENDATIONS:
 - Special children can be mainstreamed into facilities with normal children, by adding the necessary facilities and resource persons
 - Socialisation of special children with normal children

Functionality of Children's Homes/Places of Safety

- Has to be assessed against the aims and objectives of the Homes
- A Children's Home is not the ideal place for a child, rather the child's own home
- Children are sometimes institutionalised to the point where they do not want to leave the Children's Home
- RECOMMENDATIONS:
 - Half-way houses are needed for children over 18 when there is separation from care
 - There needs to be day-schooling for children who need special education
 - There needs to be a greater of cooperation/collaboration with all the parties concerned via communication

- Separation of children charged with offences from other children (the weaker children are prey to the stronger)
- There should be Home specialising with certain behaviours
- Homes are constructed like barracks – therefore the physical structure needs to be amended)
- Although a person is in the Home on a Fit Person Order, this does not necessarily mean that they have not committed an offence. It could be that they were too young to be charged.
- Standards of Care must be circulated to all the Homes, i.e. the A-Z manual of the Family Court
- Police sometimes take juveniles without the necessary forms being completed
- Suggestion: Superintendents should not take children without the necessary forms being completed
- There is a need for the provision of adequate J2 Forms for the Superintendents of the Homes (Suggestion: to photocopy enough of these forms so as to have them in stock
- There needs to be some uniformity in the management process in admitting children to Homes
- Members of staff sometimes have to use their own resources for the running of the Homes

Finance

- Imprest is “woefully inadequate”, so the Home has to say afloat by the ingenious abilities of the staff to make things “stretch”
- Homes are not properly funded
- Private institutions receive half of what the government institutions receive
- There is overcrowding in the Homes
- Supervision orders are not effective
- Return children to their parents if Homes are unable to care for them
- Homes still have to pay GCT. Homes need to have concession on Water, Light, GCT exemptions, and waiver on custom duties. Any allowances would be welcomed
- Suggestion: Government can pay staff for Private Homes
- There needs to be concessions even on the education of the children

- Children are important elements of any society, therefore, money needs to be spent for their welfare
- Proposal for concessions for the Homes
- The objectives of Children's Homes are ultimately for the return of children to parents/guardians
- Suggestions to reduce the numbers in Homes
- Social Problems
 - Attack the problem at the source: poor parenting, irresponsible men and women, dancehall music, disk jockeys
 - Tie tubes of mentally ill persons
 - National education on stopping promiscuity
 - Censorship on TV, radio
 - Place importance on values and attitudes
 - Start with the babies
 - There can be no more double standards between society and homes
 - Change has to start somewhere, it has to start now
 - Public education via the different media houses on a continuous basis
- Something needs to be put in place for the treatment, housing of children with HIV/AIDS
- Distribution of children: some places under capacity, while others filled and over-flowing. This in turn affects the behaviour of the children in the over-filled Homes
- Some children have no bed to sleep on
- Children are having sexual relations with much older adults
- There should be a database to monitor the placement of children with Homes/POS
- Children abscond frequently
- Private Homes can refuse children, Government Homes cannot

Monitoring

- The present Standards of Care is the 4th fourth set in the last 10 years
- Recommendations:
 - The person who monitors need to have knowledge of children and Children's Homes

- The CDA must give an external body the directive to monitor the institutions: persons from CDA, Ministry of Education, HEART, artistes (music), physical education, residential practitioner, Minister of Religion.
- Standards should deal with everything from how they live to the physical premises of the Home/POS, i.e. internal and external standards.

Juvenile's Complaints

- RECOMMENDATIONS:
 - All parties concerned should be present
 - Process may start with child individually. Complain to whom? – the caregiver, the Supervisor, the teacher, the principal. The Superintendent is the last resort. There has to be chain of command
 - There needs to be a legal person within the CDA: a child defender available to children within the Home
 - There needs to be a grievance process

Concerns Raised by Superintendents:

- Superintendents express feelings of being tested by children
- Who counsels Superintendents/Staff/all Caregivers?
- Recommendations:
 - Action should be from Probation Office, instead Superintendent at POS has to agitate the system
 - There needs to be biographical data on Children 's Homes and POS
 - The institutions need strong trade training within the Homes, so that when a child is fit and well they can be sent out to traditional centres
 - Networking/linkages between the institutions to alert other caregivers with especially difficult children / children who may have hurt other caregivers

Look at Model of Miami Boot Camp

Law:

- Corporal punishment can be instituted by the Superintendent on the buttocks or in the palm of the hand
- Remand Centre for Girls needs to be in place
- Half-way house for children should be introduced

FOCUS GROUP MEETING WITH NON-GOVERNMENT ORGANIZATIONS

Assessment of Employees

- There are concerns about the persons who look after the children, as they may not have a genuine concern for their welfare but only works in the home for financial reasons.
- Employees are not sufficiently educated in the field of child care
- Children are taught to act and do thing in a certain way that is not appropriate for the outside communities.
- Staff is not reported to the police when they commit a crime they are instead transferred.

Community Life

- Children are not adequately exposed to the community life outside of the homes.
- Children are ill equipped to deal with community social events and activities such as church attendance.

Financing

- Mismanagement of funds for the homes by board members and superintendents.
- Homes are viewed as money machines, as they are usually recipients of large monetary and material contributions.
- Funds are diverted for personal use by board members.
- Lack of proper monitoring by the Government agencies act as a catalyst for improper activities.
- No authority is wiling to or able to demand accountability.
- Donations of materials for building are misused.
- Superintendents are often left to fend for themselves by asking for donations from the community or using their own personal funds to offset shortfalls.

- Management would sometime solicit sponsorship for a particular project from duplicate sources.

Material Donations

- Superintendents would at times mismanage items donated
- Members would store items at their homes and would grudgingly give a portion at a time to the homes as they see the need for it.

Monitoring

- There is a lack monitoring procedures from governing agencies.
- At most the responses to these queries are that of disinterest and indifference.
- As long as the children are fed and clothed it is of no concern of theirs (the Agencies) as they the homes are at most times privately owned.
- No interest in demanding accountability for the enforcement of childcare laws.

Physical Environment

- Children are forced to sleep study and recreate in tight cramped quarters.
- Sanitary convenience is an inconvenience. Often there are water problems
- Toilets and other daily used facilities are not maintained and as a result often do not fully operate.
- Few fire extinguishers or drills to prepare the children in case of an emergency.
- No inspection by the relevant authorities.

Treatment

- No preparation is made to allow a child a period of transition from private care to home care.
- Medical care is often delayed until the problem is out of control
- Therapeutic care is often nonexistent even when ordered by the court.
- No medical personnel especially large homes/places of safety.

Education

- Often times so called teachers have never been properly trained for students with remedial problems or any other learning problems
- Many “teachers” are not formally trained
- Skills training is thought to be of better use than academics to the residents of the home
- Children are not encouraged to participate in external examinations or are unable to because of lack of proper documentation.

Abuse

- Children are subjected to all type of treatments from the staff and other children ranging from sexual, physical, and emotional abuse.
- Little or no guidelines are present on how to discipline so caretakers take matter into their own hands.
- No recourse for the children when they are mistreated and so they don’t complain.
- Any member of staff beats children with belts, hose, and pipes.
- Girls are hit in the pubic area, and boys locked up for days.

Possible Solutions

- Operations of Children’s home must begin and end with a comprehensive in-depth look at management and the role of the relevant authorities given mandate to oversee their operations.
- Management to be scrutinized very carefully.
- System to be replaced with of one with integrity, accountability and effectiveness.
- Affirm the validity of the regulations, governing the operation of children’s homes
- Regulatory bodies must execute their responsibility in a proactive manner.
- Homes need to have frequent, inspections to ascertain whether or not rules and regulations are being followed
- Impose sanctions when the rules are violated.
- Homes to be financially accountable to the public and to their charitable donors.

- Should be able too justify that every dollar that was received in the name of the children is being spent for their benefit
- Regular audits of financial statements to determine the manner in which homes use their funds.
- Infusion of new culture of discipline, respect for the law, a zero tolerance for corruption and a growing awareness of children's needs.

LIST OF PERSONS/PUBLIC INTEREST GROUPS WHO CONTACTED THE REVIEW TEAM

ATTENDANCE AT FOCUS GROUP MEETINGS

{ Social Workers }

1. Beverley Clarke
2. Carol Daley
3. Mrs. Gordon-Peck
4. Yvonne Hood
5. John Small
6. Gloria Walters
7. Stephaney Webb

{ Superintendents of Homes/Police }

1. Delores Bailey
2. Myrtle Campbell
3. Sister Susan Fraser
4. Beverley McHue
5. Claudette Mitchell
6. Donna Palmer
7. Major Ixmail Poluscha
8. Mr. Stamp
9. Mr. B. Samuels
10. Genard Taylor

{Non Government Organisations}

1. Sherene Barnes
2. Jos Chambers
3. Mildread Dean
4. Monica Dias
5. Glenda Drummonds
6. Marcia Duvall
7. Ronald Good
8. Maxine Jarrett
9. Margarette Macaulay
10. Inez Morrison
11. Patricia Patterson
12. Abdul Rahman
13. Carol Samuels
14. Georgia Scott
15. Iris Soutar
16. Richard Troupe
17. Pauline Watson-Campbell

{PHYSICIANS}

1. Dr. Margaret Robinson
2. Dr. Sandra Chambers
3. Dr. Maureen Samms-Vaugh
4. Dr. Ganesh Shetty

INTERVIEW/CONTACTS MADE WITH THE REVIEW COMMITTEE

UNICEF	-	Mrs. Laila Ismail Khan, Ms. M. Dias, Mr. K. Russell
JCRC	-	Mrs. Margaret MacCauly
Parent	-	Mrs. Renee Irving
Past Ward of the State	-	Dr. Kingsley Stewart
Current Wards of the State	-	24

[Staff of the Ministry of Health]

Mrs. Allison Anderson

Mr. Winston Bowen

MS. Audrey Buddhai

Mrs. Claudette Hemmings

Mrs. Yvonne Hood

Ms. Marjorie Tummings

WRITTEN SUBMISSIONS & TELEPHONE CONTACTS

Ms. Janet Brown	-
J.M. Brown	-
Mrs. J. Rose Brown	
Dr. Sandra Chambers	
Ms. Rose Davis	-
Mr. William Duffs	-
Mr. Ronald Good	-
Prof. Elsa Leo-Rhynie	-
Mr. Pablo Mcneil	-
Dr. Julie Meeks-Gardener	-

Ms. Kay Osbourne
Dr. Phyllis Ramsay -
Mrs. J. Stubbs Ruddock -
Dr. Maureen Samms-Vaughn -
Dr. Leachim Semaj
Ms. Aldene Shillingford -
Dr. Elizabeth Thomas-Hope -
Dr. Rebecca Tortello
Ms Kristin Troy -
Office of the Leader of the Opposition

Appendix VII

ORGANISATION CHARTS OF THE CDA.

Appendix VIII

ORGANISATION CHART OF THE CDA – REGIONS

QUESTIONNAIRES

J2 Form
