



# Annual Report 2011

teen counselling

DRUMCONDRA | CLONDALKIN | TALLAGHT | FINGLAS | DUN LAOGHAIRE | BLANCHARDSTOWN



This report presents information from across the service, but each Centre prepares an individual report which reflects the character of the community which it serves and the particular needs of the local funders and services. These reports are available directly from each Centre. (see pages 27 -29 for Centre details and staff members).

Teen Counselling is funded by:

the Health Service Executive (HSE)  
the Family Support Agency  
the Young People's Facilities and Services Fund  
the Charitable Infirmary Charitable Trust  
as a programme of Crosscare  
voluntary donations.

We are very grateful for the support of these bodies in our work.

Cover picture by Dominic McCarthy





## **MISSION STATEMENT OF CROSSCARE**

**Crosscare's mission is to contribute to the building of an inclusive society by:**

Developing and modelling innovative, high quality, rights based services which meet emerging and unmet needs.

Providing localised support programmes that assist people to attain their rights and fulfil their true potential.

Challenging inequality and prejudice through the development and promotion of evidence based solutions to intractable social problems.

**Homeless Services    Young People's Services    Community Services**



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## Introduction

As I reflect on 2011, it is a challenge to remain positive as the recession is having a significant impact on family life. Some issues which emerged during the year were:

- Parents having to borrow money from teens, thus inverting the normal relationships and dynamics.
- Redundancy or job loss and the increase in parental stress leading to a rise in family conflict which results in reduced skills for problem solving and calm negotiation.
- Separated parents saying that their maintenance allowances are being cut as a result of their ex-partner's redundancy.
- Some parents are remaining in dysfunctional relationships due to financial constraints.
- Parents putting unhelpful levels of pressure regarding school work on 1<sup>st</sup> and 2<sup>nd</sup> year teens because of their own worries for the future for their children.

Despite the problems there were many things to be positive about in our work with teenagers and their parents or carers. In 2011 we managed 480 new referrals to our six Teen Counselling centres and provided a service to a total of 437 families, 281 new families and 156 existing clients. Of the referrals made 92% were placed on the waiting list. Some other figures worth commenting on are:

- only 36% of new teen clients lived with both their biological parents.
- substance misuse and mental health issues have always been high on our list of concerns. 2011 showed an increase in these figures with 19% of new teens misusing drugs (17% in 2010) and 48% of new teens drinking (44% in 2010).
- similarly with self-harm, 12% of new teens were referred for this reason (6% in 2010) but nearly a quarter of new teens, 22%, disclosed during counselling that they had engaged in self-harm (11% in 2010).
- the number of new appointments for the consultant psychiatrist was up in 2011 at 23 compared to 19 in 2010. At the end of 2011 Dr Moya O'Beirne, our consultant psychiatrist of 21 truly supportive years retired and we all joined in wishing her well in the next phase of her life.

In 2011, 276 cases were closed and 41% of families attended a closing session to complete their therapy. We use a wide range of evaluation methods in Teen Counselling (see [Appendix 3 for Teen Counselling Performance Indicators](#)). For families who completed their evaluation process, 93% of parents reported that their ability to cope with the problem had greatly improved or improved, while 88% of teens reported that for themselves the problem had greatly improved or improved.

In September, Teen Counselling Drumcondra saw their 4,000th family since the start of the service on the Clonliffe campus in 1972 and since then 6,706 families have been seen throughout the city. Profiles of 2,008 teenage clients who attended between 2004 and 2011 is presented in [Appendix 4](#). The values and philosophy which underpinned the service in 1972 – of working with teen and parents on a shared set of goals, rather than the teen in isolation from parents – are still valid today. Some recent media reports are worth quoting: The Guardian reported on 17<sup>th</sup> June that according to a survey of 5,700 young people aged 13 -16 (commissioned by the Joseph Rowntree Foundation),\* parental behaviour turns out to be a major influence on adult drinking patterns.

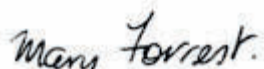


The interim report on the riots in London during summer of 2011 by the Riots Communities and Victims Panel\* concluded that the riots were fuelled by a range of factors including poor parenting. Recommendations included earlier and better support for troubled families.

The theme of the family impact of parental alcohol and drug misuse was highlighted in October when Teen Counselling was invited to present to the national conference "A Family Affair? Supporting children living with parent's substance misuse". Teen Counselling's figures in 2011 for parental alcohol problems among the new families seen were; Fathers 19%, Mothers 13% and siblings 1%; drug misuse problems were: Fathers 4%, Mothers 6% and siblings 1%. The premise that substance misuse problems are 'A Family Affair' is certainly born out in our work.

Research into the effectiveness of the Teen Counselling model of work, which Professor Alan Carr, UCD started in 2010, is well underway. To date there are 50 families in the treatment group. Thirteen (13) families have completed the entire study and 10 (77%) showed statistically significant improvements. There are 20 families in the control group and 7 of those families have completed the study and are now clients. ([See Appendix 2 for Teen Counselling Evaluation Study](#))

As ever, it is the work with young people and their parents which sustains us all. Co-operative work with the Northside Inter Agency Project (NIAP), Substance Abuse Service Specific to Youth (SASSY), and other services proved helpful for clients and productive for both services. Visits to Mater CAMHS and links forged with Child Protection Officers helped to enhance practice for us all. Reducing resources exacerbates the problems of this difficult time and also leads to a reduction in services to help solve the problems. Looking ahead into 2012 we hope that vulnerable teens and parents will not have their services too badly reduced by the on-going funding cuts.



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**Mary Forrest**  
**Clinical Director**

\*Young People, alcohol and influences: A study of young people and their relationship with alcohol by Pamela Bremner, Jamie Burnett, Fay Nunney, Mohammad Ravat and Dr Wilm Mistral for the Joseph Rowntree Foundation, June 2012. (<http://www.jrf.org.uk/sites/files/jrf/young-people-alcohol-full.pdf>);

\*5 Days in August: An interim report on 2011 English Riots, by the Riots, Communities and Victims Panel. (<http://riotspanel.independent.gov.uk/wp-content/uploads/2012/04/Interim-report-5-Days-in-August.pdf>)

## Teen Counselling Highlights 2011

### Referrals made during the year

**480 referrals were made and 92% placed on the Waiting List.** Most referrals were made by parents, **Mothers (63%), Fathers (6%),** highlighting the accessibility of the service. **School (17%), Community Care (18%) and Family Doctors (13%)** were most likely to have suggested Teen Counselling to families. **9%** were recommended by **past clients** and **5%** were **re-referrals** of teenagers who had previously attended.

### Attendance

**437 families** attended during the year, **281 new** and **156** carried over from 2010. The average wait for a first appointment was **128 days** almost 3 weeks longer than in 2011. **5,172** appointments were made. **70%** individual appointments, **71%** of family appointments and **81%** of first family appointments were **kept**.

**Teen Counselling** has a family based model of service; is professionally staffed; has well developed clinical policies and procedures; is readily accessible to local communities; can respond to families in a flexible way and is adolescent friendly.

### Profile of 281 new teenage clients

**56% were under 16 years, 44% over 16 years. 48% were male, 52% female.** 3% were non-Irish. **89%** of new teenage clients were in **second level school**, 20% in 3rd year, 19% in 5th year. **36%** were **living with both biological parents**, 41% living with one parent only, 17% with a parent and partner/step parent.

**22%** of new teenage clients reported **self-harm**, (12% noted on referral). **Suicidal ideation** was reported by **21%** and **suicidal intent** by **11%**.

<b>Drugs</b>	19%	( 8% under 16 years)
<b>Alcohol</b>	48%	(20% under 16 years)
<b>Cigarettes</b>	24%	( 6% under 16 years)

### Why referred

**Behavioural problems at home, school or in the community (59%), family problems** such as conflict, adversity or parental separation (37%), **emotional problems** such as mood disturbance and anxiety (36%), were most frequently referred.

### Underlying problems

**Relationship and communication problems** were evident in **83%** of families. Other family issues were also significant: **parental separation (26%), parent's personal problems (27%), bereavement (20%).**

**Teen Counselling** has a flexible model to meet the needs of teenagers and their parents. The average time from first appointment to closure was **9 months** involving **9 sessions and 24 clinical hours**. Minimum attendance was one session. Maximum attendance was several years.

### Cases closed

**276 cases were closed** and **161** were carried forward into 2012. The cases closed involved **2,572 counselling sessions**. **41%** of families attended a closing session to complete their therapy.



## Teen Counselling Highlights 2011

### Client's evaluation

**32% of families** completed an evaluation process. 90% of parents reported improvement or great improvement in the presenting problem and 93% in their coping ability. 88% of teenagers reported improvement or great improvement for themselves. Positive change at home (89%), school (74%) and with friends (54%) was also rated.

### Counsellor's evaluation

Counsellors using CGAS and GARF scales assessed difficulties for teenagers and their families initially and on completion when they attended consistently. **Average CGAS change was 17 points. Average GARF change was 13 points.**

Counsellors assessed change in presenting and underlying problems for 65% of families.

**Liaising with other services** is vital to ensure optimum support for clients and staff. Staff attended partnership meetings & committees, gave presentations on their work and consulted with other professionals on adolescent issues. They also committed personal time & resources to maintain their professional registration standards (see page 30).

**594 consultations, most usually by phone supported concerned adults.**

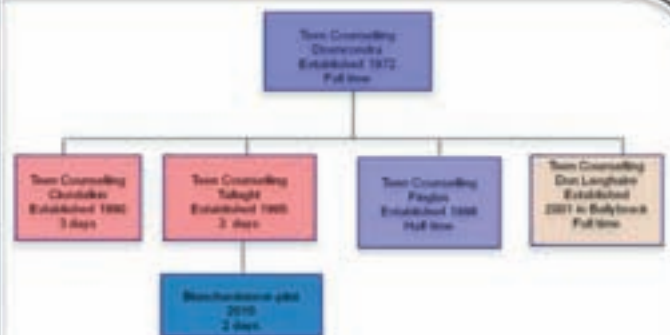
**Psychiatric consultations: 23 assessment appointments and 18 reviews** were arranged for teenage clients with a Consultant Psychiatrist during the year. Referrals were made for 12 males and 11 females.

A research project under the supervision of Alan Carr, Professor of Clinical Psychology in UCD has been ongoing since 2010. This research will identify how well counsellors adhere to the Teen Counselling therapeutic model; how effective 9 sessions of counselling is in alleviating the presenting emotional and behavioural problems and how families experience the service (see page 22 of report and Appendix 2).

### Teen Counselling is funded by:

- Health Service Executive (HSE)
- Family Support Agency
- Young People's Facilities and Services Fund
- Charitable Infirmary Charitable Trust
- as a programme of Crosscare
- voluntary donations

The average cost per family for one year is **€3,164.00**



*For further information about the service contact:*

**Crosscare Teen Counselling, The Red House, Clonliffe Road, Dublin 3.**

**Tel. 01 837 1892 [www.crosscare.ie](http://www.crosscare.ie)**

### Teen Counselling is:

- no fee
- community based
- a generalist counselling service
- for adolescents (12 to 18 years) & their families
- part of Crosscare, the Social Care Agency of the Catholic Diocese of Dublin

**Teen Counselling Drumcondra 837 1892**

**Teen Counselling Clonsilla 623 1398**

**Teen Counselling Tallaght 462 3083**

**Teen Counselling Finglas 864 6014**

**Teen Counselling Dun Laoghaire 284 4852**

**Teen Counselling Blanchardstown 462 3083**



## Referrals to the service

### Referral management, assessment and triage

There is a comprehensive referral management, assessment and triage process in place in Teen Counselling. Referral management and triage is an interlinked process. Triage, the process of prioritising action, is a decision making process that, in the context of Teen Counselling, ensures that the client accesses an appropriate service at an appropriate level and ensures that resources are used in the best possible manner. It provides an immediate first level response to the referrer or potential client, a second level response, and also allows for contact from the referrer whilst the teenager is on the waiting list. It is a recursive process involving clinical and secretarial assessment and judgement. Triage is usually by phone, but sometimes a referrer will call to a local Teen Counselling centre. It involves information gathering, supportive listening, the provision of information and advice, and in some instances telephone counselling by the clinical team. It involves identifying appropriate referrals to the service, identifying appropriate other services for the referrer, and offering a range of support, interventions and advice when required whilst families await an appointment.

#### **Level 1: Screens all referrals to determine if they are generally appropriate to the service**

**Phone call from referrer:** at this level the task is to identify the appropriateness of the referral whilst providing support and guidance to the referrer. Issues including presenting problem, severity of problem and age of young person are considered. The issue of risk and child protection are also considered at this point and our 'interrupt policy' supports this assessment. This may also include recommending referral to the family GP where concerns re: suicide or mental health care are evident and to the HSE social work department where a child protection issue is disclosed. If the problem is such that a young person's needs would be best met in a different service the clinical administrative secretary will recommend an appropriate service and provide information on accessing that service. This decision may be clear at either Level 1 or 2 (see below). The response may also include the provision of written information by post (e.g. an information booklet on bereavement, drugs, alcohol) or guidance on where to best access this information.

**Administrative Outcome at Level 1:** a referral is taken or a consultation form is completed. The consultation form records the contact with the referrer and the information or advice offered.

In 2011, **594 consultation/advice calls** were managed by the team of five clinical administrative secretaries in Teen Counselling.

**480** referrals were taken.

**Level 2: Screens the referrals taken to determine their specific appropriateness for Teen Counselling, to consider any extra information required and the immediate support needs of the family.**

**Centre meetings:** The clinical administrative secretary and counsellors in each Centre consider: the specific appropriateness of each referral and what further information is required. For example if the family is engaged with another service is inter-agency liaison a possibility? This ensures good management of resources and that an appropriate service is offered. Written permission is sought from parents to contact other services if necessary to ensure compliance with confidentiality.

If the referral is appropriate a decision is taken regarding priority, which is guided by the Teen Counselling policy on prioritisation. The clinical administrative secretary notifies the counselling team of any risk concerns and whether a call-back to the referrer by a counsellor has been requested or would be useful.

#### **Administrative Outcome at Level 2:**

- **Referred elsewhere.**  
**In 2011, 35 families were referred to more appropriate services after the Centre meetings.** The high percentage of suitable referrals reflects the familiarity of local professionals and agencies with the work of Teen Counselling and the experience of our administrative staff which facilitates referrers to access services when Teen Counselling is not appropriate.
- **Placed 'on hold' pending the outcome of further clarification e.g. contact with other services.** At the end of 2011, 4 referrals were awaiting clarification.
- **Placed on waiting list.**  
**In 2011, 441 families were placed on the waiting list.**  
The family are advised they are on the waiting list. They may contact the service in the interim to establish where they are on the list, to provide new information in relation to the referral, or to request support from a counsellor.

#### **Level 3: Waiting List**

The clinical administrative secretaries manage the waiting list to ensure that any referrer's need for reassurance and information is met and to maximise attendance at first family appointments. This includes contact with families who do not follow up on their initial referral and those who do not attend or cancel their first appointments, to discuss their need for a service and, in consultation with clinical colleagues, responding to any new information provided by family.



### **Administrative Outcome at Level 3:**

In 2011, **572 referrals were managed on the waiting list**, 131 carried forward from 2010 and 441 new ones.

**281 families became clients (49%)**

**178 families did not become clients (31%)**

- 28 did not attend their first appointments
- 18 cancelled their first appointment
- 132 did not follow up on their initial referral

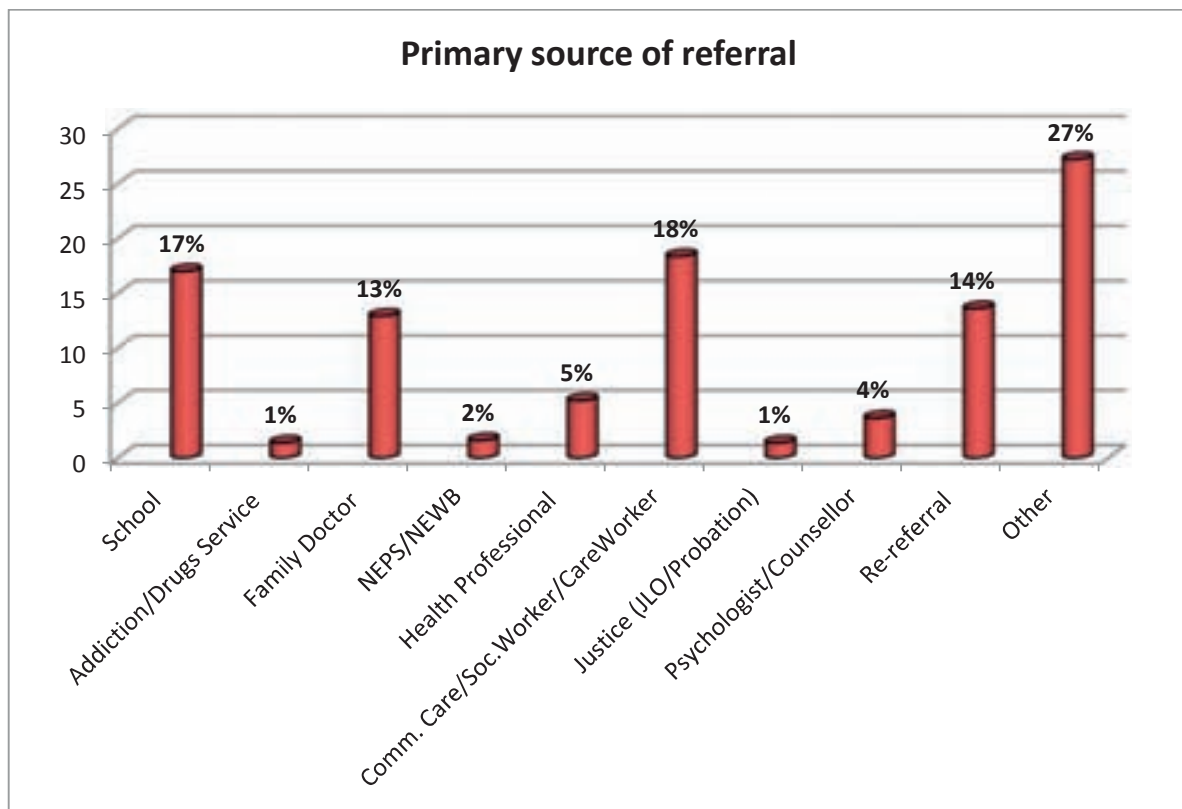
**113 referrals were carried forward into 2012 (20%)**

## **Source of referrals**

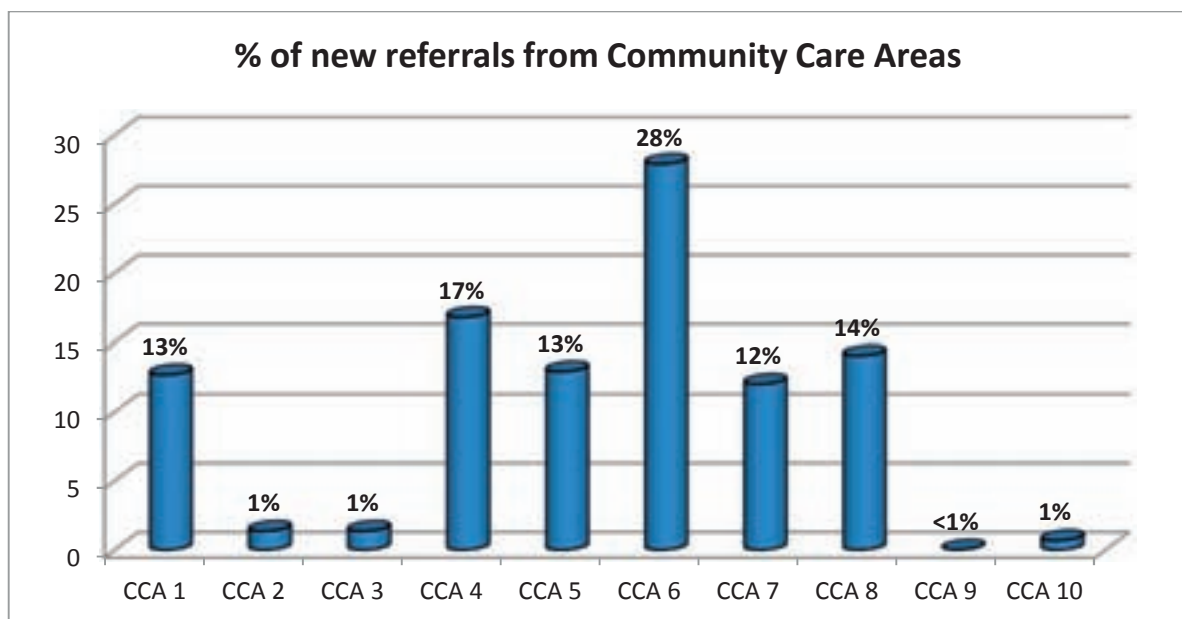
Over two thirds (**69%**) of referrals were made directly by parents, mostly mothers (**63%**). Parental involvement in the referral process increases the likelihood of successful engagement in counselling.

Parents access information about Teen Counselling from a wide range of sources such as the internet (**7%**), word of mouth (**6%**) or various community groups/services (**6%**). However, most are recommended to make a referral by professionals and agencies that have links to their local Teen Counselling.

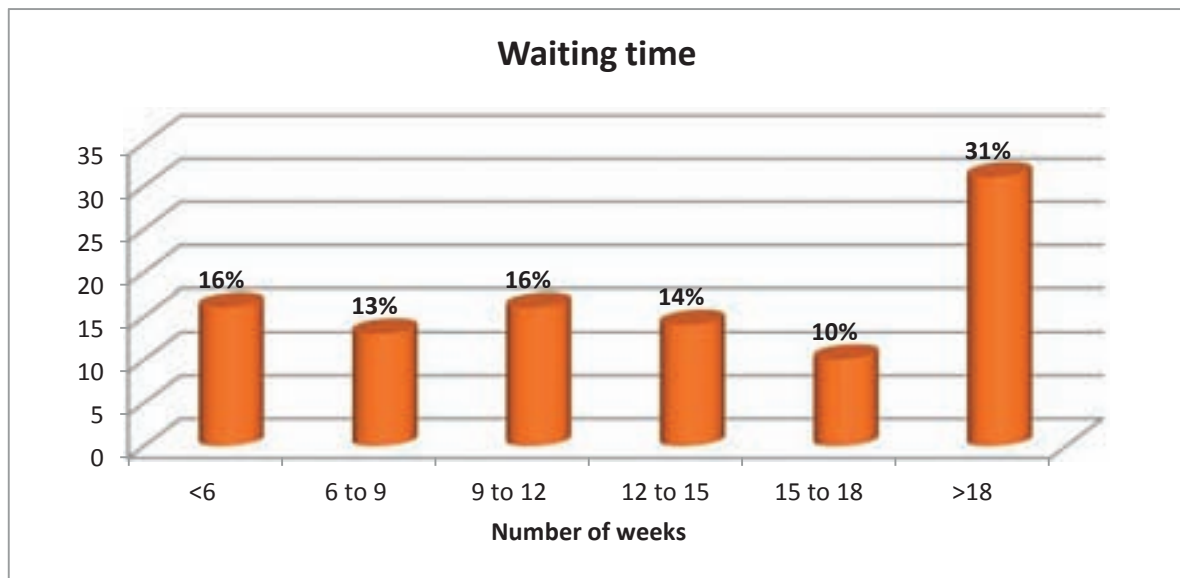
**Schools** were involved in (**17%**) of referrals, either making the referral directly (**4%**) or suggesting to parents that they contact their local centre (**13%**). **Community Care social workers** were involved in **18%** of referrals, most usually direct referrals (**13%**) for teenagers and families they are supporting. **Family Doctors** suggested **13%** of referrals. **9%** of referrals were suggested by past clients and **5%** were re-referrals of a teenager who had previously attended.



Referrals were made from all areas of Dublin. A small number were accepted from families who lived outside the designated catchment areas as the teenager attended school in the area or the presenting problem was early substance use which we prioritise.



## Waiting times

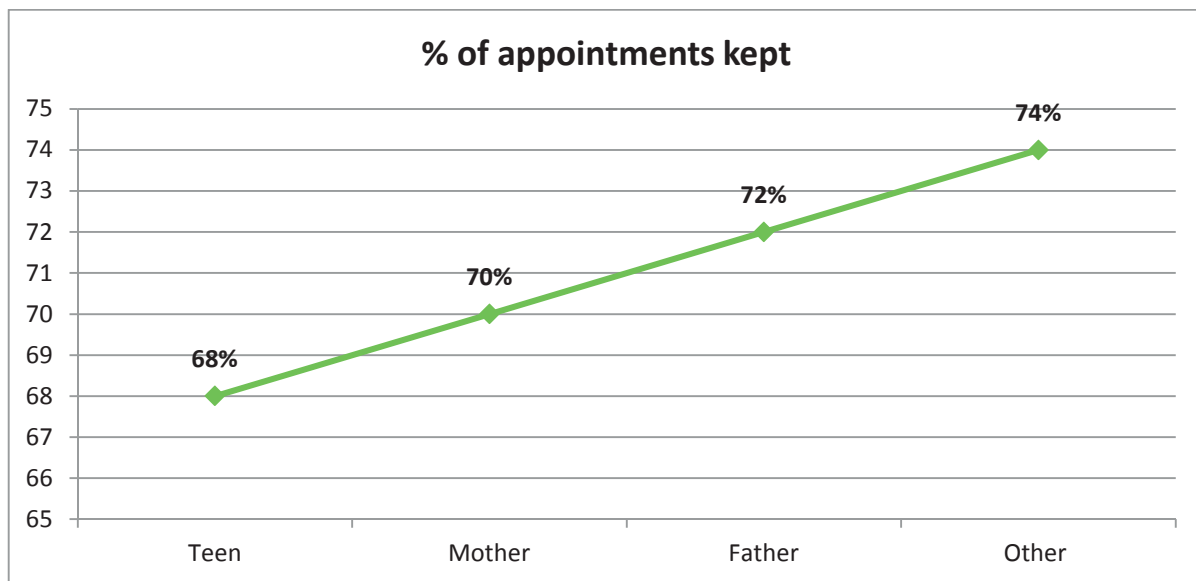


The average waiting time for a first appointment across the service was **18 weeks** (2005, 11 weeks: 2006, 14 weeks: 2007, 16 weeks: 2008, 12 weeks: 2009, 12 weeks: 2010, 15 weeks). Long waiting times do not only reflect the availability of the service, but involve factors relevant to potential clients.

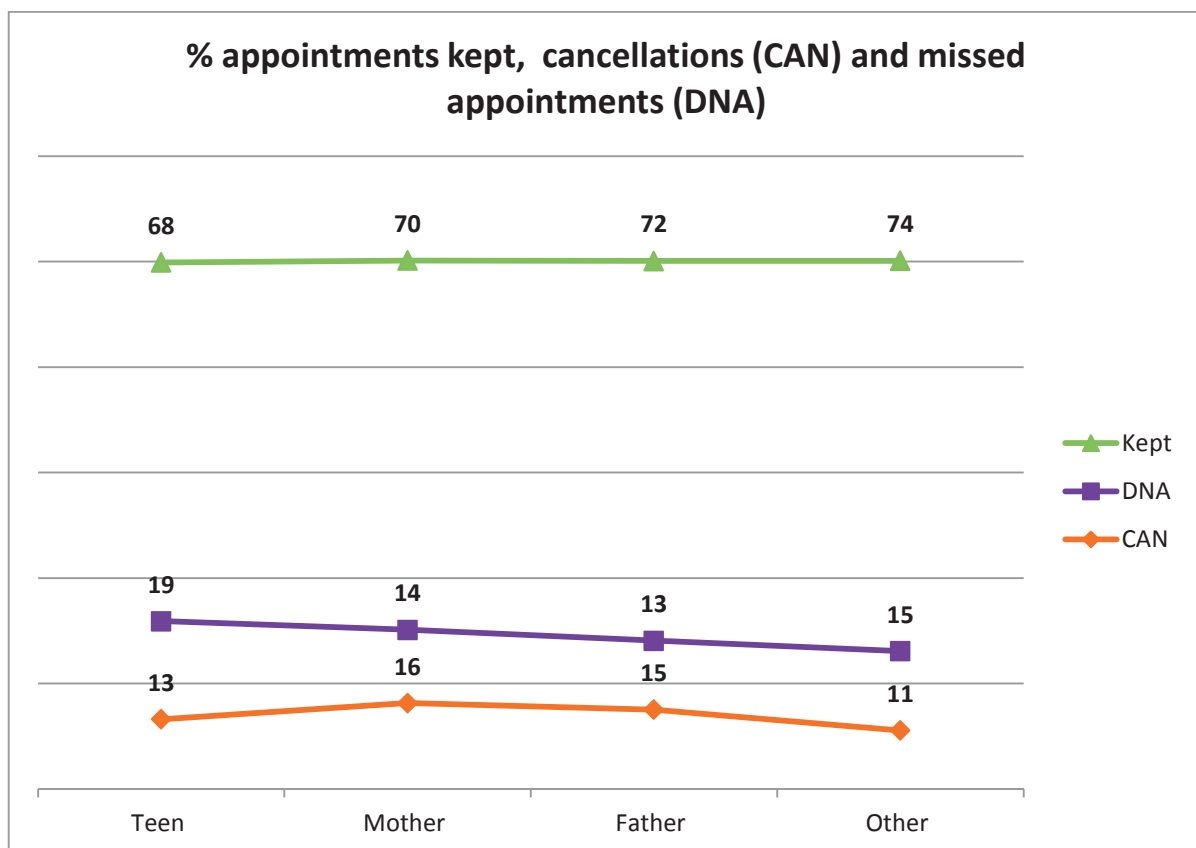
## Attendance

The total number of families who attended the six Teen Counselling Centres during 2011 was **437**. Two hundred and eighty one (**281**) of these were new families and **156** were carried forward from 2010.

A record is kept of both individual and family visits to the counselling centres. Over five thousand, **5,172, appointments were made** for teens, their parents and other people significant in the life of the teenager e.g. grandparents, care workers. On average **70% of individual and 71% of family appointments were kept** with **81%** of first family appointments attended. The attendance rate of teenagers (**68%**) is a good indication of their commitment to counselling. During 2011, strategies were developed to try to further minimise the number of appointments which were not attended or cancelled. The need to maximise our resources at this time of funding uncertainty was discussed with each new family and a system to manage their appointments, which best suited their needs, was implemented.



Others included: grandparents, siblings, care workers, social workers

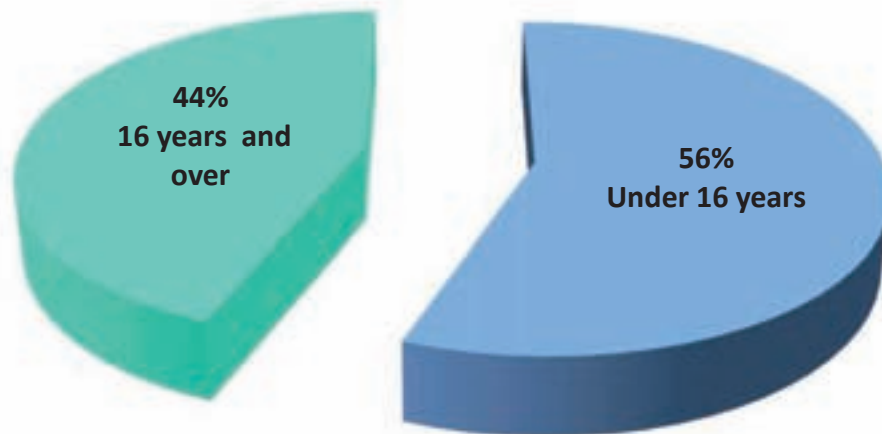


**Total appointments offered 5,712. Family appointments offered 741.**

## Clinical work with new clients 2011

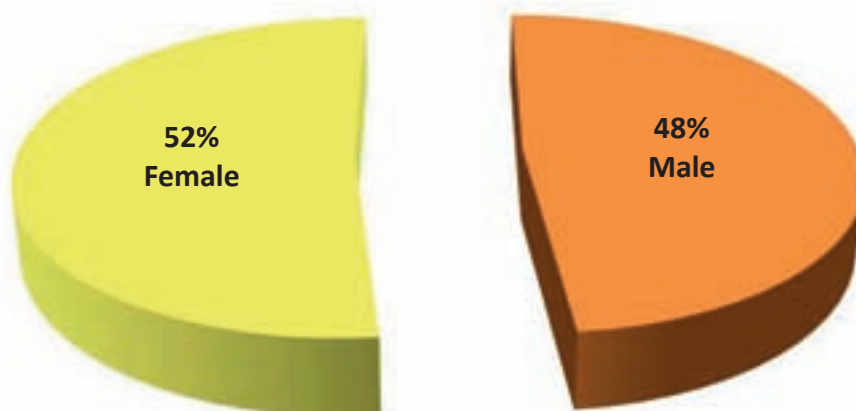
### Profile of new teenage clients N=281

Age profile of new teenage clients

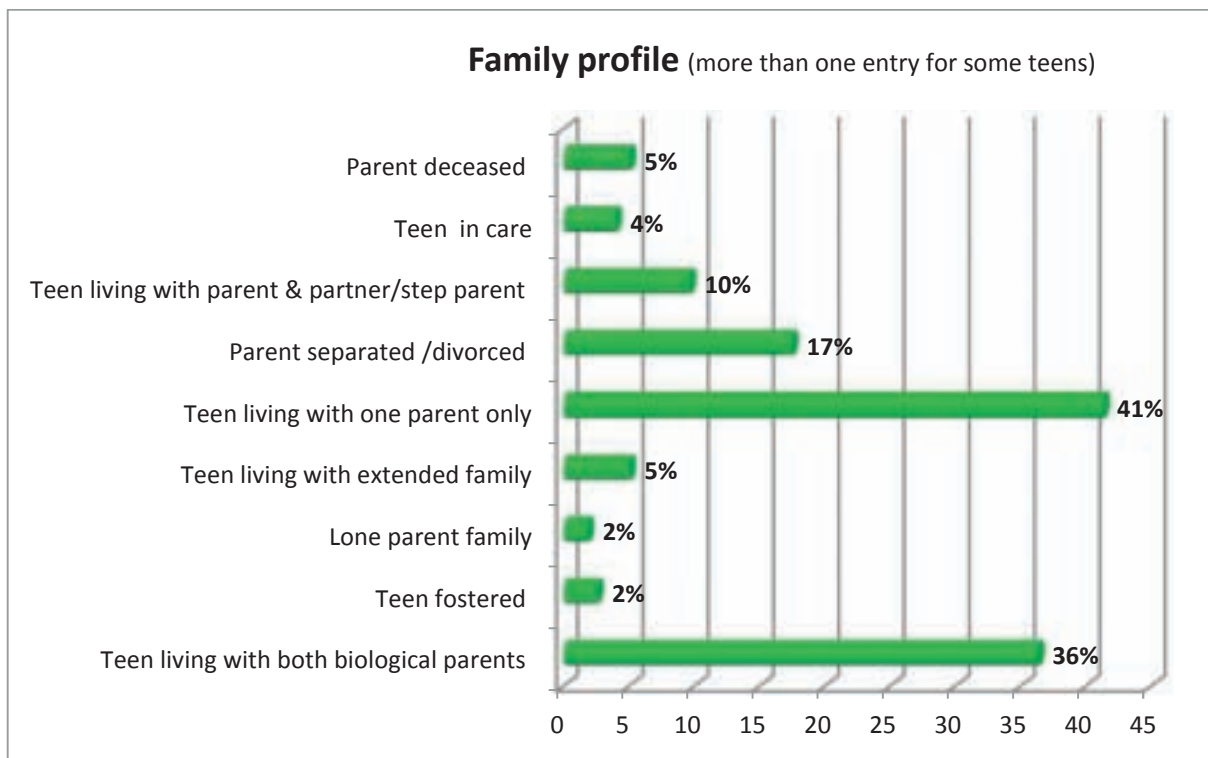


Over the last six years we have noted an increase in the percentage of older teens attending: **2006, 33%; 2007, 38%; 2008, 46%; 2009, 44%; 2010, 44%; 2011, 44%**. The majority of new clients were Irish, with just 3% of families from other backgrounds (Other White 2%, African < 1%, Other Black < 1%).

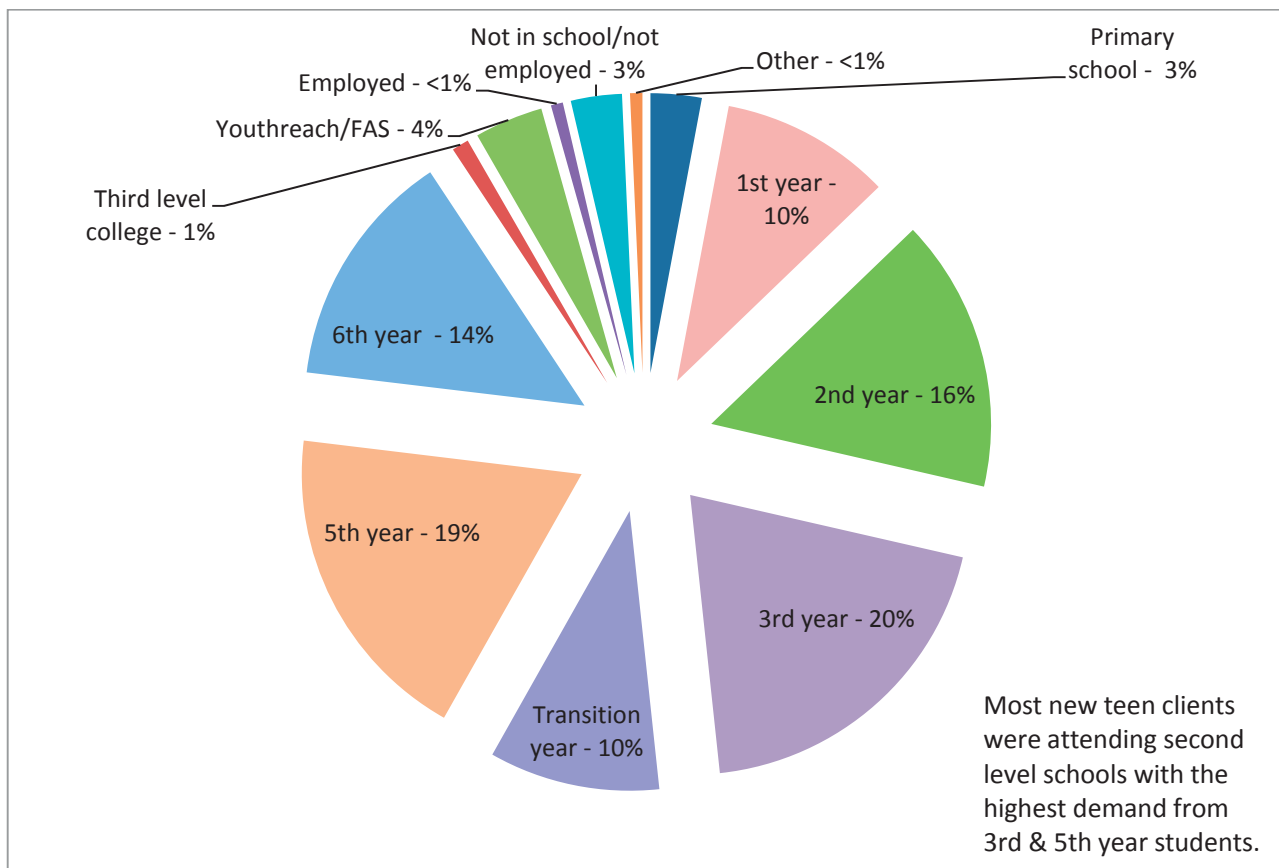
Gender profile of new teenage clients





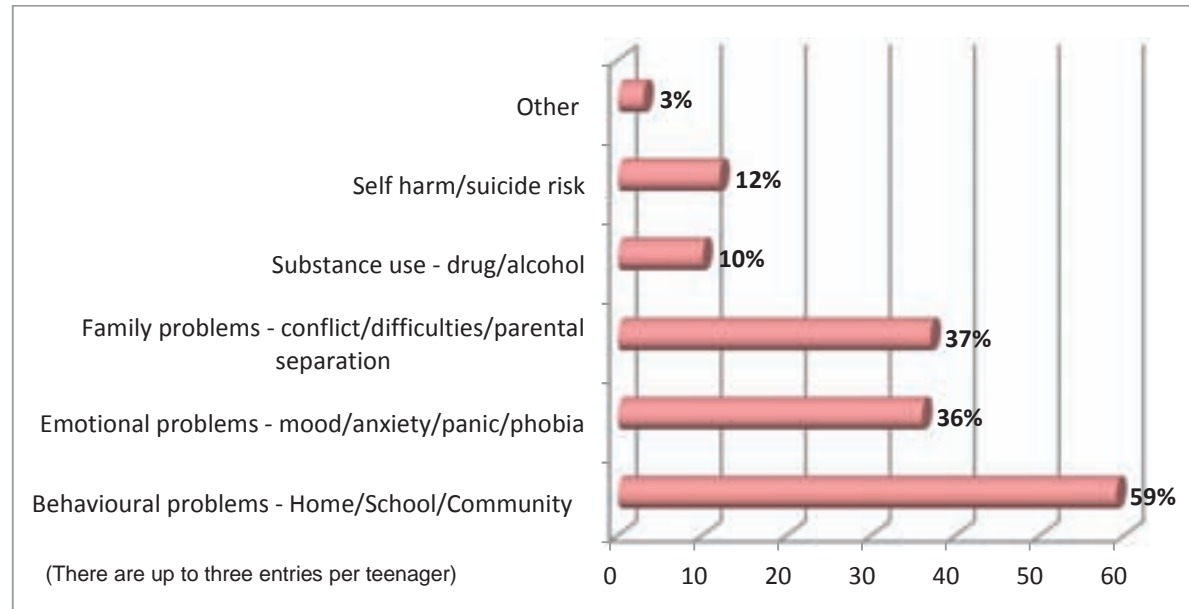


## Education and training



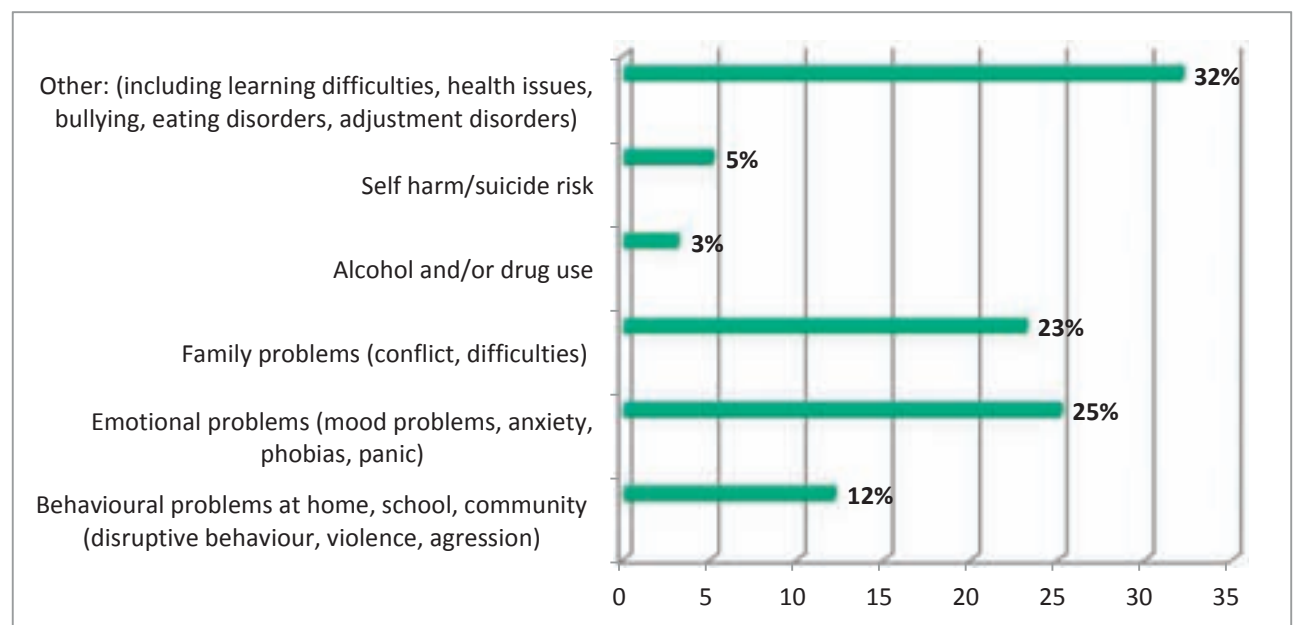
## Reasons for referral

The reasons for referral are shown in the following table. As most referrals are made by parents these figures mainly reflect parent's concerns before counselling starts. Up to three reasons for referral can be recorded for each teenager and these are collated. Less usual reasons for referral are recorded under 'Other'.



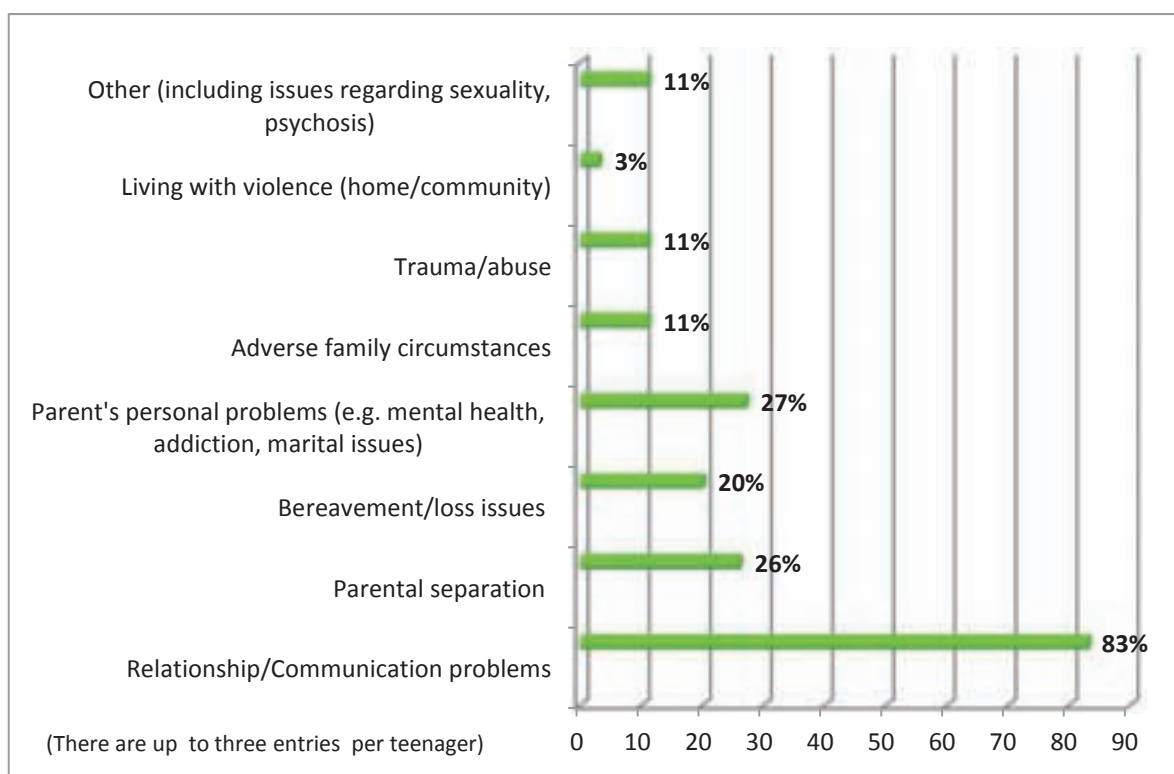
## Most significant problems

The counsellors make an assessment of the **most significant problem** following their first meeting with teenagers and their parents/carers.



## Underlying problems

**Underlying Problems** reflects the underlying issues addressed by counsellors with teenagers and their parents/carers. **Relationship and communication problems** were evident in **83%** of families. Other family issues were also significant: parental separation (26%), parent's personal problems (27%), bereavement (20%) and adverse family circumstances (11%). The Teen Counselling model is well suited to address these family issues.



## Substance use

The following table shows the Drugs and Alcohol Use profile recorded in relation to new teenage clients in 2011 (**N=281**).

Drugs Use			Alcohol Use		
On Referral	Intake	Subsequent	On Referral	Intake	Subsequent
9%	4%	6%	12%	25%	12%

Substance use has long been a standard part of our assessment protocol for new teenage clients and a confidential self-report questionnaire is used to explore the issue. Information in relation to teenagers requiring treatment for substance use is returned to the National Drug Treatment Reporting System. The following tables compare substance use by age group and gender.

Drugs Use	Under 16	16 and Over	N	%
Male	13	22	<b>35</b>	13
Female	9	8	<b>17</b>	6
<b>Total</b>	<b>22</b> 8%	<b>30</b> 11%	<b>52</b>	19

Whilst a significant minority of young people continue to have problems with drugs that impact on their health and development, the amount of drug use acknowledged amongst our teen clients has generally decreased over the years. In 2009, only 13% of new teen clients had used or were using drugs. However, in 2010 this was up to 17%, the same level as 2007 (17%) and in 2011 another small increase was noted. Drug use was noted on referral for only **9%** of teenagers.

For the **52** (19%) new teenage clients who were currently using drugs or had used them in the past, the following table shows the range of drugs used. Hash continued to be the most commonly used and some teenagers used more than one drug. Head shop drugs are included in other. No clients were using heroin, but the numbers using pills/medicine showed a 10% increase on 2010 figures.

Hash	Cocaine	Ecstasy	Solvents	Pills/medicine	Other
90%	10%	8%	6%	17%	8%

Alcohol use continued to concern us with almost half of our teen clients drinking. Twenty per cent (**20%**) of them were under 16 years old.

Alcohol Use	Under 16	16 and Over	N	%
Male	25	41	<b>66</b>	23
Female	31	38	<b>69</b>	25
<b>Total</b>	<b>56</b> 20%	<b>79</b> 28%	<b>135</b>	48

Twenty four percent (**24%**) of the new teen clients **smoked cigarettes** with 12% of these smokers under 16 years of age. The rates of smoking amongst younger clients had fallen over the years, which was very positive (2006 19%; 2007 11%; 2008 7%; 2009 8%; 2010 6%) so an increase of 6% in 2011 is something to watch.

Cigarette Use	Under 16	16 and Over	N	%
Male	13	18	<b>31</b>	11
Female	21	16	<b>37</b>	13
<b>Total</b>	<b>34</b> 12%	<b>34</b> 12%	<b>68</b>	24%

As can be seen in the table below, addictions are a problem for many of the families that attend Teen Counselling. The percentage of fathers abusing alcohol increased from 11% in 2010 to 19% in 2011, and for mothers an increase from 9% to 13% was noted. These problems present very significant challenges for teenagers.

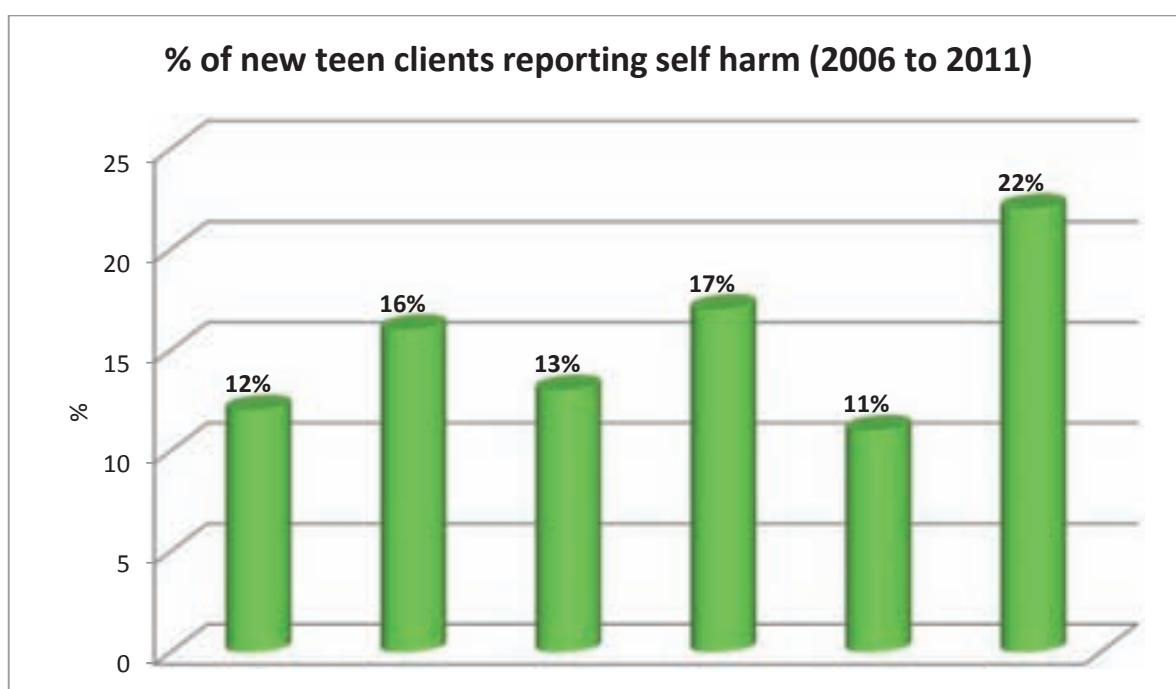
Addiction in the Family	Alcohol	Drugs	Gambling
Father	19%	4%	<1%
Mother	3%	6%	0%
Sibling	1%	1%	1%
Other	3%	4%	<1%

(There is more than one entry for some families).

## Self harm

We continue to be very concerned about the number of teenagers who are harming themselves, often by cutting and/or taking overdoses. It has been a significant focus of clinical work for many years and trends over six years are shown below. We use the following definition to record self-harm.

‘Have you ever done anything on purpose to injure, hurt or harm yourself or your body (but you weren’t trying to kill yourself)?’ Laye-Gindhu and Schonert-Reichl. Journal of Youth and Adolescence. Vol. 34. No. 5. October 2005.



Although in 2011 only 12% of teenagers were referred for self-harm a further 10% were subsequently found to be hurting themselves. 6% of parents also reported that they had engaged in self-injurious behaviour.

Suicidal ideation was reported by 21% teenagers (and 4% parents) and suicidal intent was reported by 11% teenagers (and 3% parents). The percentages for teen clients are again an increase on previous years.

### Suicidal ideation:

2006 14%: 2007 17%; 2008 18%: 2009 20%: 2010 17%: **2011 21%**

## Family illness

Supporting family members who have physical and/or mental illnesses is often a significant challenge for the families we see. Physical illnesses or disabilities were noted in **9%** of families. Mental illnesses were noted in **12%** of families.



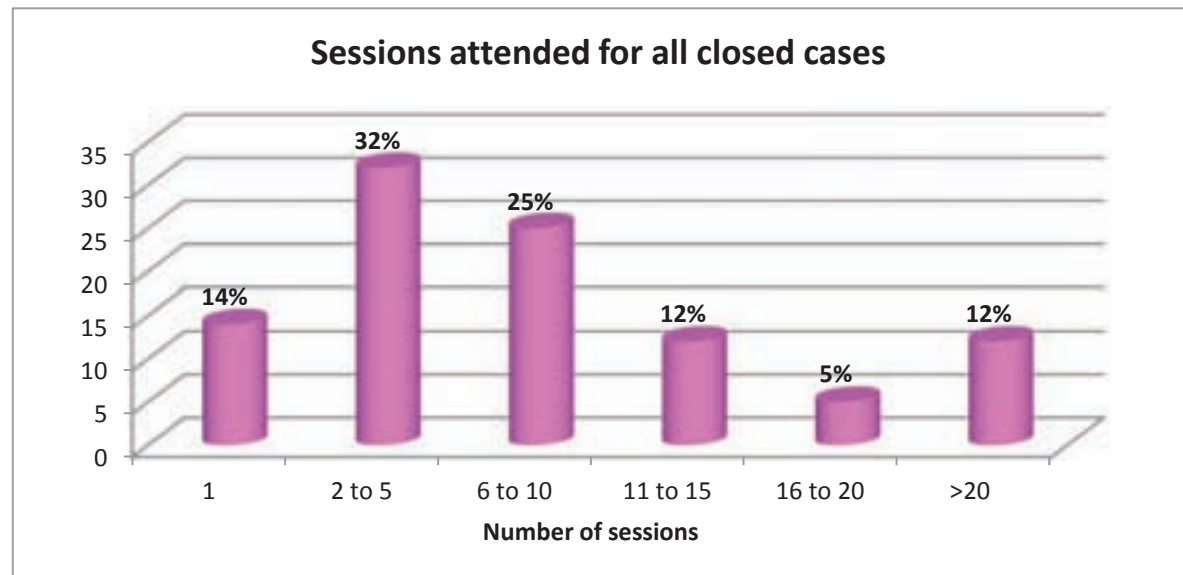
## Outcomes: evaluation of clinical work

### Cases closed during the year

In 2011, **276** cases were closed and **161** were carried forward into 2012. The cases closed involved **2,572 counselling sessions**.

**41%** of families attended a closing session to complete their therapy.  
**1%** of families were referred elsewhere after their initial session.  
**2%** of families were referred elsewhere subsequently.  
**1%** of families were referred elsewhere and Teen Counselling worked collaboratively with another service to support them.

The pattern of attendance is shown below:



A session may involve:

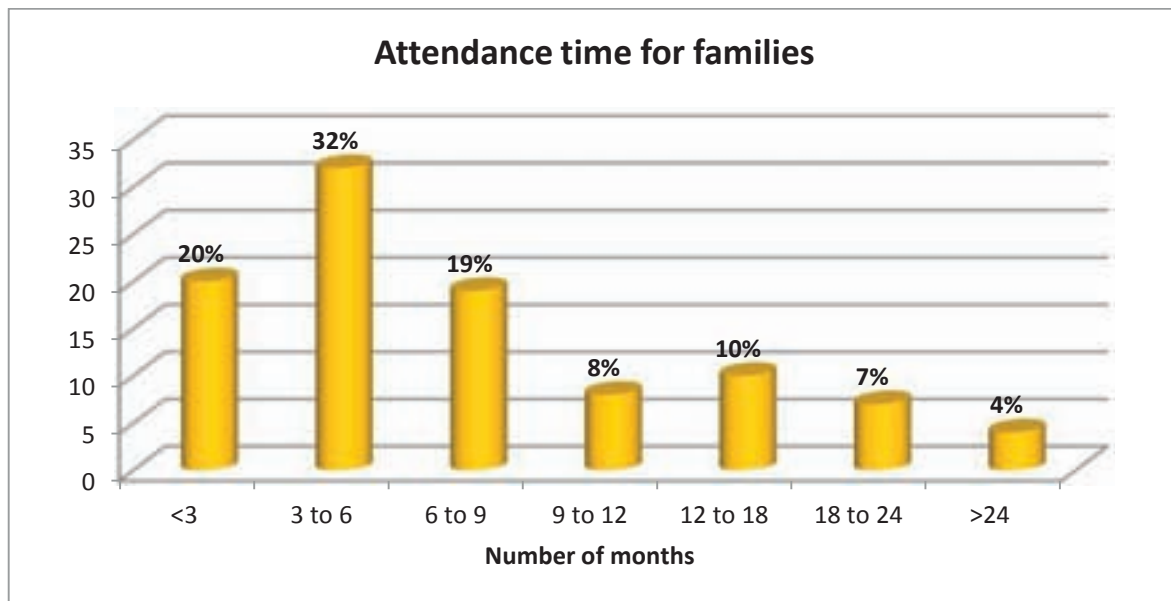
- An individual teen or parent/carer with one counsellor.
- Both parents together with one counsellor.
- A family group with teens and parents together, sometimes with siblings or other significant people. When teens and parents attend together two counsellors work with them.

For families whose cases were closed during 2011:

- ❖ the total number of sessions attended was **2,572**
- ❖ the maximum number of sessions was **59**.
- ❖ the minimum number of sessions was **1** for families referred on to another service after their first appointment and for those who chose not to attend further sessions or did not require further support.
- ❖ the average number of sessions across the service was **9**.

## Time commitment

The average duration of a case from initial appointment to closure was **9 months** with families attending an average of **9 sessions** involving an average of **24 clinical hours**. However, there was a very wide range as some families attended only once and others attended over several years. Teen Counselling has a flexible model to meet the needs of teenagers and parents. Clinical time includes counselling sessions, the management of the case and any case conferences involved.



## Counsellors' evaluation

For most teenagers a general assessment of functioning is made after the initial appointment and again on closing when they have attended consistently, without reference to the initial assessment.

**The Children's Global Assessment Scale (CGAS)** is used and a score from 1-100 noted on a hypothetical continuum of illness-health.

**On admission** the CGAS scores ranged from a minimum of **35** to a maximum of **74** with the average being **55**.

**On completion** the CGAS scores ranged from a minimum of **52** to a maximum of **88** with the average being **72**.

**The average change was 17**

**The Global Assessment of Relational Functioning DSM-IV (GARF)** is used to make an initial and concluding evaluation of the functioning of the family.

*A score of 100 indicates the family is functioning well and family members report their relationships to be satisfactory. A score of 1 is indicative of dysfunction to a point where the family is unable to maintain continuity of contact and attachment.*

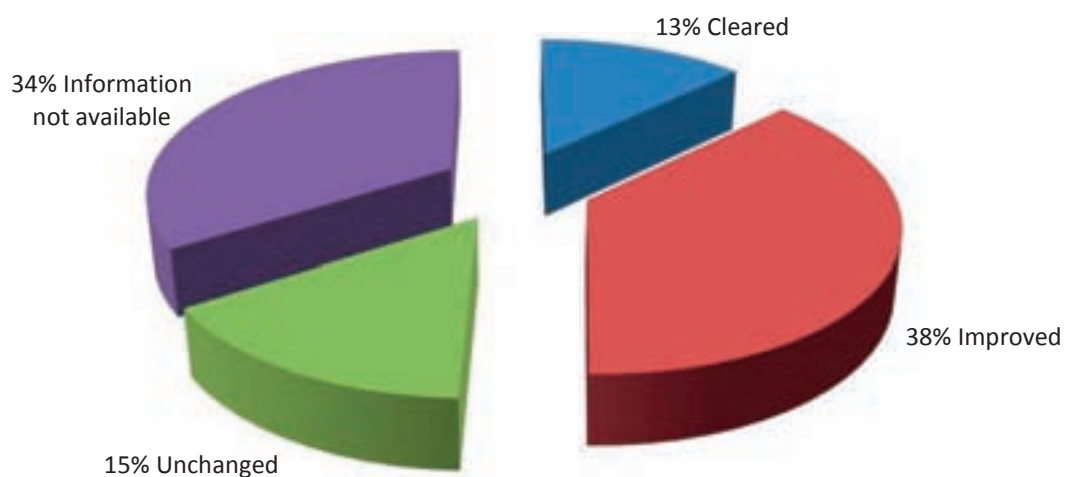
**On admission** the GARF scores ranged from a minimum of **27** to a maximum of **83** with the average being **58**.

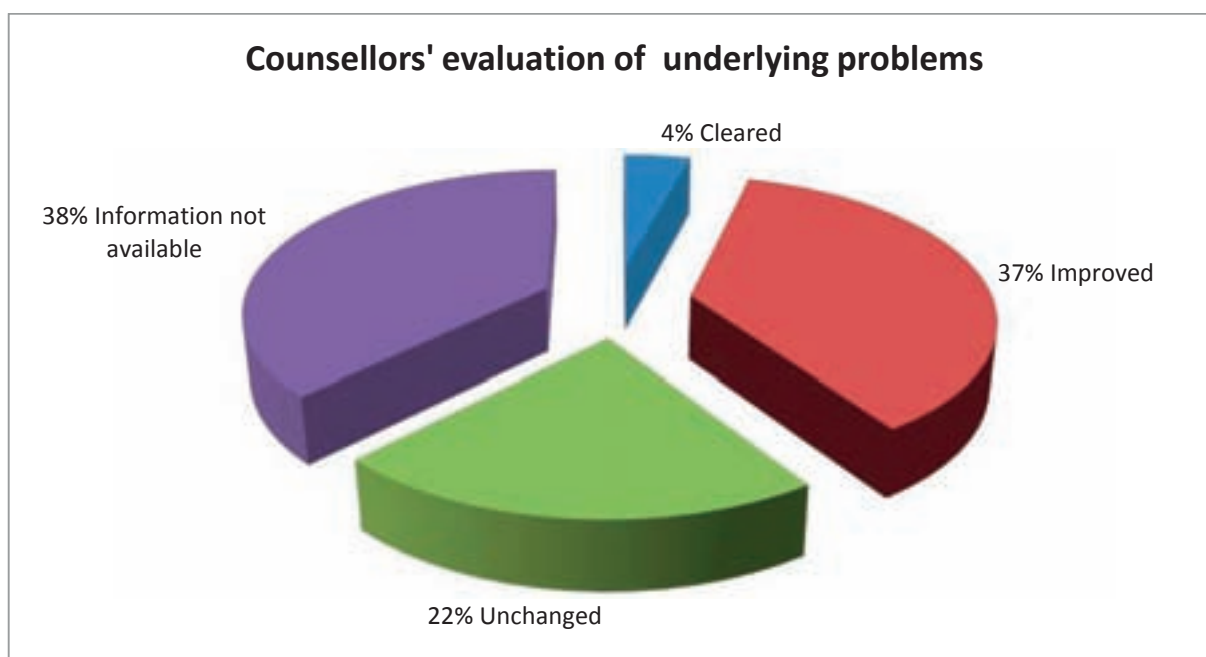
**On completion** the GARF scores ranged from a minimum of **46** to a maximum of **88** with the average being **71**.

**The average change was 13**

On closing cases the counsellors also assess **change in the presenting and underlying problems**. Again this is only possible when clients have attended consistently.

### Counsellors' evaluation of presenting problems



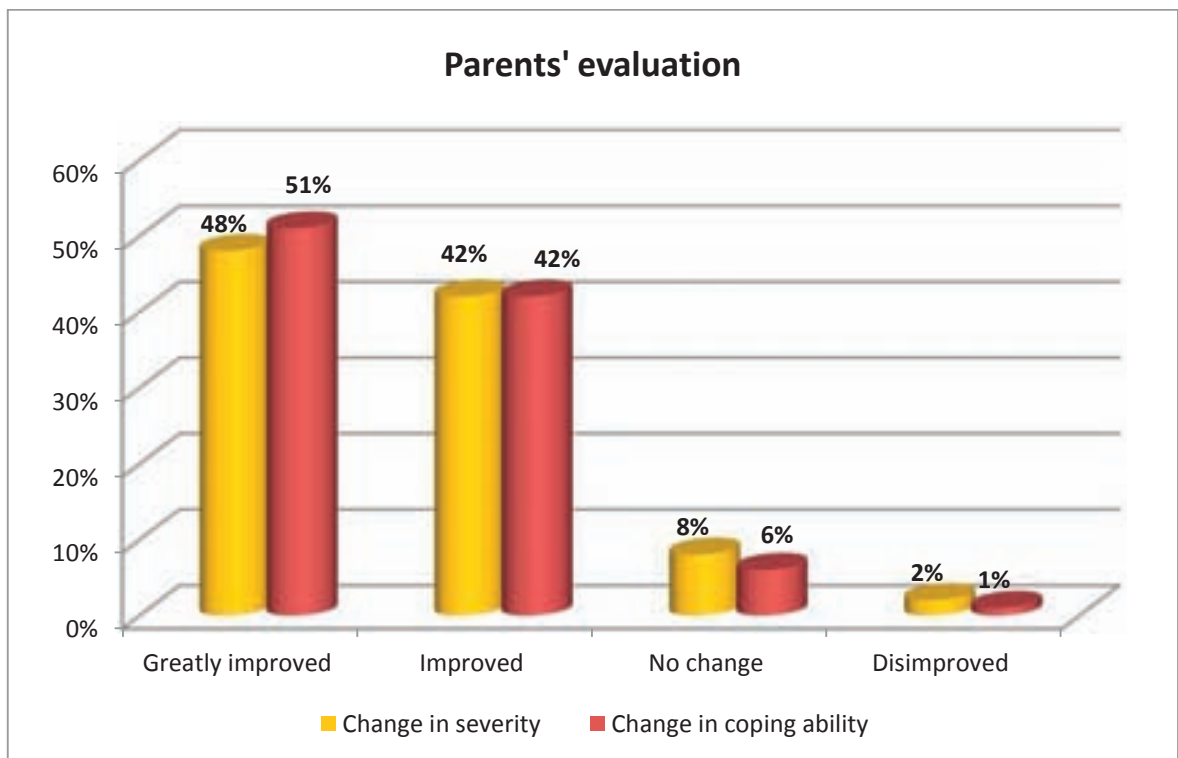


## ■ Clients' evaluation

At the beginning of counselling most parents and teenagers are asked to evaluate and record the extent of their difficulties. On completion they are again asked to make an assessment and to note any changes. In 2011, either the teenager or the parent(s) from **89 families (32%)** completed the evaluation process and most parents and/or teens reported improvements.

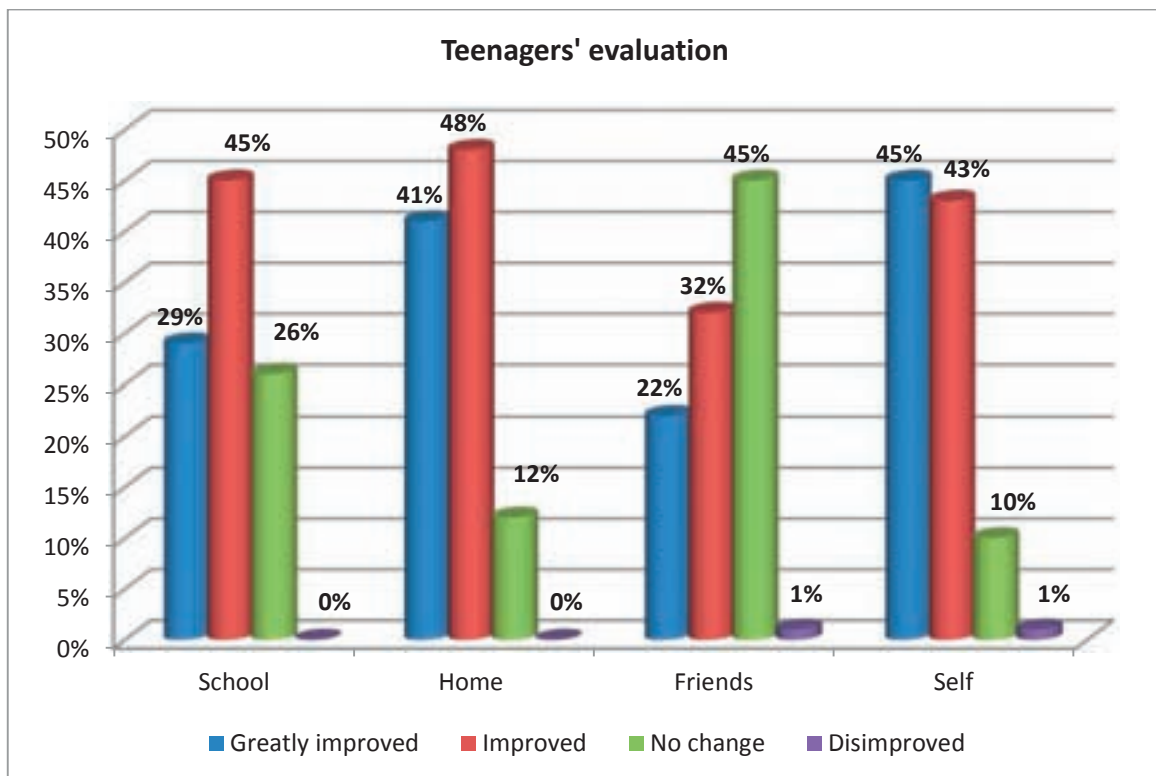
## ■ Parents' evaluation N = 88 (32%)

Parents are asked to assess the severity of the problems they are experiencing as Mild, Moderate, Serious, Very serious or Dangerous to self or others. They also evaluate their ability to deal with them as Cannot manage, Very difficult, Fairly difficult or Not difficult.



## Teenagers' evaluation N = 69 (25%)

Teenagers are asked to consider their main problem and the severity of its impact on four important areas of their life: School, Home, Friends and Self. On completion they are again asked to rate the severity of the problem and any changes in these four areas.





## Other work

### Appointments with the Consultant Psychiatrist

When the counselling team is concerned about the level of anxiety a teenager exhibits, very low mood and/or persistent self harm, or if teenagers have existing medical issues, an appointment is arranged with a Consultant Psychiatrist. The psychiatrist meets teenagers at the counselling centres which reduces their anxiety about referral for psychiatric assessment and allows for consultation with parents and the counselling team. The psychiatrist contacts the family doctor when medication is recommended and continues to review referred teenagers whilst they attend for counselling.

During 2011, Consultant Psychiatrist Dr. Moya O'Beirne provided **41** appointments for new clients and for clients who were carried over from the previous year. There were **23** assessment appointments and a further **18** review appointments.

The table shows a breakdown of the age and gender of teens referred to the psychiatrist for assessment.

Age	14	15	16	17	18	Total
Male	4	1	4	2	1	12
Female	1	1	3	3	1	11
Total	5	4	7	5	2	<b>23</b>

### Marital and separation issues

Teen Counselling provides a service to the parents of teenagers who are experiencing marital/relationship problems and to parents who have separated and are having difficulties sharing parenting. The role of the non-resident parent is given particular focus and importance. Parental acrimony, whether living together or separately, is a major contributory factor in adolescent adjustment problems. Working with parents on this issue and with adolescents on their own issues simultaneously, creates change and has a ripple effect to other siblings.

In 2011, only **36%** of new teenage clients were living with both parents. This figure changes annually (see below), but is always significantly below the national statistic which was 75% in 2011.

#### Percentage of teens living with biological parents 2006 – 2011

2006, 44%: 2007, 36%: 2008, 42%: 2009, 41%: 2010, 43%: **2011, 36%**

**41%** of teens were living with one parent, compared to the national figure of 18% and **10%** of teenagers were living with one parent and partner or step parent. Parental separation was identified as an underlying problem for **26%** of teens.

One hundred and thirty five (**135**) teenagers availed of counselling in relation to parental separation, 31% of all teens attending during the year. This involved 1,223 counselling hours. In addition, **32** couples and **119** individual parents received relationship counselling. This work involved 1,069 counselling hours. These figures are returned annually to the Family Support Agency.

## Bereavement issues

Teen Counselling is regularly called upon to support families coping with deaths, both untimely and in the natural order of things. The death of a loved one can have an immense impact and if this death is by suicide, then profound confusion can be another component of the grief. In addition, bereavement can impair a parent's capacity to parent at this crucial stage in a young person's life.

Bereavement was identified as an underlying issue for **20% of families** seen in 2011.

One hundred and forty four (**144**) individuals and **66** families availed of bereavement counselling and support in 2011, involving 924 counselling hours. These figures are also returned annually to the Family Support Agency.

## Child Protection

The safety and wellbeing of clients is a priority for the counsellors and Teen Counselling has a well-developed Child Protection Policy, which is under regular review by our Child Protection Officer in consultation with the Health Service Executive (HSE). Before referrals are taken, the boundaries of confidentiality are explained to referrers and again, when families attend for their first appointments; our policy is made very clear before any discussion takes place. Information given by family members which subsequently causes concern, including retrospective disclosures made by parents, is most usually discussed with families before contact is made with the local Child Protection teams.

During 2011, staff had child protection concerns regarding **29** teenagers. Referrals were made to the HSE as shown:

Physical abuse	6
Emotional abuse	5
Sexual abuse	13
Neglect	5
Total	29

Seventeen (17) teenagers referred were Under 16 years and 12 were Over 16 and involved 5 males and 24 females. Included in emotional abuse are 2 teenagers who were

out of parental control and at risk. Sexual abuse included teen pregnancy, underage sexual activity and a retrospective disclosure of sexual abuse by an adult.

## **Liaison work**

Teen Counselling centres liaise with schools and a wide range of statutory and voluntary agencies in their catchment areas. Every year schools are involved in making or suggesting a very significant number of referrals (**17% in 2011**) and we try to ensure that Guidance Counsellors in particular, are well informed about Teen Counselling. Staff presented and provided an information stand at The Dublin SW Guidance Counsellors seminar in April; individual Guidance Counsellors and Home School Liaison Officers were invited into local centres or visited in schools during the year; in November Guidance Counsellors in Finglas attended an information morning.

All centres are in regular contact with the Community Care Child Protection teams in their catchment areas, who are responsible for making or suggesting many, often very complex referrals (**18% in 2011**). A presentation and information pack was prepared in the autumn for staff to use in liaison with their local community care teams. This highlighted how the HSE and Teen Counselling best worked together to benefit young clients.

Familiarity with other services, and the good relationships established over the years, greatly enhances the support available for families and ensures an appropriate continuum of care for adolescents. Services we liaise with include: addiction - Youth Drug and Alcohol Service (YoDA), the Substance and Alcohol Service Specifically for Youth (SASSY); the Youth Advocate Programme (YAP); sexual abuse - Children at Risk in Ireland (CARI); mental health - Child and Adolescent Psychiatry in the Mater Child Guidance, Lucena Clinic, St James's, Cluain Mhuire and St Joseph's Adolescent Unit. Across the service we made referrals to, and received referrals from, all of the above and more.

Teen Counselling staff is involved on an on-going basis in a very wide range of Committees and Partnerships which bring together those who provide services for young people in their local communities e.g. Suicide Awareness Networks in Clondalkin and Finglas, Young People at Risk in Dun Laoghaire, Local Drugs Task Force in Blanchardstown. Staff also contributed to local initiatives and activities during the year e.g. Tallaght Health Fairs, Croke Park seminar re: parental substance abuse. Involvement with Headstrong featured strongly during the year in Tallaght, Clondalkin and Blanchardstown as community services came together to look at the mental health needs of young people and models of service delivery with the goal to establish Jigsaw sites.

## **Professional development**

There is an implicit ethos of staff care within Teen Counselling and both formal and informal mechanisms work to achieve this. Team meetings, regular senior staff and supervisor's meetings and professional group meetings for social workers and psychologists, all help to harness and develop the professionalism of the service as well as encouraging co-operation between Centres and good working practices.

Clinical staff members have monthly individual supervision and every two months supervision is provided for each counselling team. Senior staff members who provide this supervision have external supervision when funding is available. Teen Counselling is committed to providing regular external supervision for all experienced clinical staff as resources become available.

In 2009, due to the current financial climate, it was necessary to reduce the training budget available to staff by 50%. This has remained the situation since. However, supporting the Continuing Professional Development of staff remains a priority and this has involved exploring more creative ways of utilising cost free options for training, and communicating and sharing resources and learning outcomes from courses attended ([see page 30 for training opportunities availed of by staff in 2011](#)). In addition, staff members have committed personal time and resources to maintaining their professional registration standards.

## **Training given**

In the spring, staff teams from all centres presented on a range of topics to our Crosscare colleagues in Echlin House, a residential home for teenage boys. The counselling team from Clondalkin also provided support to the Echlin House care workers on request. In the autumn the TCC team were invited by the Quarryvale Resource Centre to run a 7 week Parent Plus Programme and, following training, a counsellor from TCDL contributed to the delivery of a Strengthening Families Programme.

A counsellor from TCT spoke to 6<sup>th</sup> class parents on the Transition to Secondary School and also contributed a lecture on Attachment Theory to the UCD Masters in Social Work course. We have strong links with both UCD and Trinity College in relation to training social workers and psychologists. In 2011 a Clinical Psychology and a Counselling Psychology trainee were on placement under the supervision of experienced psychology staff. This involves a considerable commitment from staff, maintaining links with tutors and course directors and being part of the assessment process for their trainees, but all staff benefit from the enthusiasm and interest of students on placement and provide as many learning opportunities as possible to make their experience of adolescent work valuable. As part of this training commitment we were invited to contribute to the Psychological Society of Ireland accreditation processes for the Doctoral Programmes in Clinical and Counselling Psychology in Trinity College.

## **Service representation**

During the year the Clinical Director continued to represent the service at many relevant committee meetings and working groups, such as the Voluntary Drug Task Force Network, the Health Research Board, the Young People's Facilities and Services Board and the steering group for Youth Health Promotion in Out-of-School Settings. This ensures that adolescents are advocated for as policies and protocols are developed and reviewed at a strategic level. Meetings with HSE Management and other funding agencies, such as the Family Support Agency, are essential to the maintenance and development of Teen Counselling and involve senior staff on an on-going basis.

Staff in all centres supported other organisations and services for teenagers as time permitted. In 2011 staff attended events organised by Teen Between, Parents Plus, Beating the Blues and Barnardos. Barnardos launched information leaflets on Bullying and Parent's Problem Substance Use - for parents, children and teens – welcome additions to the Parenting Positively series they have developed. Having been invited to review the material, we were delighted to attend their launch and view the final product. We were also pleased to respond to a request for a submission from the Department of Education. They were reviewing their programme for students re: substance misuse and were inviting ideas and comments to update their information.

## **In-service issues**

2011 was a challenging year for Teen Counselling as staff awaited the outcome of a process initiated by Crosscare to reconfigure the service. Their aim is to restructure Teen Counselling in line with other Crosscare social care projects and with the help of consultant, Aiden Brown, a plan was prepared and accepted by Crosscare Council at the end of the year. Staff contributed a significant amount of time to this process, individually and in different groupings, as the outcome has major consequences for current roles and practice. Key features proposed are centralised administration with fewer secretaries, the employment of counsellors, rather than social workers and psychologists and the employment of a project manager. Changes are to be implemented in 2012.

## **Research**

During 2011 the controlled trial to evaluate the effectiveness of Teen Counselling was on-going and families attending all six Teen Counselling centres have been participating. The project is in partnership with Alan Carr, Professor of Clinical Psychology in UCD, and required that the Teen Counselling model of therapeutic support for families was first set out in a clinical manual. The subsequent research will identify how well counsellors adhere to the model, how effective nine sessions of counselling is in alleviating the presenting behavioural and emotional problems and how families experience the service. Ciara Cassells, PhD student under the supervision of Professor Carr, has reported preliminary results which are very promising. This is encouraging for staff as the project is very dependent on their enthusiasm and goodwill. In particular the clinical administrative secretaries have a key role in inviting families into the project and liaising with the researcher. The research is on-going for three years. In 2011 the research committee met every 3 months to discuss progress and Ciara visited all centres regularly. The advisors for the project are Professor Pat Dolan, NUI Galway and Professor Robbie Gilligan, Trinity College Dublin. They are available for consultation during the project. ([see Appendix 2](#)).

As an adolescent service we were invited to participate in a research project to assess the long term outcome for young people who had presented for treatment for self harm issues. This project was initiated by Éilis Hayes, School of Nursing, DCU.

Internal research projects during 2011 addressed strategies to minimise missed appointments, looked at waiting list and attendance time issues, and also involved the preparation of a range of electronic forms. Now that all staff members have access to computers, trials have shown that some administrative forms can be completed efficiently on line and new practices will be implemented in 2012.

## Finance

The total income received by Crosscare Teen Counselling in 2011 was **€1,374,426**.

This was received from the Health Service Executive (HSE) Northern Area Addiction Services (LHO Dublin North Central), HSE Northern Area Mental Health (LHO Dublin North West), HSE Northern Area Child Care (LHO Dublin North), HSE LHO Dublin South, HSE LHO Dublin South West Addiction Services, HSE LHO Dublin West Homeless Services, Family Support Agency, The Young People's Facilities and Services Fund, The Charitable Infirmary Charitable Trust, Crosscare and from donations. We gratefully acknowledge the support of all our funders and all donations received.

The final end of year expenditure was **€1,382,865**. This equates to the following annual costs:

Average cost per family for one year	<b>€3,164.00</b>
Approximate annual cost of running a Full-time Centre in 2011*	<b>€25,000.00</b>

*\*based on one staff team providing family counselling, telephone advice and supporting local networks.*









## **CROSSCARE COUNCIL MEMBERS 2011**

Chairperson:	Mr Frank O'Connell
Vice-chairperson:	Ms Anna Lee
Treasurer:	Mr John Masterson
	Mr Oliver Cussen
	Mr David Kennedy
	Mr Seamus Scally
	Ms Patricia McInerney
	Fr Dermot Leycock
	Sr Marion Harte

**CROSSCARE**  
Charity Reg Number 6262



## Centre details and staff members 2011

**Teen Counselling Drumcondra, The Red House, Clonliffe Road, Dublin 3.**

**Tel. 8371892, Fax 8372025**

**E-Mail: [drumcondrateenc@crosscare.ie](mailto:drumcondrateenc@crosscare.ie)**

*Full Week*

Ms. Mary Forrest B.Soc.Sc., Dip.Psych., M.Psych.Sc., Reg.Psychol. Ps.SI., Reg. Family Therapist F.T.A.I.

*Clinical Director, Principal Psychologist*

Ms. Fidelma Beirne B.S.S., C.Q.S.W., M.A.

*Senior Social Worker*

Ms. Fina Doyle B.A., H.Dip BS., M.S.W.

*Social Worker*

Ms. Patricia McGuire (*Half-time*) B.A., M.Sc., Reg. Psychol. Ps.S.I.

*Psychologist*

Mr. Simon Molloy B.Sc., M.Sc.

*Psychologist*

Ms. Monica Ferns

*Clinical Administrative Secretary*

Ms. Margaret Agnew B.Sc.

*Administrator*

**Teen Counselling Clondalkin, Quarryvale Community and Leisure Centre, Greenfort Gdns, Dublin 22. Tel. 6231398**

**E-mail: [clondalkinteenc@crosscare.ie](mailto:clondalkinteenc@crosscare.ie)**

*Monday to Thursday*

Ms. Siobhán Nic Coitir (*Part-time*) B.A., M.Sc.

*Psychologist*

Ms. Averil Kelleher B.A., M.S.W.

*Social Worker*

Ms. Catherine Fullam (*Part-time*)

*Clinical Administrative Secretary*

## Centre details and staff members 2011

**Teen Counselling Tallaght, Shalom, Raheen Park, Springfield, Dublin 24.**

**Tel. 4623083**

**E-mail: [tallaghtteenc@crosscare.ie](mailto:tallaghtteenc@crosscare.ie)**

*Full Week*

Ms. Jane Fry B.A., Dip. Psych., Reg. Psychol. Ps.S.I., A.F.Ps.S.I.

*Senior Psychologist*

Mr. Tom Casey C.Q.S.W., Dip. Integrative & Humanistic Psychotherapy

*Senior Social Work Practitioner*

Ms. Nollaig Tubbert

*Clinical Administrative Secretary*

Ms Agnieszka Szymkowska

*Housekeeping*

**Teen Counselling Finglas, Unit 2B, Finglas Village Centre, Finglas Village, Dublin 11.**

**Tel. 8646014**

**E-mail: [finglasteenc@crosscare.ie](mailto:finglasteenc@crosscare.ie)**

*Half Week*

Mr. Brian Smith (*Half-time*) B.A., B.Sc., M. Psych.Sc. (Psychotherapy), Reg.Psychol.

Ps.S.I., A.F.Ps.S.I., Reg. Family Therapist F.T.A.I.

*Psychologist*

Ms. Fidelma Beirne B.S.S., C.Q.S.W., M.A.

*Senior Social Worker*

Ms. Ann Donnellan (*Half-time*)

*Clinical Administrative Secretary*

Ms. Ann McCarthy

*Housekeeping*

**Teen Counselling Dun Laoghaire, 72 York Road, Dun Laoghaire, Co. Dublin.**

**Tel. 2844852**

**E-mail: [dunlaoghareteenc@crosscare.ie](mailto:dunlaoghareteenc@crosscare.ie)**

*Full Week*

Ms. Orla O' Donovan (*Half-time*) B.Soc.Sc., C.Q.S.W.

*Senior Social Work Practitioner*

Mr. Simon Molloy B.Sc., M.Sc.

*Psychologist*

## Centre details and staff members 2011

**Teen Counselling Dun Laoghaire, 72 York Road, Dun Laoghaire, Co. Dublin.**  
**Tel. 2844852**  
**E-mail: [dunlaoghaireteenc@crosscare.ie](mailto:dunlaoghaireteenc@crosscare.ie)**  
*Full Week*

Ms Carol Donnellan B.A., H.Dip. Psychotherapy, M.Sc.  
*Psychologist*

Ms. Ann O'Sullivan (*Part-time*)  
*Clinical Administrative Secretary*

Ms. Agnieszka Szymkowska  
*Housekeeping*

**Teen Counselling Blanchardstown, Crosscare Centre, Main Street, Blanchardstown.**  
**Tel. 4623083**  
**E-mail: [tallaghtteenc@crosscare.ie](mailto:tallaghtteenc@crosscare.ie)**  
*2 days per week*

Mr. Tom Casey C.Q.S.W., Dip. Integrative & Humanistic Psychotherapy  
*Senior Social Work Practitioner*

Ms. Averil Kelleher B.A., M.S.W.  
*Social Worker*

Ms. Nollaig Tubbert  
*Clinical Administrative Secretary*

**Note: Dr Moya O'Beirne, M.B., M.R.C. Psych., Consultant Psychiatrist, worked across all Teen Counselling centres on a sessional basis.**

## Professional development – January to December 2011

Date	Topic	Organised by	No. of Staff	Duration
<b>Jan</b>	Understanding and responding to self-injury	Kreative Interventions – School of Social Work and Social Science UCD	1	1 day
	Managing critical incidents that impact on children & adolescents in schools and in the community : the role of psychology	Psychological Society of Ireland (PSI) – Special Interest Group in Child & Adolescent Psychology (SIGCAP)	1	0.5 day
	Certificate in therapeutic use of mindfulness	IICP Education and Training	1	3 days
<b>Feb</b>	The nuts and bolts of CBT for depression	National Association of Cognitive Behaviour Therapies	1	0.5 day
	Eating disorders: CBT and beyond	National Association of Cognitive Behaviour Therapies	1	0.5 day
<b>Mar</b>	Creative research strategies for demonstrating real world effects	PSI – Dr Suzanne Guerin	1	1 day
<b>Apr</b>	Children's Rights	PSI - SIGCAP Conference	1	0.5 day
	Motivational interviewing with adolescents	Association Child and Adolescent Mental Health (ACAMH) - UK	2	0.5 day
	What trainees want from supervision	MSc in Counselling Psychology, TCD	2	0.5 day
	What we do	Samaritans	1	0.5 day
	Safe Talk Workshop (Suicide)	Quarryvale Resource Centre	1	1 day
<b>May</b>	What's working for children	Archways in conjunction with the Office of the Minister for Children	1	2 days
	Understanding and managing sexualised behaviour in children and adolescents in foster care and residential care settings	CARI Foundation	1	1 day
	Social Work practice in difficult times - Why equality is better for everyone	Irish Association of Social Workers (IASW)	2	1 day
	Substance misuse workshop	Crosscare Drug Awareness Programme	4	0.5 day
	Mindfulness and young people	Dr Tony Bates (The Sanctuary)	2	1 day
	Innovating for Good 2011 – a national conference for the community, voluntary and charitable sector in Ireland	The Wheel	1	1 day
	The Craft of Couples Therapy	Dr Colm O'Connor, Clinical Psychologist & Family Therapist	2	2 days

## Professional development – January to December 2011ctd.../

Date	Topic	Organised by	No. of Staff	Duration
<b>June</b>	Safe Talk training	Petra Daly & Jean Martin (Crosscare)	1	1 day
	Child Protection	UCD Social Work Department	1	0.5 day
	Tackling smoking youth	HSE Dublin North East	1	1 day
<b>July</b>	Guidelines on assessment & diagnosis of autism	PSI	2	0.5 day
<b>Sept</b>	Therapeutic approaches to well-being in adolescents	ACAMH - UK	2	0.5 day
	Applied Suicide Intervention Skills Training (ASIST)	Petra Daly & George Brogan (Crosscare)	3	2 days
	Freedom of information and social work records	IASW	1	0.5 day
	Innovations in working with adolescents	Parents Plus Programme	6	0.5 day
	Strengthening families programme	Dun Laoghaire-Rathdown LDTF	1	9 days
	Inside the minds of sex offenders – What professionals need to know to safeguard kids	Mentor Forensic Services	1	1 day
<b>Oct</b>	A family affair? Supporting children living with parental substance misuse	NACD, HSE and Alcohol Action Ireland	2	1 day
	Domestic violence for frontline workers	Aoibhness Women's Refuge	1	1 day
	Emerging evidence on Youth Mental Health: multi-disciplinary perspectives	ACAMH - UK	1	1 day
	Protecting children post Ryan: Real or virtual change in an era of social crisis?	HSE South & IASW	1	1 day
<b>Nov</b>	Fitness to practice – lessons to learn from international experience	IASW	2	0.5 day
<b>Nov</b>	ASIST – suicide intervention skills training	Living Works	1	2 days
	Early onset psychosis	ACAMH - UK	1	1 day
	Strengthening families programme	Dun Laoghaire-Rathdown LDTF	1	0.5 day
	Hitting home – the impact of domestic violence on children	Bray Women's Refuge	1	1 day





## **Accountants Report to the Council of Crosscare – Catholic Social Service Conference**

This report is prepared in accordance with the terms of our letter of engagement dated 31 December 2010, to carry out certain procedures, as described below under scope of work, in relation to the Income and Expenditure Account for the year ended 31 December 2011 of Teen Counselling, as set out in attached Appendix 1, to assist you in evaluating the validity thereof.

### **Respective Responsibilities of Council and Reporting Accountants**

As the Council of Crosscare you are responsible for ensuring that Crosscare maintains accounting records which disclose with reasonable accuracy, at any time, the financial position of Crosscare and in particular the extraction of the Income and Expenditure Account of Teen Counselling from the audited financial statements of Crosscare. It is our responsibility to check the accuracy of that extraction.

### **Scope of work**

For the purpose of preparing our report you have provided us with a schedule ("the schedule") showing the Income and Expenditure Account of Teen Counselling for the year ended 31 December 2011. This schedule, for which the Council is solely responsible, is attached at Appendix 1.

We have performed the procedures agreed with you. Our work was carried out with regard to the guidance contained in International Standard on Related Services 4400 "Engagements to Perform Agreed-Upon Procedures regarding Financial Information". The procedures were performed solely to assist you in evaluating the validity of the Programme Income and Expenditure amounts.

We have checked the extraction of the Income and Expenditure Account of Teen Counselling from the audited financial statements of Crosscare.

We have carried out an audit of the books of account of Crosscare to enable us to express an opinion on the financial statements of Crosscare as a whole. This involved carrying out audit tests, on a sample basis, of the Income and Expenditure in the various Centres under Crosscare's control including Teen Counselling. We have considered the results of those audit tests in the context of our audit of Crosscare as an entire entity. We reported on the financial statements of Crosscare on 15 March 2012.

We performed the following procedures:

- 1) We agreed the component income and expenditure amounts of Teen Counselling totalling €1,374,426 and €1,382,865 respectively for the year ended 31 December 2011 to Crosscare's accounting records.
- 2) We agreed the total income of €1,374,426 and the total expenditure of €1,382,865 to the audited financial statements of Crosscare for the year ended 31 December 2011.



## Findings

We confirm that the component Income and Expenditure amounts of Teen Counselling totalling €1,374,426 and €1,382,865 respectively have been accurately extracted from the accounting records of Crosscare.

We confirm that the overall income and expenditure have been accurately extracted from the audited financial statements of Crosscare for the year ended 31 December 2011.

Our audit opinion, dated 15 March 2012, in relation to the financial statements of Crosscare for the year ended 31 December 2011 is contained on page 9 and 10 of those financial statements.


The procedures as stated in our engagement letter do not constitute a detailed audit examination of the Income and Expenditure Account of Teen Counselling made in accordance with generally accepted auditing standards, the objective of which would be the expression of an opinion on the truth and fairness of the Schedule. Accordingly, we do not express such an opinion.

Our procedures, as stated in our engagement letter, do not constitute an examination made in accordance with generally accepted auditing standards, the objective of which would be the expression of assurance on the contents of the Schedule. Accordingly, we do not express such assurance. Had we performed additional procedures or had we performed an audit or review of the Schedule in accordance with generally accepted auditing standards, other matters might have come to our attention that would have been reported to you. This report relates only to the amounts and items specified above and does not extend to the financial statements of Crosscare, taken as a whole.

The audit work of Mazars on the financial statements of Crosscare was and is carried out in accordance with statutory obligations and the audit reports were and are intended for the sole benefit of Crosscare and Crosscare as a body, to whom they are addressed. Audit(s) of Crosscare's financial statements were not and will not be planned or conducted in contemplation of the requirements of anyone other than the members as a body, and consequently the audit work is not intended to address or reflect matters in which anyone other than the members as a body may be interested.

Mazars will not, by virtue of preparing this Report or otherwise in connection with this engagement, assume any responsibility whether in contract, tort (including without limitation negligence) or otherwise in relation to the audits of Crosscare's financial statements. Mazars and respective partners, employees, agents and contracts shall have no liability whether in contract, tort (including without limitation negligence) or otherwise to any third parties in relation to the audits of Crosscare's financial statements.

This report is solely for your use in connection with the purpose specified above and as set out in our engagement letter; it is not to be used for any other purpose or to be copied or distributed or otherwise made available or referred to, in whole or in part, to any other party without our prior written consent. We do not accept any liability or responsibility to any third party to whom our report is shown or into whose hands it may come.

  
Mazars

15 March 2012  
Date

**APPENDIX 1**
**Teen Counselling  
Income and Expenditure Account  
1 January 2011 to 31 December 2011**

	2011 €	2010 €
<b>Income</b>		
Donations and bequests	4,097	2,901
The Charitable Infirmary Trust	45,000	45,000
<i>State &amp; Local Authority Grants:</i>		
HSE East Coast Area	279,194	293,889
HSE Northern Area	534,357	615,637
HSE South West Area	236,594	198,164
County Dublin VEC – Young People Fund	57,036	63,374
Dept. Social Community & Family Affairs	163,800	181,900
Interest and dividends	106	21
Sundry income	<u>54,242</u>	<u>43,766</u>
<b>Total income</b>	<b><u>1,374,426</u></b>	<b><u>1,444,652</u></b>
<b>Expenditure</b>		
Payroll and pension costs	1,170,434	1,238,008
Rent, rates and insurance	72,477	75,757
Light, heat and power	6,504	7,944
Repairs, renewals and maintenance	11,924	10,021
Computer and equipment services	3,394	3,576
Printing and stationery	10,024	8,817
Telephone and postage	8,956	9,679
Travel expenses	3,554	3,577
Conference and seminars	565	645
Staff training and conferences	4,260	1,895
Cleaning and security	3,553	6,962
Advertising and recruitment costs	450	1,021
Professional fees and consultancy	24,984	20,048
Sundries	3,585	2,860
Depreciation	12,201	14,158
Central administration charges	<u>46,000</u>	<u>46,000</u>
<b>Total expenditure</b>	<b><u>1,382,865</u></b>	<b><u>1,450,968</u></b>
<b>Deficit</b>	<b><u>&lt;8,439&gt;</u></b>	<b><u>&lt;6,316&gt;</u></b>

  
 For and on behalf of Council

  
 For and on behalf of Teen Counselling



## Outline of the service

*Teen Counselling aims to provide a professional counselling service for adolescents and their families who are struggling with behavioural and emotional problems and to inform, support and complement the role of the State sector and other voluntary organisations.*

## Philosophy

Our working philosophy with adolescents and their parents is to offer them time and space in which to work out or resolve the issues that contribute to their distress. Our commitment extends to parents, as they may need support and/or therapeutic intervention in handling the adolescent's difficulties, or in coping with their own personal difficulties which appear to affect the adolescent. Our ultimate aim is to enable the adolescent and their family to deal with the issues with which they are referred and in many instances the underlying issues, so that within the context of the family cycle they develop and maintain appropriate relationships.

One of the founding principles of the service has been prevention of more serious difficulties, particularly in the area of substance abuse, and this is a philosophy we endeavour to embrace, recognising the importance of working with families, adolescents and communities at this level.

## Objectives of the service

- To provide a service in a friendly, efficient, competent and easy to access manner.
- To promote mutual understanding and respect between teenagers and parents or others in a similar position.
- To enhance a family's capacity to enjoy relationships both internally and with the wider community.
- To help adolescents to develop into well rounded adults, avoiding or at least minimising the negative effects of difficulties that teenagers and families experience.
- To share the service's expertise and experience where appropriate.

These objectives are realised through our work in the following five areas:

- Clinical work with teenagers and their parents/carers.
- Interagency co-operation and consultation.
- Community based work.
- Policy development and submissions.
- Dissemination of expertise, experience and best practice.



## Teen Counselling clinical model

Teen Counselling offers a 'generalist' family based service model developed to address the challenges that arise in the transition from childhood to early adulthood in the family's and teenager's lives. Through the process of individuating from the family a number of difficulties can arise for teenagers. In our experience a model which looks equally at the ability of the parental system in managing these transitions, and at the teenager's abilities or deficits in negotiating these transitions, is best placed to intervene in the often multiple and complex difficulties.

**Teen Counselling's** objective is to support the normal systems that support teenagers (i.e. home, family and school) and to maintain teenagers in home, in school and with appropriate friends. Utilising a model of intervention which focuses on these 'normal teenage' systems normalises the interventions and reduces stigma for teenagers and parents alike. As a result the service is more likely to be availed of at an earlier stage and in a preventive context rather than at a crisis stage. In addition, the non-medical nature and strength-based focus of the model makes it more acceptable to families and 'teenager friendly'.

**Teen Counselling** works in teams of two – most usually a psychologist and a social worker (both referred to as Counsellors). The team meets parent(s) and the adolescent together for the initial visit. Subsequently, a specific Counsellor sees the teenager and the parent(s) separately. The individual sessions are confidential and 'teens' are assured that what they say is not routinely relayed to parents and vice versa. Limits to confidentiality are clearly explained at the outset. Families know that the two Counsellors communicate about their work and combined (joint) sessions are also frequently scheduled.

A Consultant Psychiatrist attends **Teen Counselling** on a sessional basis and Counsellors are generally able to access an experienced adolescent psychiatrist within 3 weeks.

Our referral protocol of accepting and encouraging referrals directly from parents means **Teen Counselling** is more readily accessible than some traditional models of service. Noteworthy also is the fact that the '**Best Health for Children**' recommendations for adolescent services very much reflect our current and past practice.

*Teen Counselling is: no fee: community based: a generalist counselling service: for adolescents (12 to 18 years) and their families: part of Crosscare, the Social Care Agency of the Catholic Diocese of Dublin.*

## Service provision

Mater Dei Counselling Centre, the original Teen Counselling Centre, has been in existence since 1972 and is the headquarters of the service and there are four outreach Centres at present, two full-time and two part-time. A sixth centre in Blanchardstown was opened for 2 days a week on a pilot basis in May 2010.

## Crosscare Teen Counselling Evaluation Study

The Teen Counselling Evaluation Study aims to evaluate the effectiveness of the model of practice used in Teen Counselling. This model has been termed 'Positive Systemic Practice'. In order to do this a controlled trial is being carried out. Families are allocated to Treatment and Control groups when referred to Teen Counselling and teens are matched in terms of gender, age, living arrangements and problem type. Cases that score above the clinical cut-off point on the parent-report version of the Strengths and Difficulties Questionnaire (Goodman, 2001) are admitted to the trial. Participants in both groups are evaluated with psychometric measures of adolescent and family adjustment. For the Treatment group this evaluation is done before and after families complete 9 sessions of counselling over 16 weeks. This treatment intensity reflects the average number of sessions attended by families during the years 2007-9 and the average time families spent on the waiting list during that period. The Treatment group is also evaluated at 6 months follow-up. Treatment integrity and adherence to the model are also being tested. In order to do this counselling sessions are being recorded and rated. The Control group is evaluated at referral and again after 16 weeks, just before families receive their first counselling appointment. This study has been on-going since 2010 and is still recruiting families into both groups. To date there are 50 families in the Treatment group and 20 families in the Control group.

### Main changes since last year

1. In January 2012, 10 euro mobile phone credit was offered to teens as an incentive to complete the survey. This was started on a trial basis and offered to the first 10 families invited into both the Treatment and Control groups. However, following evaluation, it was decided to discontinue this as it did not make any significant difference to the numbers recruited.
2. Rating of the audio recordings of counselling sessions began this year. Catherine Rogers joined the research team and after a period of observation, to familiarise herself with the Teen Counselling model, started to rate sessions for treatment fidelity and adherence to the model of practice.

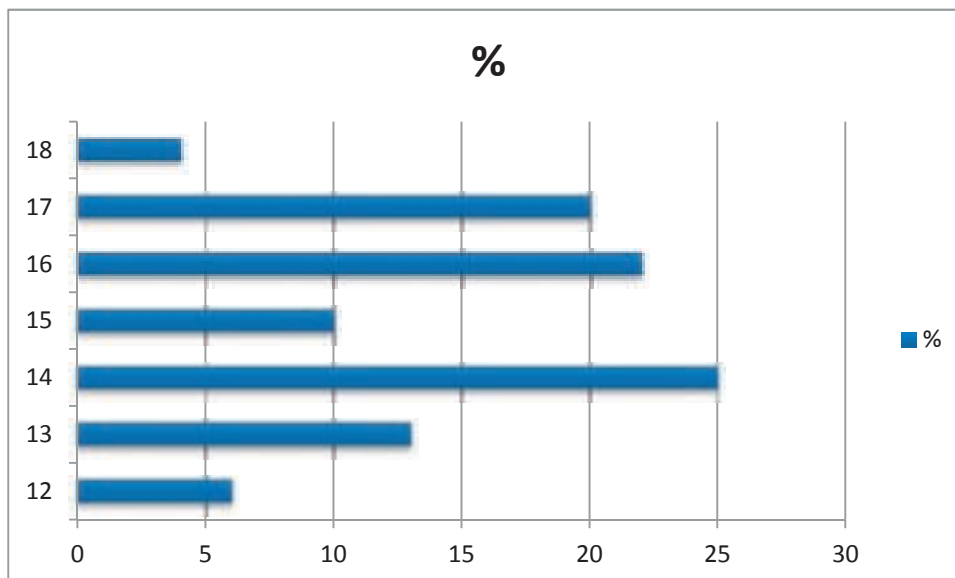
### Main challenges faced in 2011

1. Recruiting families into the Control group has proved very difficult. It is taking much longer to recruit families into this group in comparison to the Treatment group, despite the fact that the majority of referrals are being assigned to the Control group.
2. Retaining families in all parts of the study (both groups) has also proved challenging.

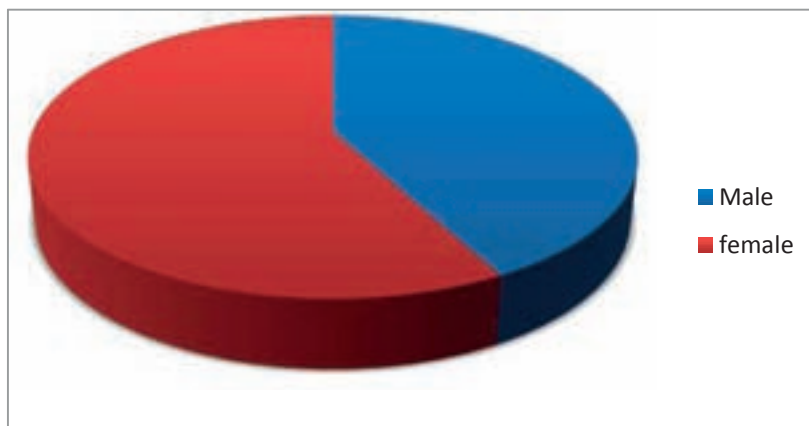
**Some of the statistics to date are:**

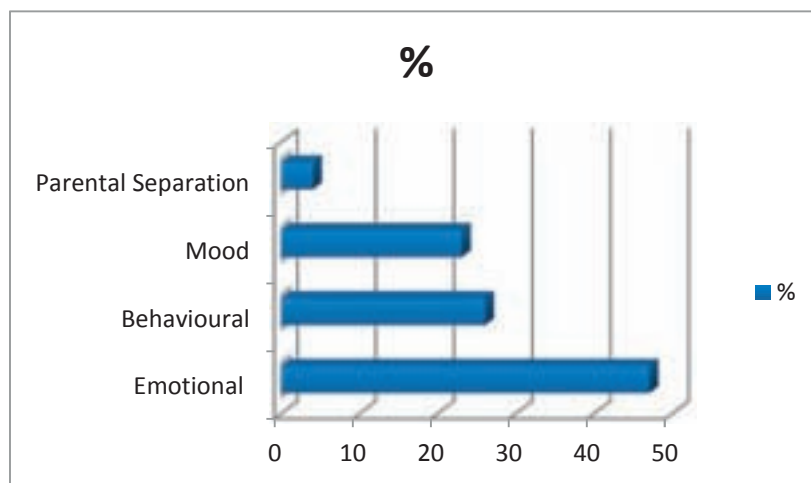
- Only 20 families surveyed were not over the clinically significant cut off score in the Strengths and Difficulties Questionnaire, 11 invited into the Treatment group and 9 into the Control group.
- 96 families (67 Treatment and 29 Control) were asked to participate in the study and declined for many different reasons e.g. did not have the time; parents had not told the teen about the referral for counselling.
- 1 family dropped out of the Control group and 7 Treatment group families either dropped out or were referred to another service
- 11 families in the Control group and 13 in the Treatment group have completed the entire study.

**Age range of teenagers in study (Treatment and Control groups)**



**Gender:** Male 38% Female 62%



**Teen's main problem at referral****Progress to date**

During 2011 recruitment into both Treatment and Control groups continued. There is a big drive to recruit families into the Control group due to the low numbers. We are almost half way there with the Control group, but this process is very slow. An archival audit of Teen Counselling over a 3 year period was completed in 2011. The results of this were very promising. Demographic information, similar to that reported in this annual report, was collected over the 3 year period 2007-2009 and summarised. Improvement ratings were also analysed over the 3 years, based on ratings collected at intake and closure from a sample of families completing counselling. For example between 2007 and 2009, for 190 families who completed counselling, 89 adolescents (47%) and 91 parents (48%) filled in improvement rating questionnaires. Paired t-tests were carried out which found that 91% of parents reported that problems had either improved or greatly improved at closure and only 4% reported a disimprovement. 92% of parents reported that their coping ability had either improved or greatly improved at closure and only 8% reported no change in coping ability. For adolescents, 76% reported an improvement at school, 85% at home, 48% with friends and 84% in self. A small percentage reported disimprovements at closure – 6% in school, 3% at home, 2% in relationships with friends and 1% in self. Results such as these are very promising and provide a great foundation for the study.

**Plans for 2012**

During 2012, data collection will continue. I aim to complete data collection by the end of 2012. Following this, the data will be analysed and the study written up as a thesis and a series of reports. The remaining audio recordings of the counselling sessions will be rated. I am currently working on a journal article for submission to the Journal of Child Clinical Psychology and Psychiatry. This article is based on the archival audit of the service and the findings and their implications are discussed.

**Ciara Cassells, Researcher, UCD School of Psychology. May 2012**



## Crosscare Teen Counselling performance indicators

In Teen Counselling clients are offered a tailor made therapeutic service with no length of involvement specified. On-going measures are taken to track the number and profile of clients attending and to evaluate the effectiveness of the therapeutic service received.

### Centre Reviews

Each Teen Counselling centre is audited three times a year. Quantitative data are analysed and trends noted re: referrals, waiting lists, attendance patterns, new client profiles and closed cases. Information re: psychiatric and other consultations, training, networking and supervision is also reported. A copy of each Centre Review is forwarded to the relevant Child Care Manager in line with funding agreements.

### Annual Reports

For each centre, data from the three Centre Reviews are collated, further analysed and published each year. Data from all six centres are collated and presented in the Crosscare Teen Counselling Annual Reports.

### Four Outcome Measures

#### Outcome Measure 1

During the first session with a family a mutual understanding of the presenting problems is reached and mutually agreed goals set. These are noted from the client's point of view. The clinical team after the session devise a set of aims which it will be necessary to achieve to successfully reach the family's goals. These intervention aims are reviewed when the case is closed.

**The other 3 Outcome Measures used involve an evaluation of change and these are reported in the Annual Report each year.**

#### Measure 2

This is the client's own subjective evaluation of the problem before and after counselling. Teens are invited to evaluate the extent of their difficulties at Home, School, with Friends and for Self. Parents are invited to evaluate the severity of their difficulties and their ability to manage them. For teenagers who completed the evaluation process Improvement/Great Improvement was recorded as follows. Home 89%: School 74%: Friends 54%: Self 88%. For parents who completed the evaluation process Improvement/Great Improvement was noted as follows: Severity of difficulties 90%: Coping Ability 93% ([Crosscare Teen Counselling Annual Report 2011](#)).



### Measure 3

After the initial appointment with parents and teens the counsellors note the main presenting problem and underlying problems; on closing cases the counsellors assess change in the presenting and underlying problems. For presenting problems information was available for 66% of closed cases: Cleared 13%: Improved 38%: Unchanged 15%. For underlying problems information was available for 62% of closed cases: Cleared 4%: Improved 37%: Unchanged 22%. ([Crosscare Teen Counselling Annual Report 2011](#)).

### Measure 4

After the initial appointment, a general assessment of each teenager's functioning is made and noted by the counselling team using the Children's Global Assessment Scale (CGAS). On closing the case an assessment is again made without reference to the initial assessment. Similarly the Global Assessment of Relational Functioning (GARF Diagnostic and Statistical Manual-IV) is used to make an initial and concluding evaluation of the functioning of the family. For closed cases an average CGAS change of 17 points and an average GARF change of 13 points was noted ([Crosscare Teen Counselling Annual Report 2011](#)).

**In summary there are four ways in which performance is routinely evaluated in Teen Counselling.**

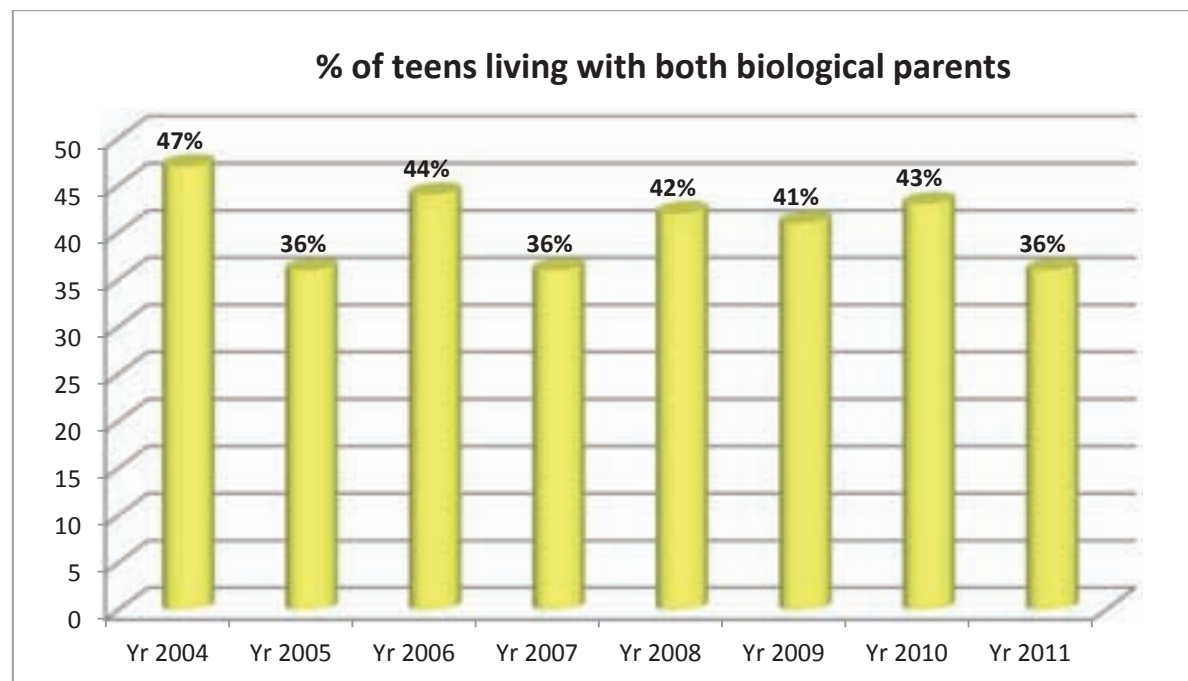
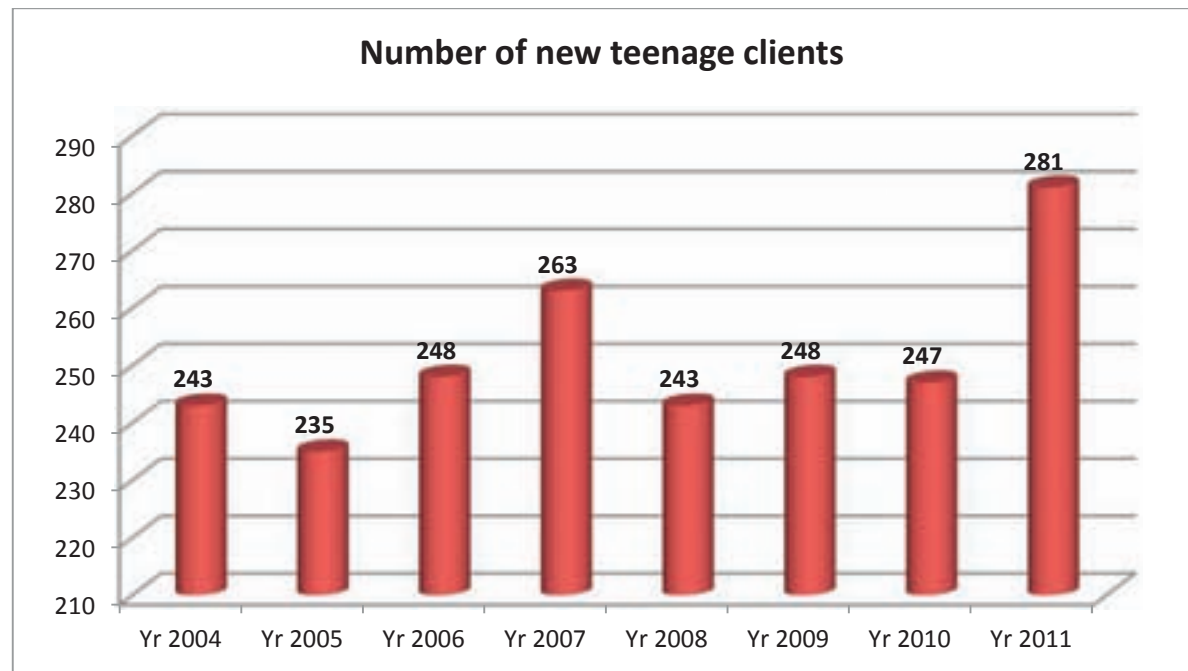
- Intervention aims are noted by the counselling team at the start of counselling and reviewed on closing cases.
- Teen and Parent ratings of problems are made by clients before counselling and change assessed after counselling.
- Presenting and Underlying Problems are noted by counsellors at the beginning and end of counselling and changes evaluated.
- Assessments of functioning are made for teenagers and families before and after counselling using the CGAS and GARF scales and change reported.

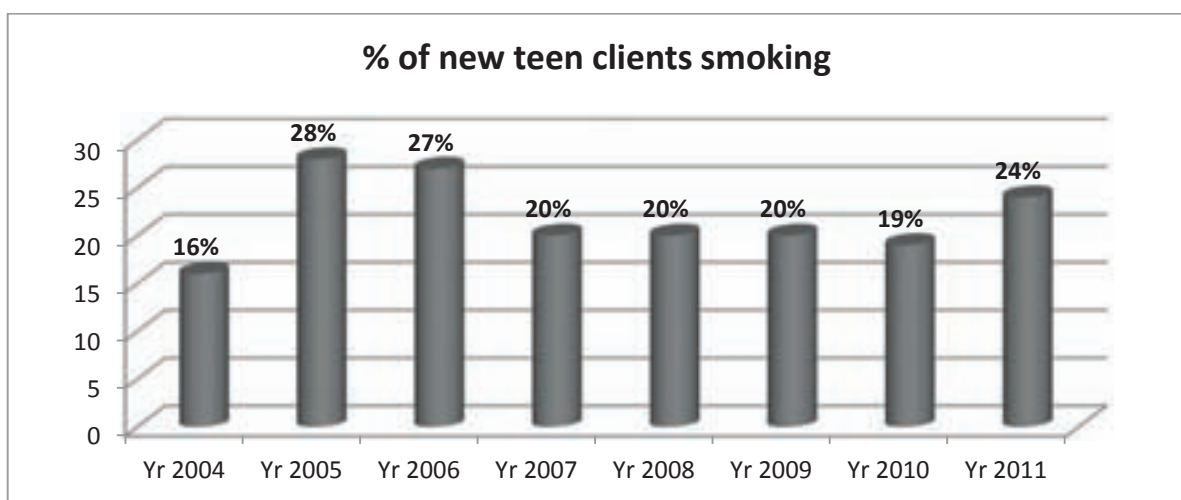
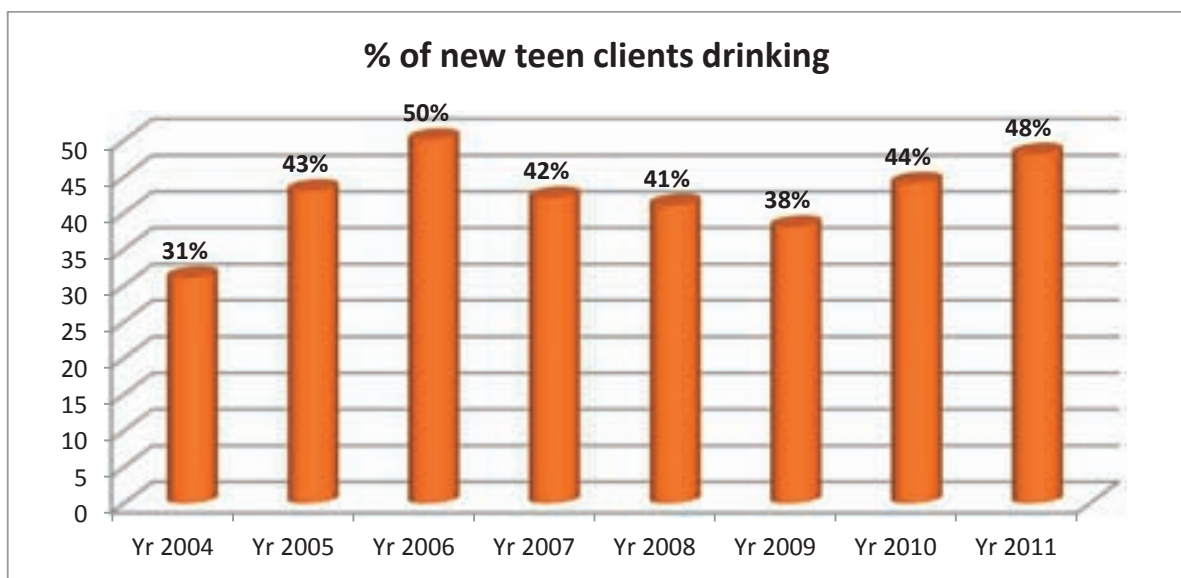
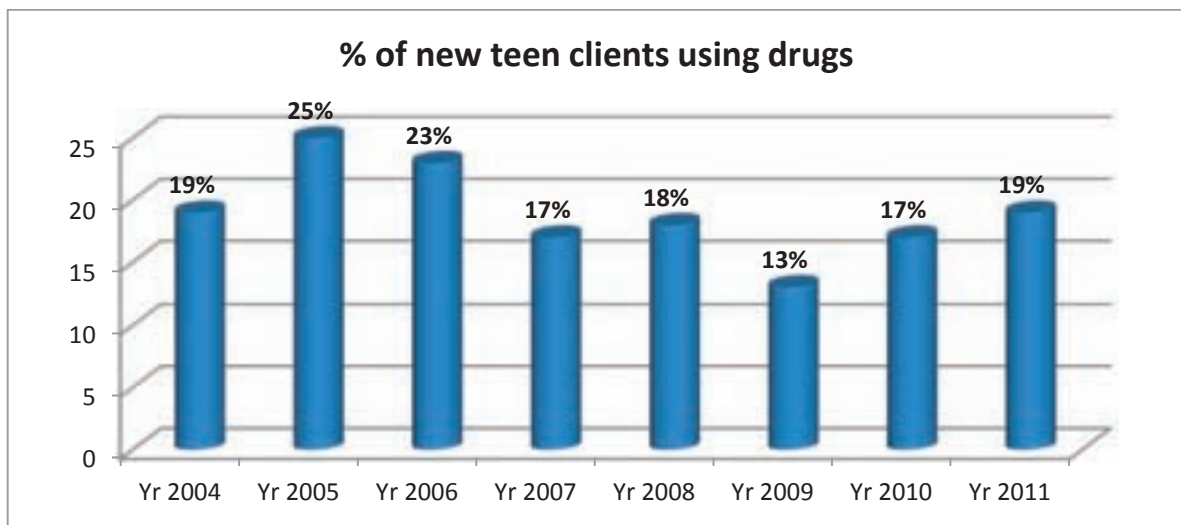
**In addition** each Teen Counselling centre has an anonymous satisfaction questionnaire and comment box in their waiting room.

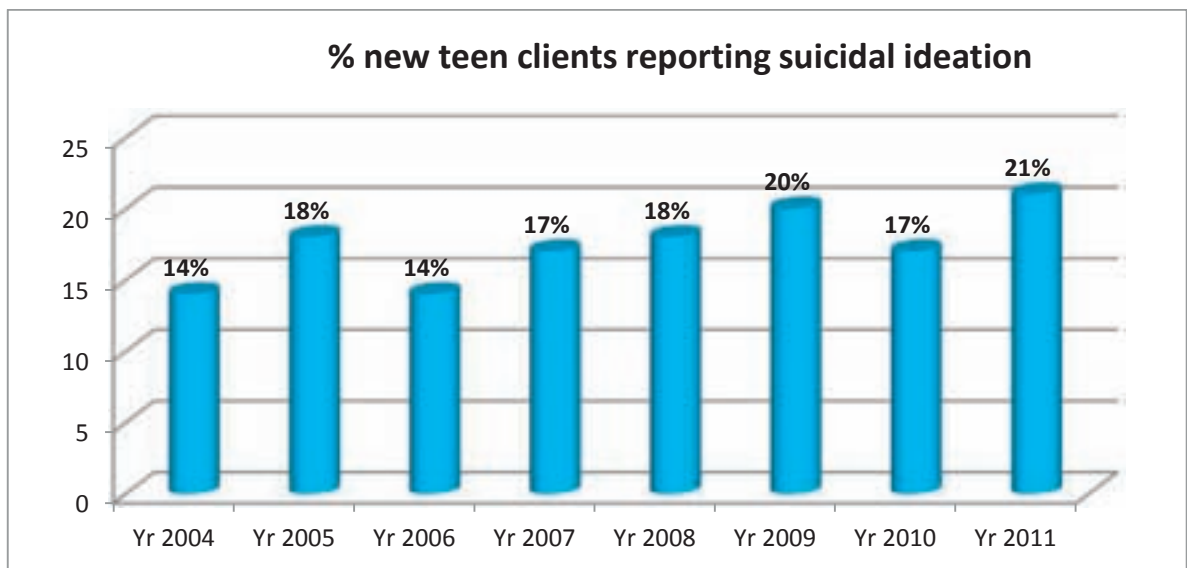
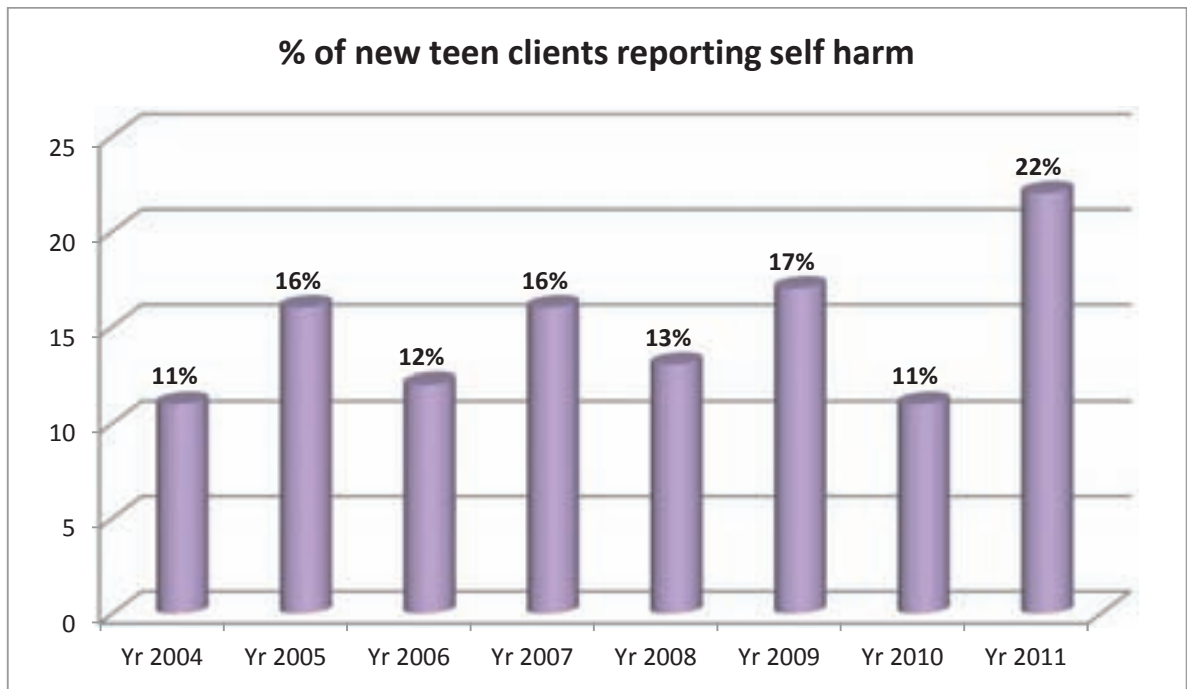
**Currently** an external evaluation by Professor Alan Carr, School of Psychology UCD is in process. ([see Appendix 2](#))

## Teen Counselling 8 year profile of teenage clients

From the beginning of 2004 to the end of 2011, two thousand and eight (**2,008**) teenagers attended Teen Counselling. Some profiles of their family situation, substance use and self-harm/suicide risk are presented below.









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Crosscare believe that every person is created in the image and likeness of God. This places responsibility on us to work to the highest possible standards while treating every person who uses our services and who works for or with us with care, courtesy and love. Our work is guided by four core values:  
Respect, Human Rights, Integrity and Excellence.

◆ Homeless Services ◆ Young People's Care Services ◆ Community Services