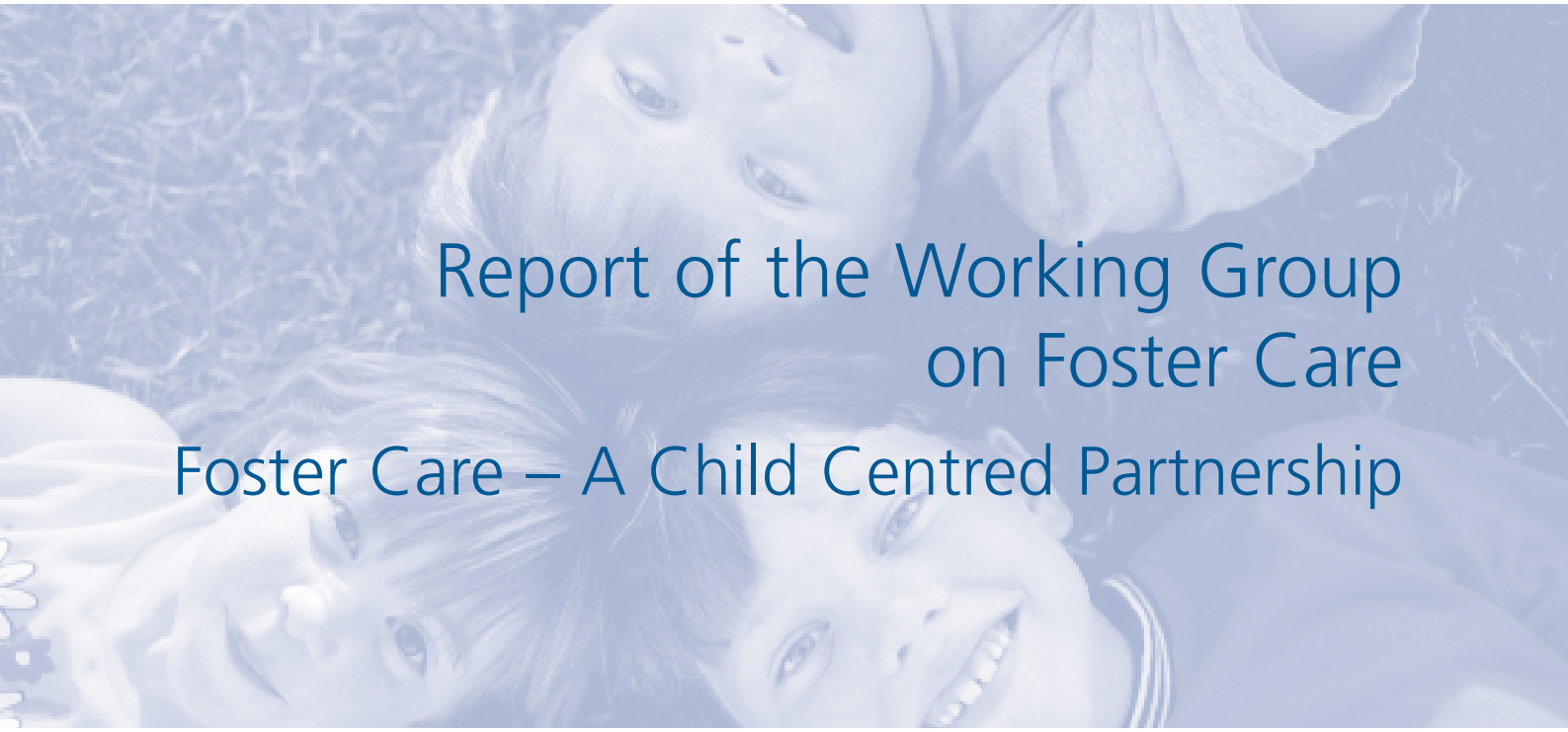
# Report of the Working Group on Foster Care

## Foster Care – A Child Centred Partnership

MAY 2001

DEPARTMENT
OF HEALTH AND CHILDREN
AN ROINN
SLÁINTE AGUS LEANAÍ



# Report of the Working Group on Foster Care

## Foster Care – A Child Centred Partnership

Illustrations by Tom and William

# Foreword by the Minister for Children

Families and family life are very important for all children and the opportunity to experience the qualities of family life is one of the objectives of the National Children's Strategy.

Unfortunately it is not always possible for a child to remain in their own family, for a variety of reasons. Health boards provide alternative care services for these children, the main form of which is foster care.

Foster care is therefore a critically important part of the child protection and welfare service. It is important for all children placed in care, including foster care, that they receive the support and services necessary to meet their needs. Foster carers provide a place in their own home for these vulnerable and often troubled children. Their dedication to helping the children in their care is an example of social and civic commitment at its best. Therefore there is also a need to ensure that they are supported to help them respond to the needs of the children placed with them.

The Government is committed to further strengthening the child welfare and protection and family support services, including foster care. This Report I believe will point the way forward to strengthening the service and provide the guidelines to improve standards in foster care.

I would like to thank the members of the Working Group for producing the Report and all of the individuals and organisations who contributed to its preparation.

Táim sásta gur féidir dul chun cinn a dhéanamh ar son na bpáiste agus ar son iad siúd a thugann aire dóibh.

Mary Hanafin

Mary Hanafin T.D.
Minister For Children

# Table of Contents

INTRODUCTION ....8
Terms of Reference....8
Membership of the Working Group ....8
Structure of the Report ....10
Approach adopted by the Working Group ....11
Acknowledgements ....12

PART 1 ....13
Chapter 1 – Foster Care Services in Context ....15
Social Trends ....16
Changes in Child Protection and Welfare Services ....16
Legislative Framework ....16
The Child Care Act, 1991 ....16
The Child Care Regulations, 1995 ....17
UN Convention on the Rights of the Child ....17
Protection for Persons Reporting Child Abuse Act, 1998 ....18
The Children Bill, 1999 ....18
Other Important Policy Developments ....18
Expansion of Family Support Services ....18
Children First – National Guidelines for the Protection and Welfare of Children ....19
Social Services Inspectorate ....19
The National Children's Strategy ....20
Developments in Education ....20
Developments in Foster Care....21
Increased Demand ....21
Relative Foster Care....21
The Voluntary Sector ....21
The Future of the Foster Care Service ....22

Chapter 2 – Objectives & Principles of a Foster Care Service ....25
Objectives of Foster Care ....26
General Values and Principles of Foster Care....26
National Standard ....28
Devising the National Standards....29

PART 2 .....31

Chapter 3 – Meeting the Needs of Children in Foster Care .....33

Assessment and Matching .....34

Assessing the Child's Needs .....35

Care Planning .....36

Care Plan Reviews .....38

Child and Family Social Workers (CFSW) .....38

Maintaining the Child's Contact with his or her own Family .....39

The Child's Education Needs .....39

Aftercare Planning .....41

Adoption Options for Children in Care .....42

Chapter 4 – Foster Care for Children with Additional Needs ....47

Introduction .....48

Children with Phyiscal, Sensory or Intellectual Disabilities or Autism .....48

Children with Serious Behavioural Difficulties in Need of Special Care .....50

Shared Rearing for Travellers .....52

PART 3 .....55

Chapter 5 – Helping Foster Carers to meet the Children's Needs .....57

Introduction .....58

Recruitment and Retention of Foster Carers .....58

Timeliness of Assessment Process .....62

Training of Foster Carers .....62

Provision of a Link Worker to Foster Carers.....63

Liason between Child and Family Social Worker and Link Worker ....64

Out of Hours Service .....65

Support Groups .....65

Financial Support .....65

Chapter 6 – Placement of Children with Relatives .....71

The Development of Relative Care .....72

Issues in Relative Care .....73

Implications for Service Provision .....74

Chapter 7 – Providing Safe Care .....77
Background to the Issue of Safe Care in the Foster Care Setting .....78
Incidence of Abuse in Foster Care.....78
Characteristics of Abuse in the Care Setting .....79
Ensuring Safe Care .....80
Dealing with Allegations of Abuse.....82
Conclusion.....84

PART 4 .....87
Chapter 8 – Future Organisation and Management of the Foster Care Service .....89
Child Care Services – Three Year Development Plan .....90
Management Structures .....92
Foster Care Teams.....94
Use of Non-Statutory Agencies to supply Foster Care Services .....95
Staffing Levels .....96
Training and Education of Service Providers .....97
Introduction of a Complaints Procedure .....98
Record Keeping and Management Information .....99
Confidentiality .....100
Management Information Systems.....101
Research .....102

# Introduction

Many people involved in the foster care service, including professionals working in the area, voluntary agencies and foster carers, have expressed concerns over the last number of years that the infrastructure and policies around foster care need urgent review. As a result of these concerns, the Minister of State at the Department of Health and Children with special responsibility for children established a Working Group in October 1998 to review and make recommendations on all aspects of foster care service.

## Terms of Reference

The terms of reference for the Working Group were as follows:

"Accepting that where a child requires care outside their own family, in particular if they require care for long periods, they should, as a general rule be cared for in another family; the Working Party on Foster Care is asked to make recommendations, as soon as possible, on all aspects of foster care and in particular in relation to the following areas:

- the requirements for the recruitment and training of foster parents;
- the ongoing training and support that should be provided for foster families;
- the development of relative fostering;
- the requirements for the further development of the foster care service;
- the support and training required for special fostering arrangements;
- the support and training required for fostering arrangements for children with behavioural problems."

## Membership of the Working Group

The following were appointed to the Working Group:

**Mr. John Collins**, (Chairman until October 1999)
Principal Officer,
Child Care Policy Unit
Department of Health and Children

**Mr. Eamon Corcoran**, (Chairman from October 1999)
Principal Officer,
Child Care Policy Unit,
Department of Health and Children

**Ms. Mary Collins**
Development Officer,
Irish Foster Care Association

**Mr. Jim Gibson**
Acting Director of Child Care,
South Eastern Health Board

**Ms. Rio Hogarty**
Foster Carer

**Dr. Johanna Joyce-Cooney**
General Manager,
Community Services,
Midland Health Board

**Ms. Grace Lynam**
Social Worker Fostering and Adoption Team,
Midland Health Board

**Ms. Roisin Maguire**
Child Care Manager,
North Eastern Health Board

**Ms. Augusta McCabe**
Social Work Advisor,
Child Care Policy Unit,
Department of Health and Children

**Mr. Michael McGinley**
Programme Manager,
North Western Health Board

**Ms. Pat Whelan**
National Co-ordinator,
Irish Foster Care Association

**Ms. Joan McLoughlin**
Irish Foster Care Association
Longford Branch

**Ms. Alice Parkinson**
Irish Foster Care Association
Louth Branch

**Ms. Ann McWilliams**
Head Social Worker,
Eastern Health Board

**Ms. Marie Smith**
Social Worker,
Fostering Co-ordinator,
Western Health Board

**Mr. David Smith**, (Secretary)
Assistant Principal,
Department of Health and Children

**Ms. Siobhain Phelan**, (Assistant to the Secretary)
Higher Executive Officer
Department of Health and Children

Mr. Eamon Corcoran was appointed to the Working Group in October, 1999 to replace Mr. John Collins who resigned following his appointment to the Cross-Departmental Team on the National Children's Strategy. Ms. Augusta McCabe resigned in January 2000 when she retired. Ms. Grace Lynam was appointed in December 1999 to replace Dr Johanna Joyce-Cooney who resigned following her transfer to other duties within the Midland Health Board.

## Number of Meetings

The Working Group met on seventeen occasions, which included seven full-day meetings and one two-day meeting.

## Structure of the Report

The Report is divided into four parts.

### Part One

Part One of the report deals with the principles and objectives of the foster care services and the trends and developments within the service over the last number of years.

### Part Two

Part Two of the Report deals with the needs of children in foster care. This covers a range of issues including assessment of needs, care planning, matching and review of placements, education and after-care planning. It also emphasises the need for dedicated social workers to work with the child and his or her own family. The importance of maintaining contact between foster children and their own families and communities is also considered. Particular reference is made to children in foster care with special needs such as specific learning difficulties and behavioural problems. The issue of ensuring equality of access to services for children with special needs is considered. Other issues considered in this part of the report are the further development of the Shared Rearing Service for Traveller Children and the issue of adoption for children in long-term care.

### Part Three

Part Three of the Report considers how best to help foster carers to meet the needs of the children in their care. The Report specifically addresses issues relating to recruitment and assessment of foster carers and the provision of adequate training and support. It also considers issues surrounding the retention of existing foster carers in the system and financial supports. Part Three also considers the placement of children into foster care with relatives (relative fostering) and the provision of a safe care environment for foster children.

### Part Four

Part Four of the Report considers the organisation, management and planning of the foster care service in the context of the overall development of the child protection and welfare services. It makes a number of recommendations

regarding the strengthening of management structures with the objective of delivering a comprehensive and integrated service at community care area level. Planning of the services including the need to develop planning indicators and child care service development plans are also considered.

## Approach adopted by the Working Group

In preparing the Report, the main concern of the Working Group was to review the current service and make recommendations that would enhance the delivery of a high quality service to improve the life chances of children in foster care and promote the best possible outcomes for them. The Group consulted international and national research on fostering and engaged in an extensive consultation process with people and organisations involved in fostering.

- A survey was conducted with foster carers by circulating a questionnaire to every foster carer in the country to ascertain their views on their experience of fostering and to afford them the opportunity to make a submission to the Working Group. A copy of the questionnaire is in Appendix 2 and responses to selected questions of the questionnaire are in Appendix 3.
- The Working Group consulted widely with personnel in each health board area including Child Care Managers, Team Leaders and Social Workers.
- The Secretariat of the Working Group visited Lissadell House – a voluntary organisation providing foster care services in North Dublin.
- The Group invited and received submissions from many organisations involved with fostering or whose activities affected fostering. A list of the groups and individuals that made submissions is attached in Appendix 4 of the Report. In a number of cases individuals and groups were invited to elaborate on their submissions or their experience of an aspect of fostering services.

In addition, in preparing its Report, the Working Group wished to highlight the crucial role of foster care in the child protection and welfare service. It was anxious to put this service in context - as part of a continuum of care designed to promote the wellbeing of children who are not receiving adequate care and protection in their own families. Finally, the Working Group wish to emphasise that the approach adopted in the Report is that the "welfare of the child" principle is the paramount consideration in any decision on the care of an individual child or the future development of the foster care service in Ireland.

The purpose of the Report is:

(i) to set out good practice guidelines for the delivery of the foster care service and

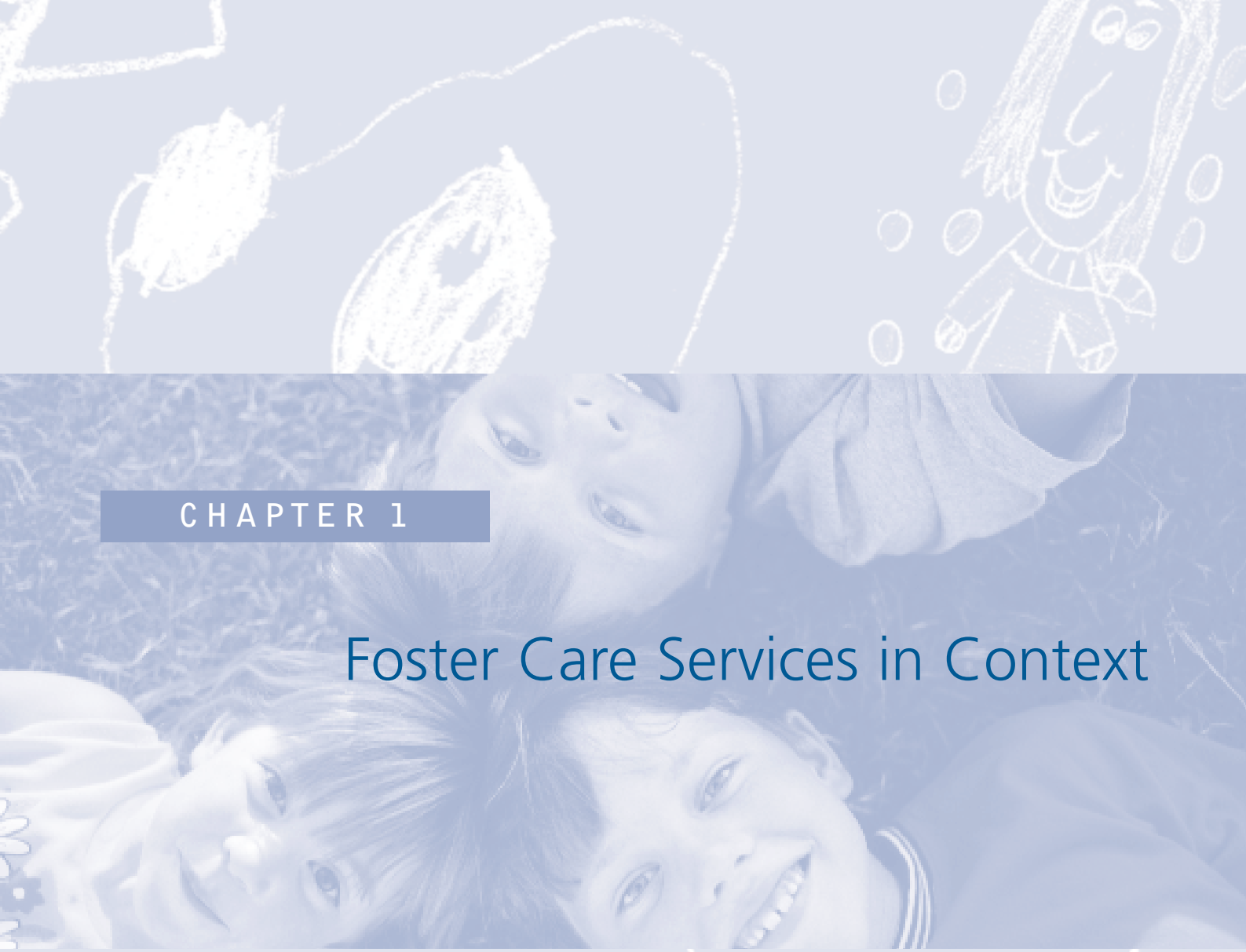
(ii) to make recommendations, which, when acted upon, will ensure that the structures and services necessary to meet the needs and demands of children in foster care, their families and foster carers will be in place for the future.

## Acknowledgements

The Working Group would like to express its appreciation to the individuals and organisations that made submissions and to acknowledge that the consultation process contributed significantly to the preparation of this Report. The Working Group would also like to thank the staff of health boards, voluntary organisations and individuals and groups who took the time and trouble to discuss ideas and make presentations to the Group. It is encouraging to see the extent of the goodwill towards children in need of care and the concern to promote their welfare.

We are deeply indebted to our Secretary, David Smith, for all he contributed to the preparation of this Report. His efficiency and commitment at all times deserves the highest commendation. Siobhain Phelan was excellent in her supporting role. Her reliability and thoroughness in organising and collating the material from the foster carers questionnaire and arranging our discussions and visits were of the highest standard. We are also grateful to Gerard Hughes, Janet Buckley, Miriam Maguire and Liz Canavan of the Department of Health and Children for all their assistance in the editing and production of the Report.

# PART 1



CHAPTER 1

# Foster Care Services in Context

# Chapter 1
# Foster Care Services in Context

## Social Trends

1.1 Ireland has gone through a period of major social and economic change over the past two decades. Child protection and welfare services have also undergone significant change in the last ten years and with it there has been an increase in demand for foster care. Awareness of the problems of vulnerable children, children at risk and their families has been growing since the 1980's and a number of public inquiries have served to bring attention to the need to strengthen our child welfare services. In considering the needs of the foster care service, the Working Group considered it important to look at the service in the context of the developments in the area of child protection and welfare and the wider social trends.

1.2 The increase in demand for foster care has also taken place in the context of significant economic and social changes. There has been substantial economic growth in recent years. Gross Domestic Product has increased at rate of 9.7% on average over the last three years leading to increasing demand for labour[1]. This is one of the factors, which has led to an increase of the number of married women now working outside the home, particularly in the large urban areas. This in turn has led to an increase in the level of demand for paid child care services.

1.3 In addition women are generally marrying later than was previously the case and having children later in life. This is in line with the trends in the rest of the Western world[2]. According to those involved in the foster care service, these trends have had an impact on the number of families coming forward to foster. This inevitably has led to increasing pressure on the system as health boards attempt to meet increasing demand for placements from a smaller pool of foster parents.

## Changes in Child Protection and Welfare Services

## Legislative Framework

### The Child Care Act, 1991

1.4 The purpose of the Child Care Act, 1991 is to update the law in relation to the care of children, particularly children who have been assaulted, ill-treated, neglected or sexually abused or who are at risk. The Act was brought into operation on a phased basis and was fully implemented by December 1996.

1.5 Section 3 sets out the fundamental principles of the Act. It places a statutory duty on health boards to promote the welfare of children who are not receiving adequate care and protection. In carrying out their

1. Webmaster @ CSO.ie
2. Central Statistics Office, That was Then, This is Now, Changes in Ireland 1949–1999, pg 30, 54

functions the boards are obliged, having regard to the rights and duties of parents under the Constitution, to regard the welfare of the child as the first and paramount consideration and in so far as practicable to give due consideration to the wishes of the child, taking into account his or her age and understanding.

1.6 The Act also obliges the boards to have regard to the principle that it is generally in the best interests of a child to be brought up in his or her own family. The focus of the boards' services is therefore on maintaining children within their own families. However, there will always be exceptional circumstances in which children will have to be placed in alternative care arrangements. The Act provides the legal framework for the provision of these services, including foster care. It is in this context that policies in relation to foster care and other alternative care arrangements have been developed.

1.7 The implementation of the Act has been supported by a sustained programme of investment. Additional revenue funding of £135m (€171m) has been provided since 1991. The additional funding is directed at meeting the statutory obligations of the health boards, contained in the Act, by improving infrastructure of child care services in the boards and providing for additional staffing to support new and expanded services.

### The Child Care Regulations, 1995

1.8 Under sections 39 and 41 respectively of the Act, *The Child Care (Placement of Children in Foster Care) Regulations* and *The Child Care (Placement of Children with Relatives) Regulations* were brought into operation in 1995. The Regulations provide for:

- Promotion of welfare of the child
- Pre-placement Procedures
- Monitoring of Placements
- Removal of Children from Placements

A copy of the regulations is attached at Appendix 6.

### UN Convention on the Rights of the Child

1.9 Ireland ratified the *UN Convention on the Rights of the Child* in 1992. The Convention is in essence a "bill of rights" for all children. It contains rights relating to every aspect of children's lives including the right to survival, development, protection and participation. The underlying principles of the Convention may be summarised as follows:

- Non-discrimination (Article 2): All rights apply to all children without exception. The State is obliged to protect children from any form of discrimination and to take positive action to promote their rights.
- Best Interests of the Child (Article 3): All actions concerning the child shall take account of his or her best interests. The State shall provide

the child with adequate care when parents or others charged with that responsibility fail to do so.

- Survival and Development (Article 6): Every child has the inherent right to life, and the State has an obligation to ensure the child's survival and development.
- The Child's Opinion (Article 12): The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

1.10 The Convention recognises the critical role of the family in the life of a child. It states that the family, as the fundamental group of society and the natural environment for the well-being and growth of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities in the community.

### Protection for Persons Reporting Child Abuse Act, 1998

1.11 The purpose of the Act is to provide protection from civil liability to persons who report child abuse "reasonably and in good faith" to a designated officer of a health board or to any member of the Garda Síochána. The other main provisions of the Act provide protection to persons reporting child abuse from being penalised by their employers and also creates a new offence of the false reporting of child abuse.

### The Children Bill, 1999

1.12 The final piece of primary legislation relevant to foster care is the Children Bill, 1999, which is currently before the Oireachtas. This Bill deals primarily with the area of juvenile justice. However, it also places additional responsibilities on health boards in relation to children whose behaviour is such that it poses a real and substantial risk to their health, safety, development or welfare and who are in need of special care and protection. The Bill contains new legal provisions under which such children can be taken into care, and if necessary detained in special care units. The boards will also be empowered to provide accommodation other than special care units in respect of children for whom special care orders are made. One of the alternative forms of care that may be provided is special fostering.

## Other Important Policy Developments

### Expansion of Family Support Services

1.13 The development of services has taken place in the context of a number of policies and initiatives designed to promote social inclusion. The publication of the strategy statements by the Department of Health and Children *Shaping a healthier future* and *Working for health* underlined the commitment to developing child care and family support services. Public policy in relation to families has also been informed by the Report of the Commission on the Family *Strengthening Families for Life.*

1.14 The aim of preventative family support services is to reduce the risks to vulnerable children by enhancing their family life and so avoiding their entry into care. A number of initiatives have been undertaken to strengthen these services. These include the establishment of pilot projects under the *Integrated Services Process* the aim of which is to develop new procedures to ensure a more focused and better co-ordinated response, by statutory agencies, to the needs of communities with the greatest levels of disadvantage.

1.15 In January 1998 the *Young People at Risk* programme was established, the centrepiece of which is the young people's facilities and services fund. An allocation of £7.2 million was made from this fund to launch the *Springboard* Initiative under which fifteen pilot projects have been established. The objective of the projects is to prevent at risk children and young people from engaging in various forms of anti-social behaviour by providing a pro-active, inter-agency response to support these young people and their families. The projects provide for the establishment of formal collaborative structures involving relevant public agencies, the voluntary sector and the local community. These in turn provide for the identification or establishment of a local centre, which will act as a focal point for the delivery of services to children, young people and their families. An evaluation study of the projects is being undertaken at present.

### Children First – National Guidelines for the Protection and Welfare of Children

1.16 In September 1999 *Children First - National Guidelines for the Protection and Welfare of Children* were published. These are national over-arching guidelines, which apply to all individuals and agencies that are dealing with children. They are intended to support and guide health professionals, teachers, members of the Garda Síochána and those involved in sporting, cultural, community and voluntary organisations that come into regular contact with children. The Guidelines are being implemented as a priority by the health boards and a national advisory group has been established to ensure their implementation. The number of reported cases has increased from 3,252 in 1989 to 10,031 in 1999, the latest year for which figures are available.

### Social Services Inspectorate

1.17 The *Social Services Inspectorate* (SSI) was established on an administrative basis in 1999. It is proposed to establish it on a statutory basis. The main function of the SSI, at present, is to support the child care services by promoting and ensuring the development of quality standards. It does this by monitoring the organisation, operation and management of child care services and by evaluating the quality and responsiveness of services as experienced by both users and service providers. While the initial focus is on residential care it is anticipated that the Inspectorate will be looking shortly at standards in foster care.

### The National Children's Strategy

1.18 The National Children's Strategy was launched in November 2000. It is a ten year plan to improve the quality of all children's lives and includes a wide range of proposed actions across areas such as tackling child poverty. It sets out three National Goals and the measures to implement them. The Goals are that:

- children will have a voice;
- children's lives will be better understood;
- children will receive quality supports and services.

The Strategy involves a major reform of how the Government manages services for children including:

- the establishment of a Cabinet Committee for Children chaired by the Taoiseach;
- an expanded role for the Minister of State with Special Responsibility for Children, to be known as the Minister for Children to oversee the co-ordination of all Government policies for Children;
- a new National Children's Office to operate on a cross-departmental basis and support the new role of the Minister for Children;
- a full review of the current Departmental responsibilities for children among Government Departments.

The National Children's Office has already been established on an administrative basis.

### The Health Boards Executive

1.19 The *Health (Eastern Regional Health Authority) Act* was enacted in 1999. The main function of the Act was to provide for the establishment of the Eastern Regional Health Authority and three subsidiary health boards to improve the planning and delivery of health and social services in Dublin, Kildare and Wicklow. In addition the Act establishes the Health Boards Executive. The membership of the Executive is made up of the Chief Executive Officers of the Health Boards. It will carry out functions on behalf of the health boards at a national level to improve the efficiency and effectiveness of health and personal social services.

### Developments in Education

1.20 An issue which is of particular importance in relation to children in care is education. It has been recognised in the Department of Education and Science's recently published document *The New Deal, A Plan for Educational Opportunity* that leaving school early is the most significant indicator of those likely to be caught in cycles of disadvantage. While there are no national figures in relation to the educational attainments of children in care the indications are that a very high proportion suffer

from educational disadvantage. Research abroad would indicate that the majority leave school with minimal or no qualifications[3].

1.21 There have been various initiatives undertaken in recent years to tackle educational disadvantage such as the *8-15 Year Old Early School Leavers Initiative* and the *Stay in School Initiative.* Other developments in this area include the introduction of the *Education Act, 1998* and *the Educational Welfare Act, 2000*. The provision of education and the putting in place of mechanisms to enable these children to stay in school and reach a standard level of education remains one of the major issues that needs to be addressed in the context of improving services for children in care.

## Developments in Foster Care

### Increased Demand

1.22 Foster care has become the main form of alternative care for children provided by the health boards. There has been a very significant increase in the numbers entering into foster care in recent years. In 1989 there were 1,986 children in foster care, in 1999 there were 3,289. This is an increase of 66%. In the same period there was an increase in overall numbers in care of 52%. The increase in the numbers in foster care represents an increase from 16 per 10,000 to 31 per 10,000 persons under eighteen. This increase has occurred largely from the impetus given by the *Report of the Task Force on Child Care Services (1980)* and from the introduction of the Child Care Act, 1991.

### Relative Foster Care

1.23 There are a significant number of children placed in the care of their relatives and this too is a growing trend. This reflects a recognition of the importance of family identity and of the positive role that other family members can play in the care of vulnerable children or children at risk. It is evident from this trend that relative fostering will become an increasingly more important part of the service.

### Long-Term Care

1.24 An aspect of the child welfare alternative service, which the Working Group noted with some concern, is that there is a higher proportion of children in long-term care in Ireland than is the case in either the U.K or the U.S.A.[4]. These trends are considered in more detail in the report to the Working Group.

### The Voluntary Sector

1.25 Other developments in the service have been the establishment of the *Irish Foster Care Association* (IFCA) and the *Irish Association of Young People in Care* (IAYPIC). The IFCA was established in 1981. Its aim is to

3. Pinkerton. J, in Kelly and Gilligan, Issues in Foster Care, Policy, Practices and Research, Jessica Kingley Publishers, pg 94
4. Gilligan R, Children Adrift in Care can the Child Care Act 1991 rescue the 50% who are in care five years or more, Irish Social Worker, Vol 14, No.1

promote and support foster care. Its membership includes foster families, social workers and others involved in the foster care service. The Association has produced a number of publications on foster care issues and provides a telephone help line for foster carers. It also represents the views of those involved in foster care to the health boards and the Department of Health and Children. Since 1997 the Association has received public funding to help it in its work. The IAYPIC was established to provide a forum for young people and supportive adults to represent the interests of young people in care. It believes that all children and young people who have been, or are in care have a right to express their opinion about their experience freely. Since 1999 the Association has also received public funding to help it in its work.

## The Future of the Foster Care Service

1.26 Despite the very significant developments in the child welfare services highlighted above, because of the social trends and the substantial increase in the number of reported child abuse cases and number of children being admitted into care, the services continue to experience serious pressures. This applies as much to the foster care service as any other aspect of the child protection and welfare service. In the subsequent chapters of this Report the Working Group addresses the issues arising from these pressures.

- A number of the submissions to the Working Group expressed the view that the child care system is driven by the need to respond to immediate child protection issues. The necessity for an immediate response required in these cases can have an impact on the ability to adequately plan and develop services for children who are already in the care of the boards. The Working Group feels that it is critically important to highlight that health boards have a corporate responsibility towards those in their care. The Group fully acknowledges the importance of the work carried out on child protection, however it feels that there is a need to ensure that adequate attention and resources are allocated to the alternative care services.

- Concerns were also expressed to the Working Group that the standards set out in the current regulatory framework were not always adhered to. Therefore, additional resources on their own will not be sufficient to improve the quality of care for those children coming into the health board child care system. There needs to be a greater emphasis on maintaining and improving the quality of care and measuring of the outcome of the service provided for these children.

1.27 The approach taken in making recommendations is based on building on what is already in place and is centred around two key themes :-

- Maintaining and improving the quality of care and improving the outcomes for children in care. This involves addressing issues such as assessment, matching, care planning, review of care and educational plans and aftercare strategies.
- The corollary to implementing the highest standards possible is ensuring that all parties have the information necessary to avail of their rights and meet their responsibilities. There need to be clear protocols set out for children and young people, their parents or guardians and foster carers to guide them in their dealings with the health boards. In relation to foster carers there is a need to ensure the highest standards in relation to assessment, training and support.

CHAPTER 2

# Objectives & Principles of a Foster Care Service

# Chapter 2
# Objectives & Principles of a Foster Care Service

2.1 Children come into care for a variety of reasons such as neglect, parental inability to cope, parents suffering from some form of addiction or because of physical or sexual abuse. Inevitably many of these children have already suffered traumatic experiences and there is a need for the child protection service to put structures in place to build up protective factors in their lives and enable them to become mature and responsible adults.

2.2 The majority of children in care now live with foster carers. This chapter outlines fundamental principles of good practice and values that are to be expected of a modern foster care service.

## Objectives of Foster Care

2.3 A modern foster care service should have the following objectives:

- To protect, develop and care for children who for a variety of reasons need alternative care through the foster service;
- To promote the health, education, welfare and development of children placed in foster care;
- To provide the necessary support for children to develop their self-esteem and life-coping skills to improve their life chances so as to enable them to escape the cycle of social exclusion and help them to fulfill their potential and become mature and responsible adults;
- To provide, in so far as is reasonably possible, a normal family environment with the love and support such an environment can provide.

## General Values and Principles of Foster Care

2.4 Any alternative care system, including foster care, must endeavour to not only meet the basic physical needs of children in care, but also to provide for their emotional, social and intellectual development. The guiding values and principles of such a foster service should include:

- The provision of high quality care in a family setting for all children and young people who need it, to aid their return to their own family wherever appropriate;
- Priority for the needs of the child or young person in determining foster placements – with health boards recruiting and retaining a wide range of carers to meet every child's needs;
- Respect for and recognition of the importance of ethnic origin, cultural background, religion and language of children and young people, their families and foster carers in the planning and provision of each placement;

- Consideration of the gender, sexuality and any disability of children and young people who are fostered – so that individual needs are met within each placement;
- Continuity in the lives of children and young people – so their identity and education can be maintained and developed, their physical and psychological well-being promoted and their full potential achieved;
- A partnership approach embracing parents, and children, foster carers and their families, social work staff and other staff in planning and working in the best interest of the child who is fostered;
- Continuity and consistency in training, support and information for foster carers, social work staff and other staff to enable them to meet the needs of each child;
- Respect for foster carers – as the partners of other professionals in the fostering team;
- The provision of aftercare for young people leaving foster care, in accordance with the Child Care Act, 1991 and the Foster Care Regulations 1995.

In fulfilling these responsibilities health boards have to respect the rights of the children coming into care and the rights of their parents, the foster carers and the personnel delivering the services. The principal right of the child is to be respected and provided with appropriate care and protection. The parents, foster carers and health board personnel also have the right to respect, acceptance and consideration in matters relating to the placing of a child in foster care.

2.5 However, rights also entail responsibilities and all parties have the fundamental responsibility to act in the best interests of the child. This means that there is a need on the part of all parties to co-operate in providing the best possible care for children coming into foster care. These rights and responsibilities give rise to a whole range of reciprocal rights and responsibilities in relation to assessments, care planning, reviews, training and support and the right to information. The rights and responsibilities of all parties involved in foster care are best illustrated in the list in Appendix 5.

2.6 Different children, depending on their situation and age, will require different services or mix of services. Within foster care itself there is a need to provide a range of flexible services including long-term, short-term, emergency, respite, and day fostering. **The needs of children in alternative care are often demanding and complex. In providing services to meet these needs the service providers have to bear in mind the need for flexible, and where necessary, multi-disciplinary and cross-service responses.** The foster care service therefore cannot be seen in isolation from other services. Foster care

must be seen as part of a continuum of care, which includes child protection work, residential care and family support services.

## National Standard

2.6 The successful provision of a high quality service for foster children requires a partnership approach on the part of all of those involved in the provision of the service. It also requires maintaining and constantly striving to improve the standards in relation to the provision of services. The area of child welfare is continuously developing as new approaches to providing child welfare and protection services are developed. Policies in relation to the delivery of services need to be adjusted to meet changes in society generally and more specifically the needs of vulnerable children, children at risk and their families.

2.7 The Working Group proposes that National Standards on Practices and Procedures on Foster Care be established. The standards should provide detailed guidelines to enable health boards to assess their service and ensure that the needs of the children and young people in their care are being met and that their rights are respected. National guidance on standards will improve the quality and consistency of services for children and young people throughout the country. Standards of this nature have already been developed in Ireland in relation to special residential care and inter-country adoption assessment. The experience gained through these developments should be utilised in the development of national standards for the foster care service.

2.8 The Working Group believe that the development of *National Standards* will improve the service and will ensure that each child or young person in foster care enjoys the basic essentials for a happy and successful foster placement i.e. each child:

- is in a appropriate safe, healthy and stable environment;
- is protected from all forms of abuse;
- is comprehensively assessed as to their needs;
- has a written care plan which is implemented and regularly reviewed;
- is matched with foster carers that have the ability and training to meet their needs;
- has a designated social worker who ensures that the requirements for his or her care are met and promotes her or his welfare and development;
- is encouraged and facilitated in maintaining contact with his or her own family;
- receives the health care that he or she needs for their physical, emotional and social growth;

- receives the education necessary to enable him or her to develop and meet their full potential;
- is provided with an aftercare plan to help him or her develop the life-coping skills, competence and knowledge necessary for adult life.

2.9 The development of *National Standards on Practices and Procedures in Foster Care* should also include standards and practices relating to foster carers themselves. These standards will help ensure that foster carers are:

- comprehensively assessed and formally approved to ensure they are able to carry out the functions of a foster carer;
- provided with the necessary training required to equip them with the skills and knowledge necessary to provide high quality care for each child or young person placed in their care;
- provided with a designated social worker to provide the necessary supervision and ongoing support, including formal reviews, required to enable them to give the high quality care for each child or young person placed in their care;
- given the opportunity to discuss and give feedback on the range and quality of services provided by the health boards.

2.10 Finally, the *National Standards on Practices and Procedures in Foster Care* should provide guidance to the health boards on how they can effectively meet their statutory obligations to:

- have effective policies in place to promote the welfare of children in their area that are placed in foster care;
- endeavour to recruit and retain sufficient number of foster carers to meet the needs of the service;
- effectively manage and supervise the foster care service staff;
- effectively manage and supervise foster carers;
- ensure that staff involved in the delivery of foster care services are professionally qualified and appropriately trained and supported;
- ensure that children or young people are placed with foster carers appropriate to their needs;
- put in place procedures to enable children or young people, their parents and foster carers to make effective representations or complaints regarding any aspect of the service.

## Devising the National Standards

2.11 The Working Group considers that the role envisaged for the Social Services Inspectorate suggests that they are best placed to take the lead role in the development of these standards. The Inspectorate has already drawn up draft standards for high support and special care

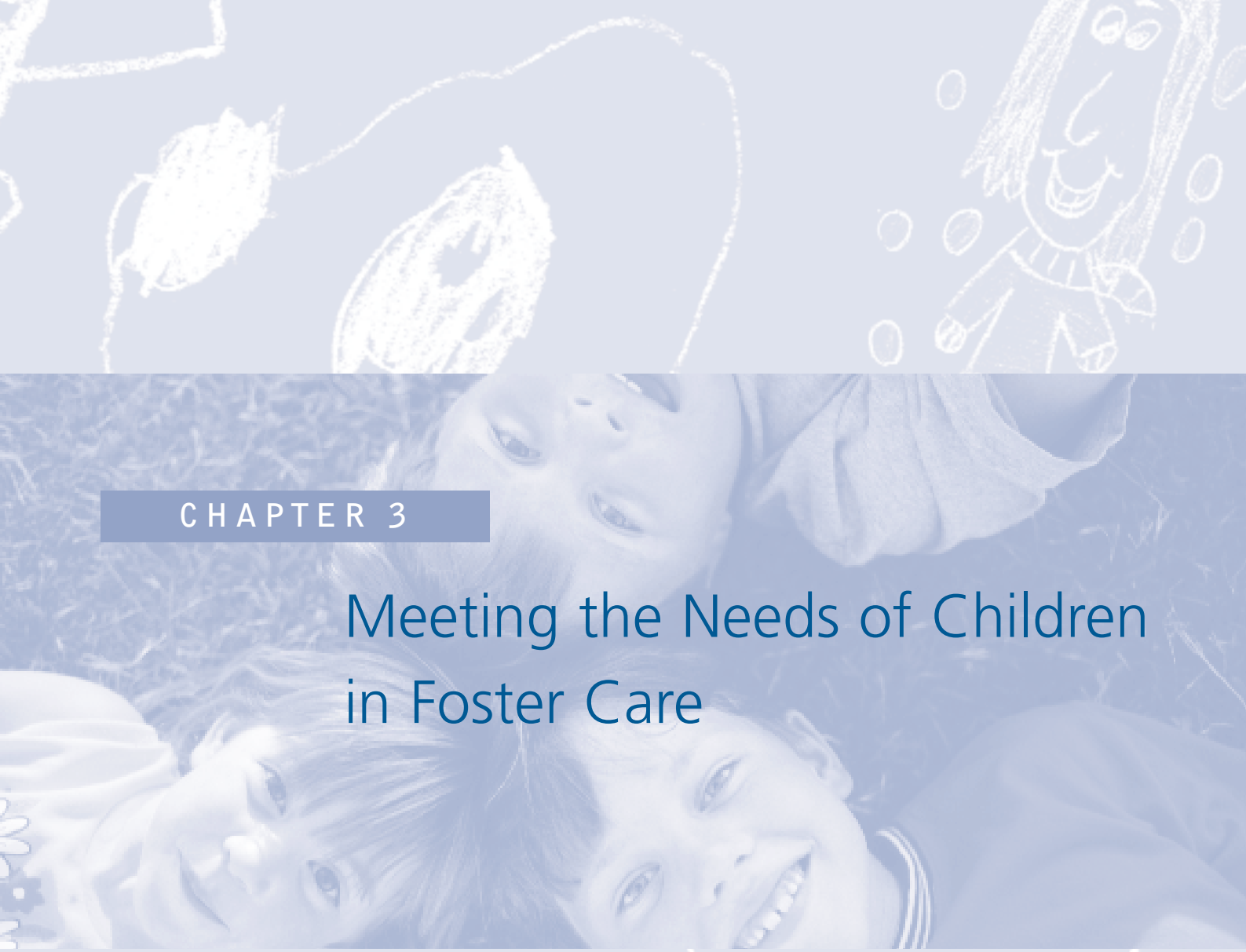
units and it is proposed that the same mechanism is used to draw up the foster care standards.

2.12 The development of the *National Standards on Practices and Procedures in Foster Care* must involve widespread consultation with the key stakeholders of the service. These include the Department of Health and Children, health board staff, both management and staff delivering the service, foster carers, children in foster care, as appropriate, their parents or guardians, and any other relevant agency.

## Recommendation

1. National Standards on Practices and Procedures should be drawn up by the Social Services Inspectorate, in consultation with the Department of Health and Children, the health boards, foster carers, children in foster care, as appropriate, their parents or guardians, and any other relevant agency (paragraphs 2.11 and 2.12).

# PART 2



CHAPTER 3

# Meeting the Needs of Children in Foster Care

# Chapter 3
# Meeting the Needs of Children in Foster Care

3.1 As indicated in the previous chapter, children coming to the attention of health boards depending on their situation and age will require different services or mix of services to meet their needs. Family support services work to provide early intervention for vulnerable children and families at risk. However, crisis interventions are still required for some children. Sometimes, the child being placed in care may be coming from complex family circumstances and have experienced trauma over a period of time prior to being placed in care. To best complement the family support service, therefore, the foster care service needs to be able to respond with flexibility to needs of particular families and children. In this chapter, we consider how children's needs can best be assessed, planned for, monitored and reviewed in the foster care setting.

## Assessment and Matching

### Assessment of Child's Circumstances

3.2 International research indicates that short-term foster care placements have a higher success rate than long-term foster care. The research further shows that mismatching or lack of support to the children and foster carers are most likely factors leading to unsuccessful foster care arrangements. The successful placement of adolescents is particularly difficult and it is this group that experiences the highest level of foster placement breakdown[1]. The regulations set out that the child's circumstances shall be assessed before placing him or her with foster carers. The assessment should include a medical examination unless the health board is satisfied that it is unnecessary[2].

### Matching

3.3 This evidence suggests that it is critically important that a child is placed with foster carers who are able to cope with the demands of the particular placement and provide the necessary care for the individual child. An essential element of the assessment process, for both the child and foster carer, is to match the specific needs of the child with the abilities, skills and experience of potential foster carers.

### Emergency Foster Care

3.4 The Regulations provide that in emergency placements the assessment should be carried as soon as it is practical to do so[3]. The Working Group recommends that health boards ensure consistent compliance with Regulations in relation to the carrying out of assessments of children's needs prior to placements with foster carers. In the case of

1. Kelly G., in Kelly and Gilligan, Issues in Foster Care, Policy, Practice and Research, Jessica Kingley Publishers, pg 69- 73.
2. Section 6, The Child Care Regulations 1995 (Placement of Children in Foster Care) Section 7, The Child Care Regulations 1995 (Placement of Children with Relatives)
3. Section 11, Ibid.

emergency placements the Working Group recommends that the health board should commence the assessment of the child's circumstances within a week of the placement.

3.5 Emergency foster care can be a very difficult task to undertake and the demands of dealing with emergency placements require specific skills and experience. There is therefore a specific role for emergency foster care in the service. The Working Group has considered the evidence that experienced foster carers generally have better skills and training to cope with children with more challenging behaviour. In light of this fact the Working Group recommends that, in general, children in need of emergency care or who otherwise have serious difficulties should be matched with more experienced foster carers.

3.6 The Working Group recommends that all health boards establish a panel of emergency foster carers who have the appropriate skills to care for children in emergency situations. The Working Group further recommends that in establishing these panels health boards should come to arrangements with more experienced foster carers to provide an emergency foster care. These foster carers should be involved when the formal assessment is being carried out.

## Assessing the Child's Needs

### Previous Assessments of the Child or Family

3.7 In general, the health board is already familiar with the case histories of the children coming into care due to previous contact with the social work department. As a result, the health board frequently has already undertaken an assessment concerning their protection and family support needs. The Working Group recommends that any relevant previous assessment carried out by the board should be taken into account in order to ensure all relevant information available to the board is properly considered in the foster placement assessment process. This will also avoid unnecessary duplication of effort by all parties involved in the process.

### The Assessment Process

3.8 The Working Group recommends that the assessment and matching process should be carried out by a multi-disciplinary team which includes an appropriate range of professionals who can address the child's emotional, psychological and medical needs. It should also include any other persons concerned with the child's protection and welfare, the child's family and the child him or herself having regard to his or her age and understanding.

3.9 The Regulations do not provide a detailed framework for the assessment of the child's needs. The Working Group recommends that comprehensive assessment of need should be carried out, taking into account the following areas:

- the child 's age,
- the child's health,
- the child's education needs,
- the child's emotional and intellectual development,
- the child's behaviour,
- the child's ability to understand their situation,
- the child's relationships with other family members,
- the child's self care skills,
- the child's cultural, religious, racial and ethnic background,
- the child's linguistic needs,
- the child's abilities and experience in relation to forming attachment with people and
- the impact of the loss, separation or trauma that the child has experienced before going into care.

### Placements in the Local Community

3.10 The Working Group considered the need, where possible, to plan the placement of a child in care in his or her own community. This will not always be possible and in a very small number of cases may not be in the child's best interests. Nevertheless, the Working Group recommends that, in assessing the needs of the child, placement in the community should be considered a priority issue. This approach is intended to ensure that the child is enabled to maintain his or her friendships, remain in the same school and maintain contact with his or her own family. The Working Group acknowledges that this approach will have implications for health boards and their foster carer recruitment and retention policies.

## Care Planning

### The Purpose of Care Plans

3.11 The Regulations provide that a health board must, before placing a child in foster care, prepare a plan for the care and upbringing of the child[4]. The care plan is to include the aims and objectives of the placement, and the supports to be provided for the child, the foster carers and the child's parents. It also covers access and care plan review arrangements. In the case of an emergency placement, the Regulations provide that the care plan is to drawn up immediately after the assessment process is completed. The regulations provide for consultations with the foster carers, the child and his or her parents or guardians, in drawing up a care plan, where it is practical to do so. In practice health board personnel make every effort to consult with all the important people in the child's life.

4. Section 11, The Child Care Regulations 1995

3.12 The transition to full social citizenship involves growing from being a child through adolescence into adulthood. In general most people acquire the social skills necessary to achieve this transformation from their family, through developing friendships and in school. Many of the children and young people in care will have experienced serious disruption to these relationships and may also be experiencing difficulties in school. As a result many miss out on acquiring the ordinary social skills that enable most people to mature and get on in life. The care plan therefore also needs to address these issues and provide for the personal development of the child or young person. The care plan should also provide for age appropriate relationships and sex education.

### Current Practice

3.13 The Working Group is concerned that not all children placed in foster care have a detailed care plan in place for them[5]. The experience of care planning for children in foster care appears similar to the experience in residential care. The Social Services Inspectorate in their *Report of Findings Relating to the Inspection of Children's Residential Centres* in October 2000 expressed concern that care plans were only completed before admission in a minority of cases. Others were written anywhere between two weeks and two years following admission. The Inspectorate found that the key factors in determining whether meaningful care plans are prepared or not was the leadership of social work managers and the expectations of managers in children's residential centres[6].

3.14 While it is acknowledged that drawing up care plans takes time and resources, the Working Group is firmly of the view that the effective operation of care plans is critical to the successful placement of a child in foster care. Care plans are an essential part of the management and planning for a child's placement in foster care. Where the aims and objectives of a placement are not defined and communicated to the relevant parties it is difficult to see how the potential benefits of the placement can be maximised. The lack of satisfactory care planning is a matter of great concern that needs urgent attention by health board management.

3.15 The Working Group strongly recommends that a care plan be drawn up regardless of whether a child is being placed in short, medium or long term care. The care plan should be drawn up in partnership with the relevant parties involved and should also be done within an inter-disciplinary framework. The care plan must, as a minimum, conform to the standards set out in Regulations. It should clearly identify the particular needs of the child, the agreed services and supports to be provided for the child, the foster carers and the parents or guardians.

5. See Appendix 3
6. Irish Social Services Inspectorate, Report of the Findings Relating to Inspection of Children's Residential Homes, pg16

An agreed allocation of responsibilities between the various parties as to who will provide which services and supports should also be included.

3.16 Care plans should be maintained in writing and a copy of the plan should be provided to the child, where it is appropriate to his or her age and understanding, the foster carer and the child's parents or guardian. The plans should be finalised at a formal meeting. In cases where a child has been involved in a family welfare or group conference all the participants at that conference should receive a copy of the care plan. A sample care plan is included in Appendix 7 for reference.

## Care Plan Reviews

3.17 The Regulations also provide that that the case of each child in foster care shall be reviewed as often as necessary and at least every six months during the first two years of the child's placement[7]. They also provide that reviews shall be carried out at least annually after that. The first review must be carried out within two months of the placement.

3.18 The Working Group is concerned that care plan reviews are not being carried out as regularly as required under the regulations for children in long-term foster care. If reviews are not carried out regularly then there is a serious danger that the children will simply drift in care and that their care plans will become obsolete. The absence of reviews can also be a sign of a lack of communication between the health board, the child, the foster carers and parents. This lack of communication can contribute to the development of problems, which, if identified too late, can have an adverse impact on the placement. **Reviews of the placement therefore need to be carried out regularly and within the timeframes set out in the regulations. The Working Group recommends that these timeframes should be regarded as the absolute minimum to which health boards must conform and that more frequent reviews be carried out as necessary.** The Working Group recommends that a designated officer of the health board should be assigned responsibility to ensure that child care reviews are undertaken in accordance with the Regulations.

## Child and Family Social Workers (CFSW)

3.19 The Child Care Regulations, 1995 provide that a person authorised by the board shall visit a child placed in foster care or with relatives as often as the board considers necessary. Social workers are the persons authorised to carry out this role and the Regulations require that a child is visited a minimum of every three months for the first two years in foster care and at least every six months for placements that last longer than two years[8].

3.20 The relationship between all the parties involved in foster care is highly complex and critical to the success of any foster placement. There is usually ongoing inter-action between health board social workers, the

7. The Child Care Regulations Section 18, Op Cit.
8. Section 17, Ibid

child in foster care, the foster carer and the child's family. It is important that all parties to the placement build up trust between them. It takes considerable time and effort to build that level of trust on all sides.

3.21 It is important that the children, parents or guardians and foster carers feel that each of their concerns is being fully taken into account. The Working Group acknowledges that social workers and other health board personnel involved in providing child care services are doing a difficult job in difficult circumstances. Nevertheless, situations will arise from time to time in which communications between the parties breakdown. Communication breakdown can lead to conflict situations and result in placement breakdown.

3.22 The Working Group therefore recommends that a designated social worker be assigned as the *Child's and Family's Social Worker* (CFSW) as soon as the family come to the attention of the social work department. A different social worker should be assigned to the foster carers. This issue is addressed in Chapter 5. The Child and Family Social Worker will be responsible for arranging the assessment, placement and development of the care plan for the child entering foster care. It is of vital importance that the Child and Family Social Worker and the social worker assigned to the foster carers develop close relationships and co-operate in the best interests of the child.

## Maintaining the Child's Contact with his or her own Family

3.23 It is important for every one to have a sense of their own identity and it is particularly the case for children in care. Research and experience shows that the longer they are in care contact between children in care and their families tends to diminish[9]. It should be the Child and Family Social Worker's responsibility to endeavour to maintain as much contact as is reasonably possible between the children and their own parents taking into account the child's safety. It is recommended that the Child and Family Social Worker should manage the contacts in line with the agreement in the Care Plan and where contact is minimal should ensure that the child has up to date knowledge of his or her family and their circumstances.

## The Child's Education Needs

3.24 Every child in foster care has a right to education. Attendance at school can promote self-esteem and can afford a normative experience for children living in different circumstances to their peers. Therefore, the care setting in which a child is placed should be one in which education is valued and the child's educational needs are actively addressed. Every child should be encouraged to attain his or her educational potential. A good education can also provide young people from a disadvantaged background the opportunity to escape the cycle of disadvantage in adulthood.

9. Kelly G. Op Cit. pg. 67

3.25 International research however, shows that the educational attainment of children in care is significantly lower than for those outside the care system[10]. This reinforces the cycle of disadvantage that these children experience. Many children entering foster care are already at an educational disadvantage and have experienced a lack of continuity of education. In many cases school attendance has suffered and there is a high drop out rate among children in foster care before they undertake state examinations such as the junior or leaving certificate.

3.26 Reasons for poor attendance and early school leaving are varied. The child's life experience to date may have had an impact on their ability to concentrate and apply themselves in the school setting and many have discipline or bullying problems at school. Children in these circumstances may need additional help such as support or remedial education. It is extremely important to promote education in the child's care plan and continuity and quality of this education should receive special attention. The health boards should regard educational attainment as a major benchmark in relation to these children.

3.27 In this regard, the Working Group notes the provisions of the *Education Act, 1998*. This Act provides for giving practical effect to the constitutional rights of children as they relate to education;

- providing as far as practical and having regard to the resources available, a level and quality of education appropriate to meeting needs and abilities of residents in the state; and
- promoting equality of access to and participation in education

3.28 In addition, implementation of the *Education (Welfare) Act, 2000* will provide for a comprehensive national system of ensuring children of compulsory school-going age attend school or at least receive a minimum education. The Act will also lead to the establishment of a *National Educational Welfare Board* and research to address the underlying causes of truancy. This Board will have a wide remit in relation to educational welfare, including ensuring the provision of a prescribed minimum education to each child, whether in a recognised school or otherwise. In view of these developments, the Working Group recommends that the *Health Boards Executive* at national level, and all health boards at local level, should establish protocols with the *National Educational Welfare Board* in relation to the provision of education for children in care.

3.29 The Working Group also notes that it is of extreme importance that the appropriate school authorities are informed of the child's circumstances and the difficulties they may be facing as a result of being in care. In its discussions with various groups, the Working Group noted the need for sensitivity and confidentiality in relation to foster children in the school context. Good inter-agency co-operation and working relationships between these parties is needed if an effective educational dimension is to be incorporated into the care plan for children in foster care.

10. Berridge D, Foster Care, A Research Review, HMSO London, pg. 30

3.30 The Working Group recommends that as part of their role the Child and Family Social Worker should regularly monitor the child's educational progress as part of the care plan review and make personal contact with the child's school. This will facilitate the building of relationships between the Child and Family Social Worker and the school authorities. It will also assist the Child and Family Social Worker in helping to deal with any difficulties arising in an educational context.

## Aftercare Planning

3.31 The major objective of any placement in care is to ensure a good outcome for the child or young person and to enable them to develop into mature responsible adults. Many of those who come into care will return to their family within as reasonable a time as possible. However, this is not always the case as the high number of children in long term care indicates. Inevitably many children will remain in care until they are eighteen. Some of them will return to their own homes when they leave care. Also some of those who are in care will experience placement breakdowns and may have to avail of other services such as residential care or supported lodgings. Research and experience has also shown that unfortunately some of the young people in care may become homeless[11]. The needs of young homeless people are being addressed by the Department of Health and Children which is preparing a National Strategy on the issue. In view of this the Group felt that it was more important to concentrate on the issues of aftercare services for those leaving care at eighteen when they cease to be children and therefore are no longer legally the responsibility of the boards.

3.32 Under Section 45 of the *Child Care Act, 1991* a health board may assist a person leaving its care up to the age of twenty one or until he or she has completed their education. The health boards have a wide range of options open to them ranging from social worker visits, supporting them in education, arranging for them to be placed in training or apprenticeships or organising hostel or other forms of accommodation.

3.33 In a recent report, the Social Services Inspectorate found that only some residential centres were providing aftercare support for young people leaving their care. The Inspectorate also found few examples of young people taking part in independent living programmes although where programmes were found, they were considered to be of a high standard. The Inspectorate concluded that generally planning for young people leaving care is being left late and in some cases it is not happening at all. Too often young people are leaving care in an unplanned way, and this is not conducive to promoting their welfare[12]. The Working Group has found similar evidence of lack of after care planning in relation to the foster care service.

3.34 There can be no doubt that young people who have been through the care process feel particularly vulnerable at this stage of their lives. The

11. Kelleher, P. Kelleher, C. & Corbett, M., Left Out on Their own, Young People Leaving Care in Ireland, Oak Tree Press Dublin pg 6-9.
12. Irish Social Services Inspectorate, Op Cit. pg. 29

Working Group also noted the potential role of foster carers in the area of after care in providing the continuity of emotional support and advice that all young people need at this time in their lives. However, if their contribution is to be effective, aftercare must be seen as an essential part of the foster care placement.

3.35 The Working Group recommends that every health board should have a clear written statement of policy in relation to aftercare including the following dimensions:

- Every young person should have an after-care plan as part of his or her overall care plan. This should include protocols to ensure that adequate education and training is provided and ensure that where possible there is continued contact with the relevant Child and Family Social Worker and foster carer.
- Every health board should have a nominated officer to act as an After-Care Support Officer to ensure that an after-care support plan is in place for every young person leaving care.
- Each health board should monitor and evaluate the outcomes of young people leaving care as part of their ongoing assessment of the effectiveness of their services.
- The preparation of the plan should be undertaken, where it is feasible, at least two years prior to the anticipated discharge of the child from care.
- The young person and foster carer should be fully involved in drawing up the plan, which should encompass accommodation, education and employment issues.

## Adoption Options for Children in Care

3.36 The Working Group is very concerned about the very high proportion of children in care for a period of two years or more and a number of the submissions to the Working Group identified the issue of allowing for adoption of children in long-term foster care. Adoption of children in care is a very complicated issue involving complex legal and constitutional issues regarding the rights of parents and children. These issues must be considered in the context of protections afforded to the family in the constitution.

3.37 Under existing legislation the natural parent is normally required to consent to the making of an adoption order before the child. The *Review Committee on Adoption Services Report, 1984* raised the issue of dispensing with consent of natural parents in relation to adoption when the best interests of the child indicated that a permanent home with adoptive parents would be the preference. The proposal related to both non-marital children and children of marriage. Under the legislation which existed at that time only a non-marital child or orphan was eligible for adoption.

3.38 It was in response to this discussion that the *Adoption Act, 1988* was introduced which now provides a health board with the power to apply to the High Court for an order to free the child for adoption where parental consent has not been given. This can be done only under certain strict conditions.

3.39 A key condition is that the child must have been in permanent foster care with the proposed adopter for at least twelve months. Only then can the High Court make an order allowing the Adoption Board to make an adoption order in respect of the child. The Court must be satisfied that the child's parents have failed in their parental duty to the child and that such failure constitutes an abandonment of the child on the part of the parent. The court must also be satisfied that the child will continue to be so abandoned until he or she reaches eighteen years of age. The annual reports of the Adoption Board show that there were only six applications in 1998 and seven in 1999 for adoption orders under the *Adoption Act, 1988*[13].

3.40 The Working Group is concerned that some children remain in long term foster care when adoption may in fact in their best interests. The Working Group recommends that health boards actively consider the option of adoption, in the best interests of the individual child, for all children in long-term foster care.

3.41 As mentioned above, existing adoption law requires the parent to relinquish any involvement with the adopted child for an adoption order to be made. Understandably, this can act as a strong disincentive for parents to consent to adoption. The Working Group received a number of submissions suggesting that there is a need to explore the possibility of open adoption arrangements for children in long-term foster care. The Working Group acknowledges that there are serious legal and constitutional issues involved in this and that the discussion of the introduction of open adoption raises issues which are not within its remit to examine. However, open adoptions could allow a child to be adopted into a stable family environment without the need to entirely relinquish their links to their natural parents and family. The Working Group recommends therefore that the Department of Health and Children undertake a study of the issue of open adoption and its possible application to the children in long-term care in Ireland.

## Recommendations

### Assessing the Child's Needs

1. In the case of emergency placements health board should commence the assessment of the child's circumstances within a week of the placement (paragraph 3.4).

2. Children in need of emergency care or who otherwise have serious difficulties, should be matched with more experienced foster carers. (paragraph 3.5).

13. Report of An Bord Uchtala 1998, 1999

3. All health boards should establish a panel of emergency foster carers who have the appropriate skills to care for children in emergency situations (paragraph 3.6).

4. Any relevant previous assessment carried out by the board should be taken into account in order to ensure that all relevant information available to the board is properly considered in the foster placement assessment process (paragraph 3.7).

5. A comprehensive assessment should be carried out by a multi-disciplinary team, which includes an appropriate range of professionals who can address the child's emotional, psychological and medical needs. It should also include any other persons concerned with the child's protection and welfare, the child's family and the child him or herself having regard to his or her age and understanding (paragraphs 3.8 and 3.9).

6. In assessing the needs of the child, placement in his or her own community should be considered a priority issue. (paragraph 3.10).

### Care Planning

7. A care plan should be drawn up regardless of whether a child is being placed in short, medium or long term care (paragraph 3.15).

8. The care plan should be drawn up in partnership with the relevant parties involved and should also be done within an inter-disciplinary framework (paragraph 3.15).

9. The care plan must, as a minimum, conform to the standards set out in the Regulations and include the agreed services and support and the allocation of responsibility to provide those services and support (paragraph 3.15).

10. Care plans should be maintained in writing and a copy of the plan should be provided to the child (where it is appropriate to his or her age and understanding), the foster carer and the child's parents or guardian. (paragraph 3.16).

11. Care plans should be finalised at a formal meeting (paragraph 3.16).

12. In cases where a child has been involved in a family welfare or group conference all the participants at that conference should receive a copy of the care plan (paragraph 3.16).

### Care Plan Reviews

13. A designated officer of the health board should be assigned responsibility to ensure that child care reviews are undertaken in accordance with the Regulations (paragraph 3.18).

14. The reviews should be carried out, at a minimum, in line with the timeframes set down in the Regulations and in practice more frequently as appropriate (paragraph 3.18).

### Child and Family Social Worker

15. A designated social worker should be assigned as the Child's and Family's Social Worker (CFSW) as soon as the family comes to the attention of the social work department (paragraph 3.22).

16. The Child and Family Social Worker should be responsible for arranging the assessment, placement and development of the care plan for the child entering foster care (paragraph 3.22).

### Maintaining the Child's Contact with his or her own Family

17. The Child and Family Social Worker should manage the contacts with the family in line with the agreement in the Care Plan and where contact is minimal should ensure that the child has up to date knowledge of his or her family and their circumstances. (paragraph 3.23).

### The Child's Education Needs

18. The Health Boards Executive at national level, and all health boards at local level, should establish protocols with the National Educational Welfare Board in relation to the provision of education for children in care (paragraph 3.28).

19. The Child and Family Social Worker should regularly monitor the child's educational progress as part of the care plan review and make personal contact with the child's school (principal/teacher) at least once per school year (paragraph 3.30).

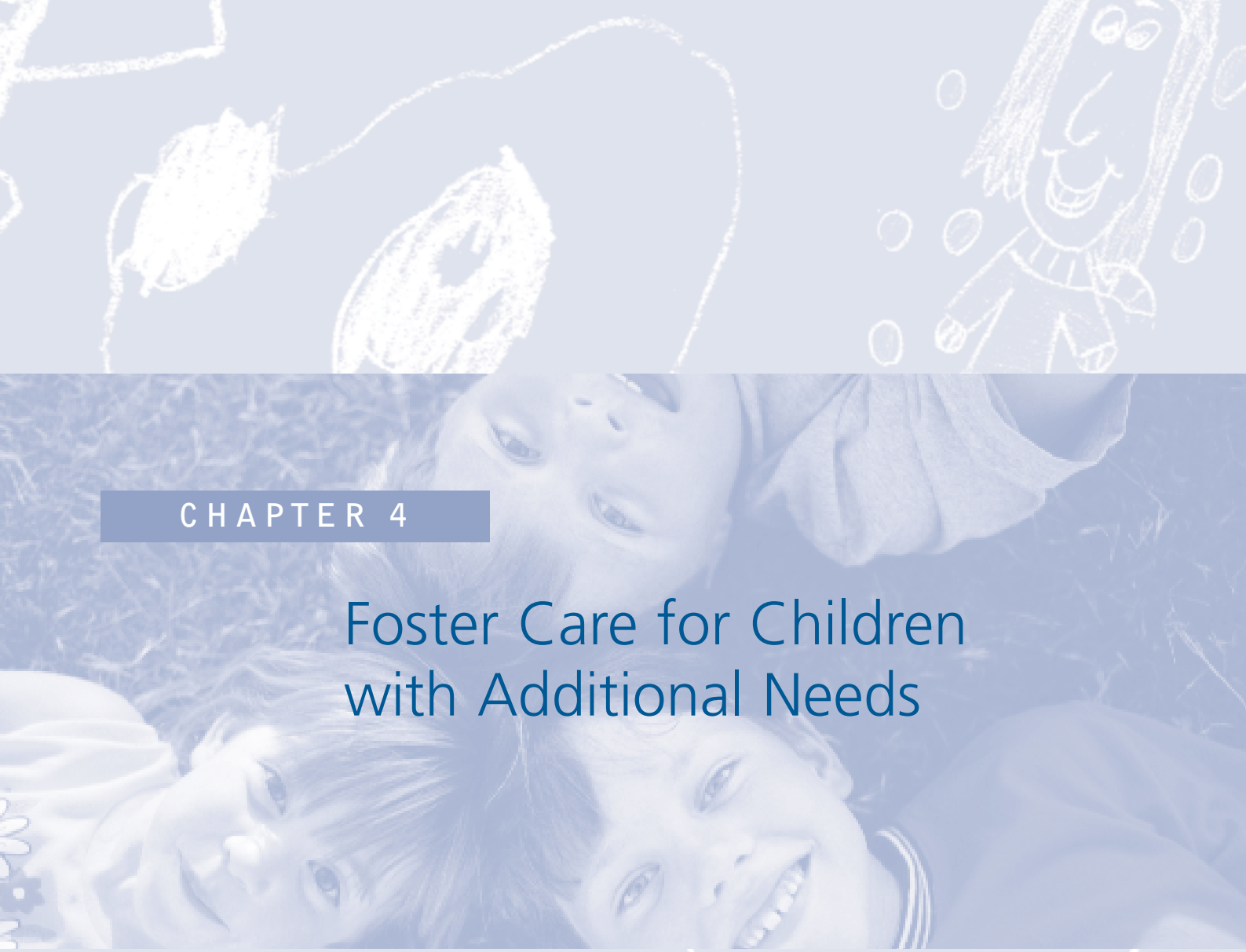
### Aftercare

20. The Working Group recommends that every health board should have a clear written statement of policy in relation to aftercare. (paragraph 3.35).

### Adoption Options for Children in Foster Care

21. The Working Group recommends that health boards should actively consider the option of adoption in the best interests of the individual child for all children in long-term foster care (paragraph 3.40).

22. The Working Group recommends that the Department of Health and Children should undertake a study of the issue of open adoption and its possible application to children in long-term care in Ireland (paragraph 3.41).



CHAPTER 4

# Foster Care for Children with Additional Needs

# Chapter 4
# Foster Care For Children with Additional Needs

## Introduction

4.1 The terms of reference of the Working Group included examining and making recommendations in relation to fostering arrangements for children with additional needs. Children in foster care with additional needs are an extremely vulnerable group and require specific attention in terms of reviewing how the foster care service meets those needs. Children with additional needs include those with disabilities and those with behavioural difficulties. Issues in relation to foster care for Traveller children are also considered here. This chapter discusses the need for extra supports for children with these additional needs and makes recommendations in relation to the support required for special fostering. **The Working Group wishes to emphasise that the principles already outlined in the previous chapter should apply in relation to providing foster care for children with additional needs in addition to any special provisions that may be necessary for them.**

## Children with Physical, Sensory or Intellectual Disabilities or Autism

4.2 The Health Research Board maintains an Intellectual Disability Database, which collates information on the number of people in the state registered as suffering from an intellectual disability. According to this database, in 1998 there were 141 children in foster care who were registered as having an intellectual disability. In addition there was a further 86 young people over eighteen years of age still in the care of foster carers they had been placed with. Unfortunately, comparable figures in relation to children with physical or sensory disabilities are not available.

4.3 The majority of these children are placed in foster care by the child care services. The basis on which children are placed in care is because they are in need of care and protection arising either from the inability of their own parents to cope or because they have suffered abuse or neglect. Where these conditions arise, given the need to ensure the proper care and protection of children concerned, it is appropriate that the child welfare service should take the lead role in placing these children in foster care, if such a placement is necessary. **However, the Working Group is clear that children, regardless of whether or not they have a disability, should only be brought into the child welfare alternative care system for protection and welfare reasons.**

4.4 Children with disabilities have needs which are different to those of the rest of the population in care. It is the responsibility of the disability service to provide any special input required to meet any additional needs of these children as these needs cannot be met by the child and family welfare service. This includes linking the various health and educational services that are provided for children and young people with disabilities and their families. Clearly, inter-disciplinary and inter-agency co-operation is essential. Therefore, the Working Group regards it as essential that the relevant disability services are involved at as early a stage as possible in the foster care placement process.

4.5 The Working Group considers that the most effective way to ensure inter-disciplinary co-operation and involvement is for the disability services to be one of the parties involved in drawing up of care plans. If there are special education requirements these should also be included in the educational aspect of the plan and the special education service should also be involved in drawing up of care plans. The Working Group also recommends that the *Health Boards Executive* should include education services for children with a disability who are in care in agreeing protocols with the *National Educational Welfare Board*.

4.6 The objective of placing a disabled child in foster care is to ensure that as far as possible they will experience a normal family life. The foster carers looking after such children will inevitably have the same experiences in caring for these children, as the parents of disabled children would have. It is crucial therefore for the success of such placements, that foster carers have the same access to the disability support structures and services as are provided for parents.

4.7 The Working Group has already highlighted the importance of after-care plans for children in foster care. In the case of young people with disabilities after-care plans should particularly aim to ensure a seamless transition into the adult disability service. This transition should be part of the care planning process over a number of years with young people and their carers receiving the same support and services that are available to others with disabilities.

4.8 The question of financial support for those carers who continue to look after the disabled people after they become adults was also raised during the Group's discussions. The Group was given evidence of some carers who were experiencing hardship in looking after people with a disability in this situation. This was particularly the case in respect of those persons with an intellectual disability, as they are more likely to remain dependent on their carers.

4.9 The Group noted that carers in this situation may be entitled to a Carers Allowance. This is a means tested payment and not all foster carers will qualify. It also noted that a young person with a disability is eligible to apply for a Disability Allowance from the Department of

Social, Community and Family Affairs. This personal allowance is intended to meet most of the day to day living expenses of the individual concerned. Like any other member of a family, the young person may contribute to the running costs of the household from the Disability Allowance, wages or training allowances. However, this still has to be viewed in the context of the overall requirements of the disabled person and his or her carers.

4.10 The costs involved in looking after an adult with a disability, particularly one with an intellectual disability are the same as those looking after a young person with such a disability. The carers in these situations have generally formed a close bond with the people in their care and wish to continue to look after them for as long as possible. The Working Group considers, therefore, that the appropriate financial assistance should be provided for carers who continue to look after these young adults, whom they cared for as children. This should be considered when the aftercare programme for young people with an intellectual disability is being agreed. Similarly, carers of young adults with a physical disability who remain highly dependent should receive financial support as part of the aftercare plan.

## Children with Serious Behavioural Difficulties in need of Special Care

4.11 Children with serious behavioural difficulties present a major challenge to the childcare service. In general, these are children in their teenage years. Research has shown that adolescents in care are a particularly troubled group[1]. Many of these children have suffered serious trauma in their lives including abuse and this can lead to them behaving in an anti-social manner. They can be aggressive and violent and often ignore rules and boundaries placed on them. This in turn can lead to a cycle of behaviour, the consequences of which will further adversely affect their life chances. The anti-social behaviour that they can display can lead to exclusion from the ordinary social situations in which young people can develop and mature. This can have an adverse impact on their health, education and emotional and psychological development. This can often lead to other social problems such as truancy, poor educational achievement, homelessness, alcohol and substance abuse. The evidence suggests that such children are more likely to be out of home, homeless and out of school. Invariably anti-social behaviour of this nature increases the likelihood of such children coming into conflict with the law.

4.12 There are a range of identifiable problems which could indicate that a child or young person may be in need of special care. They are that:

- the child has been diagnosed by a qualified psychiatrist or clinical psychologist as being moderately developmentally delayed, emotionally disturbed or having a behavioural or other disorder which requires a high degree of supervision;

1. Cleaver H, New Research on Teenagers, Key findings and Implications for Policy and Practice, Adoption and Fostering, Vol 21, No.1

- the child has severe behaviour problems (e.g. self-harm, violence towards others, sexually abusive behaviour, anti-social or criminal behaviour or chronic school non-attendance);
- the child has been diagnosed as having severe mental illness, severe developmental disabilities, brain damage or autism.

4.13 Providing foster care for children, especially adolescents, with such behavioural difficulties is particularly difficult. Research shows that there is a high level of placement breakdowns in these situations[2]. It is particularly difficult to build up a level of trust and emotional empathy with disruptive and or disturbed teenagers. It takes time, patience and skill on the part of the foster carer. To place a child with behavioural difficulties in foster care requires careful matching of the child with an experienced foster carer. This usually takes place after a preparatory period during which the child is placed in residential care or with highly experienced foster carers on an interim basis.

4.14 The Working Group acknowledges that this is a particularly challenging group to provide alternative care services for and recognises that some health boards have already adopted more sophisticated fostering arrangements for children in these situations. These initiatives should be continued and further developed. However, the Working Group is cognisant that the health boards will be obliged under the terms of the Children Bill, 1999 to provide a full range of services for these children including therapeutic and counselling services. These types of placements will need to be intensely supported by the health board and in effect it means providing a more enhanced fostering service for these children.

4.15 International approaches to this type of fostering include specialised training for the foster carer and enhanced payments. In Glasgow for example, the *Community Alternative Placement Scheme* has been established to provide placements for young people between the ages of twelve and sixteen, whose acute problems and needs have led to them being placed, or consideration being given to their placement, in secure care. The purpose of the scheme is to provide the young person with the opportunity of living in a structured and supportive family setting. The key elements of the project are:

- Careful selection and training of foster carers with a focus on the specific objectives of the scheme;
- Careful assessment and matching of the young person with the foster carer - the primary concern being the carer's skills and potential ability to meet the individual young person's needs;
- Explicit identification of all relevant support services and agreement on their contribution to the care plan;
- Provision of a high level of support to the carer including twenty-four availability of the project staff;

2. Kelly G, in Kelly and Gilligan, Issues in Foster Care, pg 71

- Planned respite care as an integral part of the scheme and availability of a range of emergency provisions for unplanned breaks;
- Identification of appropriate education support as part of the overall needs of the placement including links between the school, young person and the care team.

As can be seen from the key elements, outlined above, the basic principles of good practice in foster care arrangements are applied in the scheme.

4.16 The Working Group recommends that the standards on practice and procedures on the following issues be developed for the foster care service:

- the criteria for the placement of children with behavioural problems;
- the skills and abilities required by carers; and
- the level of supports and services to be provided by health boards.

4.17 In addition, it is recommended that health boards be given the authority to make enhanced payments to appropriately experienced skilled foster carers who agree to accept children and young persons with serious behavioural problems.

## Shared Rearing for Travellers

4.18 Traveller children leaving care have had major difficulties making the transition from care to independent living, with the result that they have had difficulties fitting into either the settled or travelling community. In the past the alternative care available for Traveller children was special residential care for Travellers, main stream residential care or fostering with families outside the travelling community. The *Shared Rearing Service* was established in 1991 as a special fostering service for Travellers, by the then Eastern Health Board and a voluntary body *Traveller Family Care*. Under the scheme a Traveller child who cannot be cared for by their own family is placed with another Traveller family who provide foster care. The advantage of this approach is that Traveller children in need of foster care are catered for within their own culture i.e. the Traveller community.

4.19 The *Shared Rearing Service* offers the same range of options from emergency to long-term placements as main stream fostering and foster carers are subject to the same assessment process, training and ongoing support. The latest figures indicate that there are at present 23 children fostered under the scheme and twenty families linked to it. An aspect of the service that differs considerably from main stream fostering is that while the children being fostered are predominantly from the Eastern Regional Health Authority area, all but one of the approved foster families are from outside that Authority's area. This reflects the social structure of the Travelling community and it is for this reason that, unlike children within the settled community, it can be

more appropriate to place a child with a family in another part of the country.

4.20 At present the three area health boards in the Eastern Regional Health Authority are the only boards involved in this service. The Working Group recommends that other health boards should assess the need for special fostering arrangements for Traveller children in their area. Given that the numbers needing this service, at any one time is likely to be quite small and that placements may need to be made outside their own health board area, the Working Group recommends that this service be developed jointly by health boards.

## Recommendations

### Children with Disabilities

1. The disability services should be involved in drawing up the care plans for disabled children being placed in foster care (paragraph 4.5).
2. If there are special education requirements these should also be included in the educational aspect of the plan and the special education service should be involved in drawing up the care plans (paragraph 4.5).
3. The *Health Boards Executive* should include education services for children with a disability who are in care, when agreeing protocols with the *National Educational Welfare Board* (paragraph 4.5).
4. After-care plans should particularly aim to ensure a seamless transition into the adult disability service. This transition should be part of the care planning process (paragraph 4.7).
5. Appropriate financial assistance should be provided for carers who continue to care for adults with an intellectual disability, who were in a long-term foster care arrangement (paragraph 4.10).
6. Where an adult with a physical disability is highly dependent on his or her carers such financial support should be provided as part of the aftercare plan (paragraph 4.10).

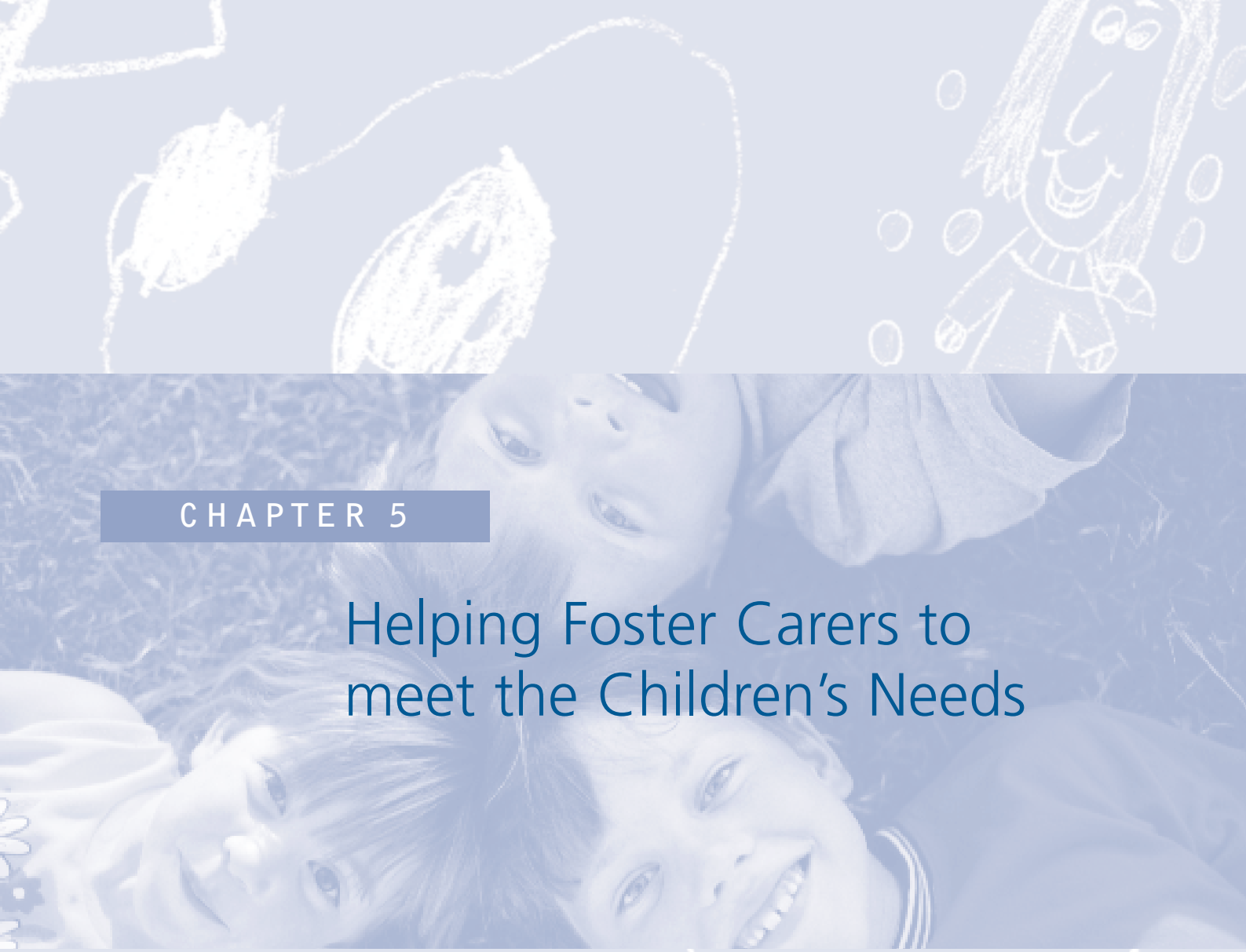
### Children With Serious Behavioural Difficulties in Need of Special Care

7. Special fostering arrangements for children with serious behavioural difficulties should be further developed and the criteria for such placements, the skills and abilities required by carers and the supports and services to be provided by the health boards should be addressed in the National Standards in Practices and Procedures (paragraph 4.16).
8. Health boards should be given the authority to make enhanced payments to appropriately experienced skilled foster carers who agree to accept children and young persons with serious behavioural problems (paragraph 4.17).

### Traveller Children

9. Health boards should assess the foster care needs of children in the Travelling community in their area and establish shared rearing schemes on a joint basis as appropriate (paragraph 4.20).

# PART 3



CHAPTER 5

# Helping Foster Carers to meet the Children's Needs

# Chapter 5
# Helping Foster Carers to meet the Children's Needs

## Introduction

5.1 When a child is in the care of a health board, either on a voluntary basis or in accordance with a court order, the health board is effectively the corporate parent of the child. **Accordingly, the board is under an obligation to ensure that these children receive the care, education, encouragement, safety and security that a good parent provides.**

5.2 Foster care is one of the services used to discharge this duty of care. Accordingly, there is an obligation on health boards to ensure that there are a sufficient number of foster carers to meet demand for the service. They must also ensure that people selected as foster carers have the right mix of skills and experience to meet the needs of these children. Finally, it is incumbent on the health boards to provide the necessary level of support and training for foster carers. This can be achieved by health boards adopting policies relating to:

- Recruitment of foster carers;
- Assessment of suitability to foster;
- Matching of foster carers to the needs of the foster children;
- Training of foster carers;
- Provision of ongoing support and supervision to foster carers;
- Provision of a designated social worker to each foster family;
- Provision of an out of hours services to deal with emergency problems;
- Retention of as many existing foster carers as is reasonably possible;
- Provision of financial support to foster carers;

## Recruitment and Retention of Foster Carers

5.3 An effective foster care service needs to have a range of emergency, short-term, respite day fostering and long-term care available. There are also requirements for the types of specialist care discussed in the previous chapters. The shortage of available foster carers gives rise to a certain amount of crisis management within the foster care service and can disrupt the health boards' planning and matching policies. This creates difficulties for boards in providing the right mix of foster carers to deal with the range of needs of children in care and affects the options open to boards in making matched placements.

5.4 It is crucial for the health boards to ensure that a steady stream of suitable carers enter into the foster care system. This is in order to

replace those foster carers who leave the service and to meet the increasing demand for foster care generally and the increasingly complex needs of the children coming into the system.

5.5 Due to the trends and pressures already discussed in Chapter One of this report, a shortage of foster carers has arisen over the last few years. All health boards have indicated to the Working Group that they are experiencing a shortage of foster carers. However, in addition to the recruitment issues, retention problems also arise. Neither of these problems are unique to Ireland and similar difficulties are being experienced elsewhere[1]. The Working Group considered both of these issues in detail.

### Recruitment

5.6 The Working Group recommends that as part of the overall plan for foster care services each health board should develop a recruitment strategy linked into the assessment process. As part of this strategy each board will have to routinely carry out profiles of existing foster carers and identify gaps in the service with a view to recruiting to fill those gaps. The Working Group considers that in order to ensure as large a pool of prospective foster carers as possible, health boards will need to target groups not previously considered.

5.7 One of the most effective ways of recruiting is through word of mouth by existing foster carers. While this will continue to be a major factor in recruiting foster carers there is a need for more targeted recruitment strategies in all health boards. The recruitment strategy will need to address the nature of the actual recruitment campaign to be used. In some cases an occasional high profile publicity campaign may be needed and in others a series of continuous low-key campaigns may be more appropriate.

5.8 Advice given to the Working Group on this issue was conflicting. Some suggested that there was a need to have high profile campaigns in order to increase the profile of foster care. Many of the health boards expressed reservations on the effectiveness of high profile campaigns. They pointed out that in their experience, this type of campaign often led to expressions of interest by large numbers of people, but in the end did not yield a significantly larger number of prospective foster carers than the more low key campaigns. However responding to a large number of queries effectively used up a great deal of the health board's administrative and financial resources.

5.9 The Working Group is conscious of the need to raise the profile of foster care and make people aware that there is a growing need for people to become involved in providing a home, emotional support, care and protection for foster children. On balance therefore the Working Group recommends that a national foster care awareness week run by the *Health Board Executive* in co-operation with the *Irish*

1. Code of Practice on the Recruitment, Assessment, Approval, Training, Management and Support of Foster Carers, National Foster Care Association, (UK), pg 33

*Foster Care Association* should be launched. The national Foster Care Awareness Week should provide a realistic view of what is required of foster carers and be co-ordinated with local recruitment campaigns that can more effectively target prospective foster carers who would be in a position to fill the gaps in the local foster care service.

5.10 The message of the National Foster Care Awareness week and the information provided generally by the health boards should give a realistic view of what will be required of foster carers and include material in relation to the type of work foster carers are generally involved in with the child. This includes:

- Providing the day to day care of the children
- Working with the children's families and their social workers
- Facilitating access between the child and his or her parents
- Helping the child with self-identity issues
- Managing behaviour
- Participating in training
- Liaising with health board personnel and teachers
- Attending meetings about the children
- Participating in the children's child care plans, reviews and possibly child protection case conferences
- Respecting the child's cultural, religious and racial identity
- Attending family welfare conferences and courts

5.11 It is vital that recruitment campaigns are critically reviewed on a regular basis so as to evaluate their efficiency and effectiveness. The Working Group further recommends that the health boards, through their health promotion services, should ensure that information on fostering is readily available to other public services and the general public, on issues relating to fostering.

5.12 The *Irish Foster Care Association* has with the help of the health boards and the Department of Health and Children produced a training pack and course for foster carers entitled *Fostering a New Horizon - the Challenge to Care in Ireland.* One of the features of the course is that it is designed to introduce an element of self-selection into the recruitment process by allowing potential foster carers to *'consider information about fostering to enable them to gain a more realistic picture of what is involved'.* The Working Group recommends that this training package be provided to all applicants for foster carer, as self-selection is an integral part of any successful recruitment campaign.

### Retention

5.13 The shortage of foster carers should be tackled not only through recruitment, but also by retaining as many of the existing carers in the

system as is reasonably possible. People leave fostering for a variety of reasons. Some will leave due to changes in their work situation or because they feel that they have made their contribution. Others may leave because of difficulties they have had with the system e.g. level of support, difficulties over financial support, inadequate information about the children being placed with them or that the task was too difficult. It could also be that they feel that fostering has had an adverse impact on their own family.

5.14 Given that the process of recruiting, assessing and training new foster carers is costly and time consuming it is important to understand the reasons why existing foster carers leave the system. The Working Group recommends that health boards conduct exit interviews with foster carers leaving the system. Analysis of the exit interviews will help establish the strengths and weaknesses of the service from the foster carer's point of view and help in the ongoing evaluation of the service. This type of analysis is especially important in view of the current recruitment difficulties of new foster carers.

### Assessment

5.15 The *Child Care Regulations, 1995* oblige health boards to establish and maintain one or more panels of persons who will act as foster parents[2]. It specifies a number of conditions that need to be met including written medical reports, two referees, authorisations to obtain Garda clearance and an assessment of their suitability and their homes suitability for the placement of foster children. The assessment of a foster carer's suitability in general and to their suitability in relation to a particular child is critically important to successful placements. The Child *Care Regulations, 1995* provide that no child should be placed with prospective foster carers unless the prospective carers have been appropriately assessed. The Working Group wishes to emphasise that health boards, in their drive to recruit sufficient numbers of foster carers, should not lose sight of the need to adhere to pre-placement screening procedures.

5.16 The screening procedures contained in the *Child Care Regulations, 1995* should be seen as the minimum standard of screening procedures and all health boards should establish more detailed, clearer and objective criteria by which the process of screening is to be conducted. To place a child with an inappropriate foster carer or in an unsafe situation could do immense damage to a child and leave the board open to litigation. Mismatching can also lead to placement breakdowns, which will add to the child's difficulties and lead to disillusionment on the foster carers' part.

5.17 The assessment must be in-depth and structured. In making the assessments the applicants household as a whole should be examined

2. Section 5, The Child Care, (Placement of Children in Foster Care) Regulations and The Child Care (Placement of Children with Relatives) Regulations 1995

and where there are other children in the household they should be involved as appropriate having regard to their age and reason.

5.18 Assessments are very time consuming for both health board personnel and the applicants. They are also by their nature very personal, as they require an in-depth inquiry into practically every aspect of the applicant's life. It can also be emotionally draining for the applicants. So while they should be conducted rigorously they should also be conducted fairly with the rights and dignity of the applicants and their families borne in mind. It should always be made clear to the applicants at what stage they are being assessed, including if some degree of assessment is being conducted at the information giving stage. It also should be made clear that the household as a whole is being assessed to ensure that it is a suitable place for a child to be placed.

5.19 The Working Group recommends that clear assessment procedures be established to enable health boards to match up foster carers to the needs of children coming into their care. These procedures should be developed in the context of national standards for the foster care service.

## Timeliness of Assessment Process

5.20 An important feature of the foster care service is that ordinary families are providing a place in their families for children in need and providing a valuable contribution to the child welfare service. Although foster carers are paid an allowance it must be remembered that they are essentially volunteers undertaking a serious task. It is important to harness the goodwill foster carers and prospective foster carers have in the interests of the children in need. One of the frustrations experienced by many applicants is the delay between the time they apply and the completion of their assessment process.

5.21 It has already been acknowledged that the child welfare system is currently under great pressure and that some health boards are not in a position to carry out foster carer assessments immediately on application. However, long delays in starting and completing assessments can lead to disillusionment among prospective foster carers and a withdrawal of application. It is especially important that foster carers are not lost to the system due to inordinate delays in their assessment process at a time when there is an actual shortage of foster parents. The Working Group recommends therefore that health boards should work towards a target of completing assessments within six months of a person or persons applying to become foster carers.

## Training of Foster Carers

5.22 Being a foster carer is demanding. It requires having the right mix of skills and experience to deal with children with complex backgrounds, many of whom exhibit their problems through challenging behaviour. In addition to their own skills and experience it is necessary to help foster

carers to develop their abilities in order to be able to meet the needs of these children. **The provision of specific training and support for foster carers is crucial to the continued development of the foster care service.** The Working Group recommends that each health board develop training strategies for foster carers as part of its foster care plan. Each health board must also develop training strategies for staff working in the area of foster care.

5.23 The Working Group considers that there is a need for basic level training and advanced level training. The target group for basic level training is all foster carers and should consist of two phases.

- **Phase one** should cover the general context within which foster carers will operate such as general child care policy, the legislative framework, the board's child protection policies and procedures and information on support arrangements.
- **Phase two** should then deal with developing communication and fostering skills.

5.24 Advanced level training should be targeted at foster cares providing carers to children with particular needs such as those with behavioural problems or disabilities.

5.25 The training process for foster carers should effectively begin at the pre-placement stage when the prospective foster carers are being given information about foster care. Training should cover discussion and debate on the many issues involved in foster care and aim to provide the skills necessary for safe fostering.

5.26 The Working Group considers that the use of the *New Horizon* material would be a valuable resource to health boards in this regard. A wide range of training options should be used such as formal training sessions, conferences, providing experts for support groups and structured discussions groups. The training should also include meeting a wide range of staff in the health board involved with foster children e.g. social workers, care workers, family support workers, psychologist and child psychiatrists.

5.27 It is important that training should not be confined to the initial stages of fostering only. Ongoing training must to be provided in order to help foster carers deal with new developments in fostering and assist those who are providing care for children with more difficult problems. An essential part of the contract between foster carers and the health boards must be that foster carers make a commitment to participate in ongoing training, as required. Health boards must ensure that training is evaluated on an ongoing basis, including the New Horizons course.

## Provision of a Link Worker to Foster Carers

5.28 A parallel requirement to the training of foster carers is the provision of ongoing support. In the previous two chapters the support for foster children has already been discussed. The provision of such support is of

course also of value to the foster carers. There is a need however for specific support in addition to training for foster carers themselves. One of the crucial supports is the contact person between the foster carers and the health board. **It is critically important therefore that when a person applies to become a foster carer, they should be assigned a named social worker, known as a link worker.** The link worker should be involved in the assessment process and be responsible for organising training and providing support to successful applicants. As part of the information supplied by the health boards to prospective foster carers it is essential that the link worker's role and remit is made clear to them. It should also be emphasised that although the link workers are the carers' contact with the board their first obligation is still to the child placed in care.

5.29 The link worker should also be responsible for ensuring compliance by the foster carer with the standards, guidelines and policies set out by the health board. Supervision of foster carers is a responsibility that the health boards must carry out to enable them to meet their obligations in relation to the protection and welfare of the children in care. The supervisory process should be seen as an opportunity to raise concerns by either party and explore difficulties and possible resolutions. It would be the link worker's responsibility to identify the training needs of carers, drawing up the necessary plans and accessing the necessary resources to implement them. As part of this process there should be a formal annual review carried out by the link worker in consultation with the foster carers with a view to identifying needs and resolving any difficulties that either party may have. It is recommended that the foster carer's link worker would be the best person to conduct exit interviews for foster carers withdrawing from the service.

5.30 As the primary contact between the board and the foster carer, the link worker needs to develop a positive relationship with the foster carers so as to appreciate their skills and circumstances. The link worker should also liaise with the foster child's social workers regarding matching children to carers. It is important that the link worker maintain regular contact with foster carers, even when there is no child placed with them. Even though their primary obligation is to the child, the link worker should also act as advocates for the foster carers where there are difficulties between the foster carer and the health board.

## Liaison between Child and Family Social Worker and Link Worker

5.31 In order to ensure the successful operation of the system both the Child and Family Social Worker (CFSW) and the link worker must be clear about their own and each other's roles. It is vital that the health boards put in place protocols to define these roles and that clear lines of communication are developed. This is particularly important where the respective workers come from different community care areas or as may happen in some cases from different board areas. The workers should

make joint visits to the foster family when making and finalising placements and conducting reviews.

## Out of Hours Service

5.32 Provision of health board emergency services outside normal office hours is a major concern to foster carers[3]. This was also raised in a number of submissions to the Working Group. The Working Group recognises that there is a need for a formal out of hours service in each health board to deal with emergency situations. The Working Group understands that the Department of Health and Children and the Health Services Employers' Agency are currently looking at this issue with a view to talks with staff representatives on the matter. It is recognised that there are a number of issues that must be addressed before such a service can be introduced but the Working Group considers that such a service is necessary.

## Support Groups

5.33 One of the difficulties that foster carers often experience is a sense of isolation. Many foster carers often feel that the situations they face are unique. The Working Group recommends that support groups for foster carers should be established and encouraged by the health boards in local areas. Foster carers should be encouraged to become involved in their local group as part of the ongoing training and support process. Such groups could provide mutual support and provide an opportunity for general informal discussions with health board personnel. The Working Group recommends that the link workers in health boards become instrumental in the establishment of these groups in co-operation with the health board fostering teams.

5.34 The role of the other children of a family who fosters is often forgotten. The Working Group has already recommended that they should be included in the placement process and their views considered with due regard to their age and ability to reason. The Working Group also notes that the *Irish Foster Care Association* is providing a forum for these children at its annual conference. However, the Working Group considers that more attention needs to be given to this important group and recommends that the development of Foster Carers Support Groups should include support structures for other children in foster carers' families.

## Financial Support

5.35 One of the most contentious issues that was raised consistently with the Working Group revolved around allowances and discretionary payments made to foster carers. Foster care involves additional costs over and above those incurred in the normal day to day costs of maintaining children in their own home. Research and experience indicates that for a number of reasons, mainly to do with the difficulties

3. See Appendix 3

that foster children may have experienced, there is additional expenditure on food, clothing, heating, electricity, household goods and services[4]. Additional expenditure is also often incurred in relation to transport costs, particularly in rural areas, as a result of access visits, meetings involving professionals providing services for the child, support group meetings and training.

5.36 Foster carers receive a weekly foster care allowance from the health board which is intended to meet the day to day costs associated with looking after a foster child, and can also avail of discretionary payments from the health boards for additionally incurred expenses. These discretionary payments cover a wide range of areas from clothes to education costs and travel costs. These payments are funded from the health boards budget and are separate and distinct from schemes operated by the health boards on behalf of the Department of Social, Community and Family Affairs. As they are at the discretion of the health boards the policies applied in relation to these payments inevitably vary from board to board. In addition, in order to meet their financial accountability obligations, health boards feel that it is necessary to insist on receipts for goods before payment is made. This situation is unsatisfactory as it often leads to conflict between the foster carer and the health boards. It also serves to create an additional administrative burden for the health boards, as payments have to be assessed and cleared.

5.37 Following the introduction of the Child Care Regulations, 1995, there has been a considerable improvement in foster care allowance itself. The allowance is split into two categories, an under twelve and over twelve allowance. The approach adopted by the Department of Health and Children towards yearly increases has been to provide for increases based on social welfare increases announced in each budget. This was also associated with additional increases on each band in alternate years. The allowance for children under twelve has increased from £45.60 per week in 1996 to £75.40 per week in 2000, which represents an increase of 65%. The allowance for children over twelve increased from £61.80 per week to £85.75 per week in the same period representing an increase of approximately 40%. This compares with a level of inflation of approximately 12.5% for the same period.

5.38 The *Irish Foster Care Association* submitted a proposal to the Working Group and the Department of Health and Children, which proposed to substantially increase the weekly allowances and introduce a four tiered foster care rate band. Table 6.1 presents these proposals with an equivalent figure at current prices.

4. Oldfield. N. The Adequacy of Foster Care Allowances, Ashgate

**Table 5.1**

| Age | IFCA submission at January 1998 | IFCA at August costs (Update to end 2000) |
|---|---|---|
| 0-4 | £68.73 | £75.78 |
| 5-10 | £85.26 | £94.01 |
| 11-15 | £106.14 | £117.03 |
| 16+ | £137.46 | £151.57 |

5.39 In addition the *Association* proposed additional payments to foster carers for a number of other items such as religious ceremonies, education, extra curricular activities and medical expenses not covered by the General Medical Scheme (GMS).

5.40 The current system of allowances evidently causes many problems. Given that the services should be concentrating on the needs of the foster children the Working Group considers that it would be more appropriate to considerably enhance the foster care allowance and abolish all discretionary payments, which are paid over and above the basic allowance. The health boards should retain the right to bring forward payments in emergency situations and meet some additional expenses relating to education fees (excluding books, school uniforms and school trips) and medical expenses not covered by the General Medical Scheme. Where possible any medical costs and fees should be agreed when the care plan is being drawn up, and reassessed at the care plan reviews.

5.41 The Working Group has given careful consideration to the whole issue of financial supports and carefully examined all submissions on this issue. In coming to its conclusion the Working Group considered the need for administrative efficiency in the payments structure as well as the adequacy of financial supports to foster carers. The Working Group considers that a move towards a more complex payments structure as proposed by the *Irish Foster Care Association* would prove to be inefficient administratively and has therefore decided to retain the current two-tier structure. However, the Working Group considers the current level of financial support to be inadequate and recommends increasing the allowance to £200 (€254) per week for children under twelve and £220 (€279) for children of twelve years of age and over. The Working Group also recommends that these allowances be increased in line with social welfare payments increases on an annual basis.

5.42 It has been brought to the notice of the Working Group that some foster carers are applying for Orphan's Allowances or Pensions under the scheme operated by the Department of Social Community and Family Affairs. Under these schemes a child is regarded as an orphan where:

- both parents are dead

or

- one parent is dead, unknown, has abandoned or refused or failed to provide for the child and the other parent is unknown or has abandoned or has refused or failed to provide for the child.

The Working Group considers that very few foster children or children placed with relatives should come within the ambit of this definition. As this Report has indicated earlier, one of the objectives of the health board in relation to a child placed in care is to work towards reuniting the child with his or her family. A fundamental feature of the foster care placement is that contact between the child and his or her family is maintained. The Working Group in making its recommendation on foster care allowances is seeking to ensure that the costs of looking after a foster child are adequately covered. It therefore does not consider it appropriate that both orphans and foster care allowances be made in respect of the same child.

5.43 The Working Group also recommends that the health boards and foster care support groups develop linkages with the Money Advisory and Budgeting Service (MABS) which is funded through the Department of Social, Community and Family Affairs. The primary aim of MABS is to help people who experience difficulties in budget management take control of their own finances. The service is free, confidential and independent. The development of these linkages will facilitate early intervention and guidance for any foster carers who may be experiencing difficulties in budget management.

5.44 It is recognised by the Working Group that in certain rare circumstances the health boards support the provision of additional accommodation. This is usually in the form of extensions to houses, provided that it is deemed necessary in the best interests of the child or children concerned. Where these rare circumstances occur, the boards should retain the flexibility to continue this support.

## Recommendations

### Recruitment of Foster Carers

1. Each health board should develop a recruitment strategy linked into the children's needs assessment process and routinely carry out profiles of existing foster carers and identify gaps in the service with a view to recruiting to fill those gaps (paragraph 5.6).

2. To ensure as large a pool of prospective foster carers as possible, health boards should target groups not previously considered (paragraph 5.6).

3. A national foster care awareness week run by the *Health Board Executive* in co-operation with the *Irish Foster Care Association* should be launched. This should be co-ordinated with local recruitment campaigns (paragraph 5.9).

4. Recruitment campaigns and information should give prospective foster carers a realistic view of what will be expected of them (paragraph 5.10).

5. Recruitment campaigns should be critically reviewed on a regular basis so as to evaluate their efficiency and effectiveness (paragraph 5.11).

6. Health boards, through their health promotion services, should ensure that information on fostering is readily available to interested parties (paragraph 5.11).

7. The *Irish Foster Care Association*, training package for foster carers entitled *Fostering a New Horizon - the Challenge to Care in Ireland* should be provided to all who apply to become a foster carer (paragraph 5.12).

### Retention Policies for Foster Carers

8. Health boards should conduct exit interviews with foster carers leaving the system – the foster carer's link worker should conduct these interviews (paragraph 5.14).

### Assessment of Potential Foster Carers

9. Assessments should be in-depth and structured, they should be conducted fairly, the household as a whole should be examined and where there are other children they should be involved, as appropriate having regard to their age and reason (paragraphs 5.17 and 5.18).

10. Clear assessment procedures should be set out to enable health boards to match foster carers to the needs of children coming into their care (paragraph 5.19).

11. Health boards should complete assessments within six months of a person or persons applying to become foster carers (paragraph 5.21).

### Training of Foster Carers

12. Each health board should develop training strategies for foster carers as part of its foster care plan (paragraph 5.22).

13. Each health board should also develop training strategies for staff working in the area of foster care (paragraph 5.23).

14. Health boards should ensure that training is evaluated on an ongoing basis, including the *New Horizons* course (paragraph 5.27).

### The Link Worker

15. On application to become a foster carer, the person applying should be assigned a named social worker, known as a link worker (paragraph 5.28).

16. The link worker should be involved in the assessment process and be responsible for organising, training, supervising and providing support to successful applicants (paragraphs 5.28 and 5.29).

### Liaison Between the Child and Family Social Worker and the Link Worker

17. Health boards should put in place protocols to define the roles of the Child and Family Social Worker and the link worker and ensure that there are clear lines of communication between them (paragraph 5.31).

18. Both workers should make joint visits to the foster family when making and finalising placements and conducting reviews (paragraph 5.31).

### Provision of Out Of Hours Service for Foster Care Placements

19. A formal out of hours service should be introduced to deal with emergency situations (paragraph 5.32).

### Support Groups

20. Support groups for foster carers and their children should be established and encouraged by the health boards in local areas (paragraphs 5.33 and 5.34).

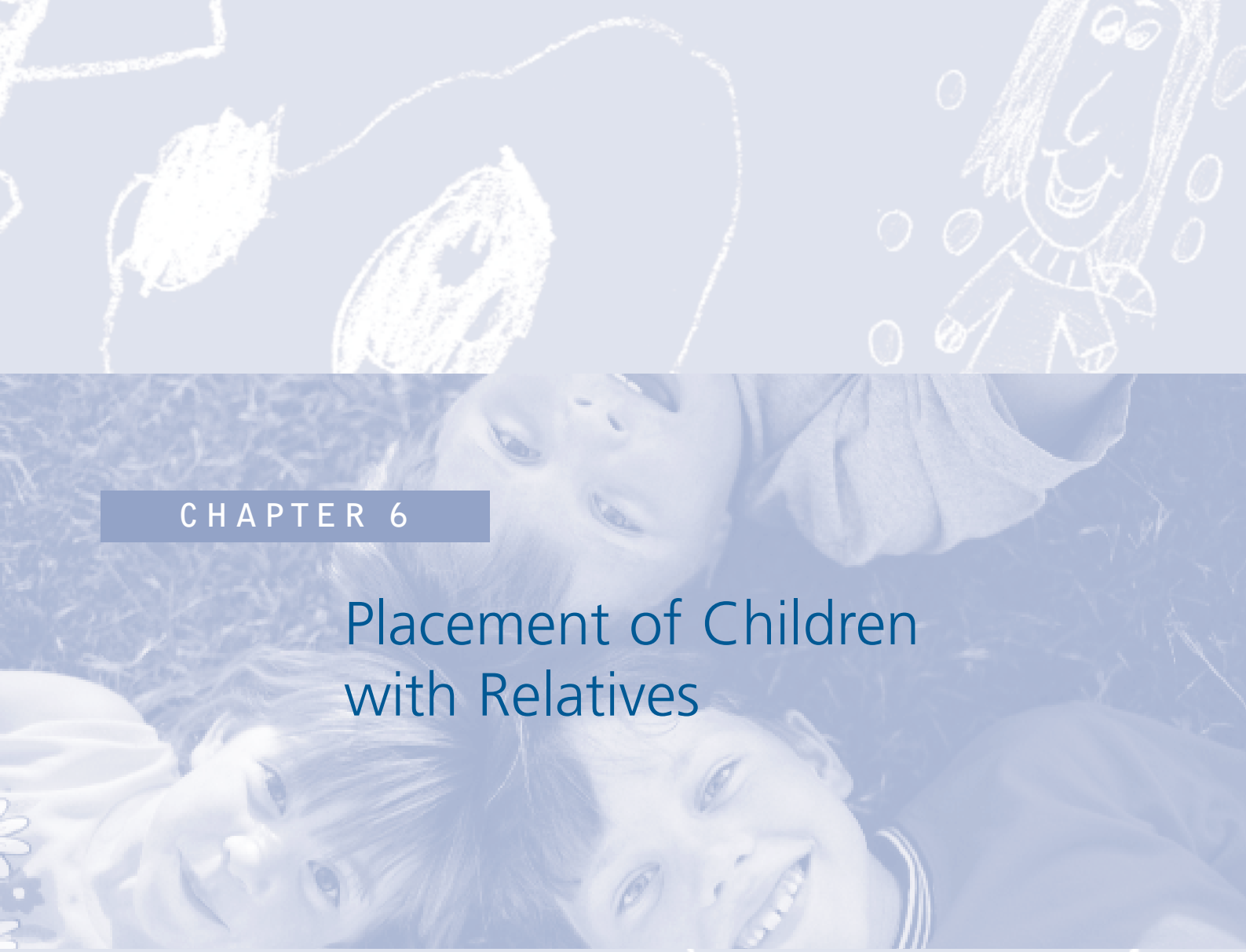
### Financial Support

21. Payments made in addition to the current basic Foster Care Allowance should be abolished and the Foster Care Allowance should be increased to £200 per week for children under twelve and £220 for children of twelve years of age and over (paragraphs 5.40 and 5.41).

22. The revised allowances should be increased in line with social welfare payments increases on an annual basis (paragraph 5.41).

23. Orphans' Allowances and pensions should not be paid in respect of children in respect of whom foster care allowances are being paid (paragraph 5.42).

24. Health boards should retain the flexibility to continue support for additional accommodation provision only where it is clearly in the interests of the child or children placed in care (paragraph 5.44).



CHAPTER 6

# Placement of Children with Relatives

# Chapter 6
# Placement of Children with Relatives

6.1 The *Child Care Act, 1991* and the *Child Care (Placement of Children with Relatives) Regulations, 1995* regulate the placing of children in foster care with relatives. They include in the definition of a relative, the spouse of a relative and a person who has acted in loco parentis of the child in respect of whom the arrangement is being made. The regulations are similar to those that are in place for the placement of children with non-relatives, the more traditional form of fostering. Separate figures on relative fostering were not collected until 1998. According to figures from the Department of Health and Children there were 635 children placed with relatives in 1998 and 713 in 1999 which represented approximately 22% of the number of children in foster care in 1999.

6.2 The Working Group received a number of submissions on this issue. It is concerned that due to the shortage of foster carers that in some cases inappropriate placements have been made under these regulations. The Group considers that in placing children with relatives the fundamental standards set out in Chapter Three must be adhered to. The basic principles that should guide these placements are:

- The guiding tenet of the best interests of the child should be adhered to in all foster care placements;
- A child should only be placed in an appropriate safe, healthy and stable environment;
- The standard of care must be equivalent to that provided in a traditional foster care arrangement;
- Placements should only be made where there is a secure attachment between the child and relative or there is the potential for such an attachment to develop;
- A *partnership* approach should be used in developing skills and supports for relatives providing foster care;
- Placements should not be made as means to provide income support.

## The Development of Relative Care

6.3 This form of foster care has developed arising from a number of trends in recent times. The child care policies already outlined have put more emphasis on supporting the family and, where alternative care is needed, relying on more family based care. This has also led to more serious consideration of family and social networks and how they can be used to provide care for children outside the immediate family home. A great deal of child care theory now addresses these issues and their importance to a child's development. At the same time, the social

trends referred to already have led to less availability of foster homes provided by non-relatives.

6.4 All of these factors have led to a greater awareness of the potential of relative fostering as a form of alternative care for children. Given the importance attached now to the issue of self-identity for children in care, the Working Group's view is that, in general, placement with a relative should be the first option explored by health boards when placing a child in care, having regard to the principles set out above.

## Issues in Relative Care

6.5 There are a number of crucial differences between relative fostering and traditional foster care, the critical one being the way in which relative foster carers come into contact with the health boards. In non-relative foster care the potential carers apply to a health board for assessment of their suitability. They are approved prior to a child being placed with them and are given the appropriate training.

6.6 The Regulations do provide that relatives have to be assessed. However, they also allow for emergency placements of children with relatives prior to assessments or the completion of assessments, if it is in the interests of the child[1]. In practice, the majority of relatives who become foster carers do so in response to a family crisis. They may have been approached by the health board or they may have approached the agency directly regarding the specific child. In a recent study it was found that approximately one-third of children placed with relatives were placed directly into their care by the children's parents. Another third were already placed with relatives when the board became involved in their cases and the remainder were placed with relatives by the board[2].

6.7 The different way in which relative carers come into the system means that they can have a different attitude towards the board and its role in the care of the child. **Although the child is placed with other family members he or she is still in the care of the board, either on a voluntary basis or by court order. The board still has the corporate responsibility for the care and protection of that child.** It must therefore, by regulation, still carry out a full formal assessment of the prospective carers, even if the child is already placed with them and an initial assessment of the child's needs has been carried out[3].

6.8 The study mentioned above suggests that some difficulties do arise in relation to this issue. Many carers do not understand the need for such an assessment and find it intrusive and threatening. This can lead to an ambivalent attitude on the part of relative foster carers to the health boards involvement in their lives. Many relative carers are relieved to

1. Section 6, The Child Care (Placement of Children with Relatives) Regulations 1995
2. O'Brien V, in Kelly and Gilligan, Issues in Foster Care, Policy, Practice and Research, Jessica Kingley Publishers, pg 198
3. Section 5, The Child Care Regulations 1995 (Placement of Children with Relatives) 1995

complete the assessment and welcome less contact with the board after that. They may even resent what they see as an intrusive monitoring role by the boards. If relationships are strained this may lead to the family and the child receiving less support than they need during the placement.

6.9 Another aspect of the situation, which has implications for the way that boards relate to relative carers, is the relationship between the carers and the birth parents. In the situation with the traditional carers the board is the link between the carers and the parents. However, in the relative carer situation there is a family link between carer and parent which inevitably means that the health board plays a different role.

6.10 Another major difference which did not arise in the Irish study but which has emerged from studies in the USA and UK is that relative foster carers tend to be older and poorer with a higher proportion of them being households headed by single women[4]. The evidence of these studies would also suggest that in these countries relative carers receive less support from child welfare agencies than traditional foster carers. It should be pointed out in this context that in this jurisdiction relative foster carers receive the same foster care allowance as non-relative carers.

6.11 It has been suggested to the Working Group that some children are placed in the care of the health boards, under the regulations, in order to provide income support for the family in relation to the child. The Group has not been given evidence that such a practice is widespread. However it is strongly of the view that such a practice would be highly inappropriate. Income support is a matter for the Department of Social, Community and Family Affairs and those in need of income support should be referred to that Department. **Children should only be brought into the care of the health boards if they meet the criteria regarding the need for care and protection set out in the Child Care Act.** In addition, the choice of placement of any child in the care system should based on the particular child's individual best interests.

## Implications for Service Provision

6.12 The factors outlined above have led many to argue that a different approach is required by health boards in dealing with relative foster carers, particularly with regard to assessment, training and support of relative carers. For example, regarding assessment, it has also been argued that relative foster carers are being chosen to look after a particular child or children. Therefore, the level of assessment need not be as in-depth as is the case with non-relative carers who are being assessed for more generally suitability to care for a range of children to whom they will be strangers.

4. O'Brien Op Cit pg 199

6.13 In relation to training and support, experience has shown that relative carers are more reluctant to seek support from the boards, which raises the issue of how best to provide the necessary support and training.

6.14 As has been repeatedly stated throughout this Report the guiding principle in relation to the provision of the services is ensuring the care and protection of the child and promoting his or her welfare. The children who are placed with relatives are as likely to have experienced the same difficulties as other children who come into care. The dynamics of the family situation may make matters more complicated or may improve the situation. Regardless of the case, the health board must be cognisant of the fact that the ultimate responsibility for the adequate health, welfare and safety of the child rests with it. **While the differences identified in relation to relative vis-à-vis non-relative care need to be addressed, the basic principle, that a child placed with relatives receives the same level of protection, care and support as a child placed with non-relatives, must be adhered to.** Therefore, the boards must carry out the necessary assessment, training and support for relative carers, which allow them to ensure that this is the case.

6.15 The assessment of the child's needs should be carried out jointly by the child and family social worker and the link worker. The assessment must include an evaluation of the attachments of the child who is being placed within his or her extended family. **Children should only be placed with a relative where a secure attachment pattern exists or, based on evidence, has the potential to develop.** The family group conference model could be used to identify the most appropriate relatives to be assessed as carers.

6.16 It is also vital that an appropriate care plan is provided for the child and the proper monitoring is carried out in relation to his or her placement. The provision of separate child and family and link social workers, as already outlined in Chapter Three, should be the same as for non-relative foster care arrangements. In practice the roles and functions of the respective workers may not be the same as in the traditional foster care situation. For example, the Group considers that the two workers should still be involved, but that the allocation of tasks may be different. As already described this should be agreed when the care plans are being drawn up.

6.17 Most relative carers only intend to accept a relative into care and their assessment therefore will inevitably concentrate on their ability to provide the appropriate care for that specific child. Non-relative children should not be placed with these carers unless they have been fully assessed and approved as foster carers in the normal way. Given the reluctance of many relative carers to seek health board assistance, the Group feels that specific training should be provided for relative carers as appropriate. The issue of further training should considered in the context of the reviews of the placement.

6.18 Some of the criteria in relation to assessments and placements in relative care, as opposed to non-relative care, may need to be different. These are practice issues. Therefore the Group recommends that the standards in relation to assessments, training, support and supervision be considered in the context of the development of national standards on practice and procedures for this area.

## Recommendations

1. Subject to the principles of good practice, placement with a relative should be the first option explored by a health board when placing a child in care (paragraph 6.4).
2. Children should only be placed in relative care under the terms of the regulations if they meet the criteria for care and protection as envisaged in the Child Care Act 1991 (paragraph 6.11).
3. In placing a child with relatives the health board must carry out the appropriate level of assessment, training, supervision and support, in line with the Child Care (Placement with Relatives) Regulations 1995, that is required to ensure the safety and welfare of the child (paragraph 6.14).
4. A child should only be placed with a relative where a secure attachment pattern exists or has the potential to develop (paragraph 6.15).
5. Appropriate care plans should be provided and monitored for a child placed with relatives (paragraph 6.16).
6. Non-relative children should not be placed with carers assessed under the Child Care (Placement with Relative) Regulations, 1995 unless they have been assessed and approved in the normal way (paragraph 6.17).
7. The standards in relation to assessments, training, support and supervision should be considered in the context of the proposed National Standards on Practice and Procedures on Foster Care (paragraph 6.18).

CHAPTER 7

# Providing Safe Care

# Chapter 7
# Providing Safe Care

## Background to the Issue of Safe Care in the Foster Care Setting

7.1 In Chapter 2 the greater awareness in recent years of child abuse as a social problem in Ireland was mentioned. A number of major inquiries have been undertaken into serious cases of child abuse. Evidence shows that not only have children been abused in their own homes, but also while they have been in care.

7.2 Health boards have statutory and moral responsibilities for children whom they place with foster carers. Some children entering foster care may have previously been abused. Such a child or young person will probably have had difficult and negative experiences. Some children act out the distress related to their past in their behaviour. For this reason, under the *Children First – National Guidelines for the Protection and Welfare of Children*, children in foster care are identified as a specially vulnerable group. All children who have been abused have experienced a breakdown in the trust which they had in someone. This can often lead to difficulties in establishing a relationship of trust with their foster family.

7.3 The *Children First* guidelines referred to above deal specifically with the responsibilities of Health boards in "*arranging, providing or supervising placements with foster parents*" emphasising yet again that the welfare of the child is the first and the paramount consideration in these situations. It also refers to the specific powers of the Health Boards under the foster care regulations when investigating alleged abuse of foster children.

## Incidence of Abuse in Foster Care

7.4 Foster carers are more likely to be the subject of an allegation of child abuse and neglect than the average family in the community and indeed, children have been abused while in foster care. The Working Group notes that the incidence of allegations of abuse against foster carers is increasing. A survey carried on behalf of the *Irish Foster Care Association* indicates that the number of allegations of abuse has risen by 121% in the period 1996 to 1998. There were 29 allegations in 1996 compared to 63 in 1998. While this is a worrying trend, it is important to note that this represents allegations against 1.1% of families fostering in 1996 and 2.1% in 1998[1]. The international research would suggest allegation rates of between 4% and 12% in any given year[2]. These variations arise from a number of factors, including different methodologies employed in the surveys and different approaches by agencies in defining what constitutes a reported allegation of abuse.

1. Kelleher Associates, Allegations of Child Abuse Against Foster Families, Irish Foster Care Association, pg14
2. Nixon S, in Kelly and Gilligan, Issues in Foster Care, Policy, Practice and Research, Jessica Kingley Publishers, pg 173

7.5 The submissions made to the Group indicate that there are a number of factors giving rise to the increase in allegations of abuse in foster care situations:

- the changing nature of foster care over the last ten years (as already outlined);
- the greater numbers of children coming into care and in particular into foster care;
- the increased emphasis on keeping children within their own families by providing family supports and a greater emphasis on maintaining contact between the children and their parents has led to a children coming into care presenting with more complex problems and
- the increased awareness of child abuse and children's rights on the part of young people.

7.6 Abuse of foster children is not confined to foster carers, it can also be carried out by persons other than the foster carers, such as other children in care who are in the home. There have also been cases of inappropriate behaviour on the part of foster children towards the foster carers' own children and other foster children in the home.

## Characteristics of Abuse in the Care Setting

7.7 No form of abuse towards a child is acceptable. It is important to distinguish between a pattern of abuse and an occasional incident, which may be an impulsive act that arises out of frustration. Such an occurrence may be an indication of stress in the family, which needs to be addressed by the board. There are a number of factors, which may contribute to these situations arising:

- insufficient information being provided on the background of the child;
- insufficient preparation and training of the foster carers, particularly in dealing with previously abused children who may have serious behavioural difficulties;
- insufficient support and contact between the foster families and the boards;

7.8 These problems can be exacerbated by the difficulties of dealing with a wide range of service providers such as schools, social workers and other health professionals, adding to stress levels in the family. The arrival of a foster child may give rise to friction or resentment on the part of the foster carers' own children.

7.9 It must also be acknowledged that higher standards are required of foster families with regard to what will be considered abuse in their homes. This is particularly the case in relation to issues such as corporal punishment. In addition, children who themselves have experienced abuse can exhibit behaviour that provokes an abusive response from

others. Children who have been sexually abused can be particularly challenging to deal with and often display highly sexualised behaviour.

## Ensuring Safe Care

7.10 In devising a strategy to ensure that safe care practices are to the fore in the foster home the health boards must work with and support foster carers in developing and maintaining quality and safe care for children. In the previous chapters the Group has already indicated its views in relation to improving the services for foster children and helping foster carers in their role. In view of the potential problems children may bring to the placement, it is clear that the proper training and support services need to be provided to foster carers. This needs to be complemented by other service developments such as a maintaining a sufficient pool of carers to ensure that foster parents are not overloaded with multiple or too frequent placements, and the provision of respite care, counselling and basic support services. Collectively, these features will assist in reducing the pressures in foster families and thereby substantially reduce one of the factors that can lead to abuse.

7.11 **The most effective way of ensuring safe care is to promote high quality of care.** In order to do so a number of basic issues need to be addressed in the care plans. These are:

- Proper matching of children or young people to foster carers;
- Taking account of the number of children already in the home;
- Provision of full information on the child or young person to the prospective foster carers;
- The taking of appropriate precautions in relation to behaviour and safety in the home by the foster carers;
- Immediate reporting of serious problems to the child and family worker by the foster carers;
- Agreement on appropriate disciplinary measures;
- Keeping of records;
- Specific training for foster carers in enhancing safe care practices.

7.12 The process of matching is also vital as mismatches between foster children and foster families can lead to the sort of strain that causes difficulties. It is also vital where children are going to be placed in a medium to long term placement that they are adequately prepared for the placement. Children coming into care, particularly those who have suffered severe neglect, often have considerable difficulty in settling into an ordinary family setting.

7.13 The Working Group is anxious that given the pressures on the system that families can be requested to accept children when they are not completely comfortable in doing so. It recommends that the option for a family to refuse to accept a child in circumstances where it feels

unhappy about the placement should be a clearly agreed part of the contract between foster carers and the health boards.

7.14 Another factor which may give rise to difficulties is the issue of the number of placements within any one home. It is the policy of the health boards to keep the number of placements with any one family to a minimum, whilst taking into account the need to accommodate sibling groups. The Working Group is concerned that given the pressures on the system that foster carers can be requested to accept a number of placements at the same time. The Group therefore recommends that health boards do not place any more than two foster children in any one home at any one time except in the interests of keeping a sibling group together. In addition, in line with best practice, it recommends that sibling groups should not be placed with other foster children.

7.15 A child or young person coming into care will probably have had difficult and negative experiences. Some children will act out the distress they feel in relation to their past experiences in their behaviour. All children who have been abused have experienced a breakdown in the trust which they had with someone. It is important therefore for foster carers to understand the psychological and emotional needs of the children coming into their care. If these needs are not met it can lead to even greater difficulties of insecurity, low self-esteem and abilities to maintain healthy relationships on the part of the foster child. **The Working Group emphasises the need to ensure that that foster carers are given all the essential information in relation to the child's background when the child is being placed with them.** This should allow them to assess whether they are in a position to provide the appropriate care for the child if s/he is placed with them. During this process, it is important for foster carers to understand their own feelings and limitations. They should be encouraged to discuss these openly with their link workers as failure to come to terms with them can lead to difficulties later on in the placement. Another aspect of the placement that must be considered is the attitudes and concerns of the children of foster carers. All of these issues should be explored in the assessment procedure.

7.16 All households develop their own rules to determine what is allowed and is not allowed in their home. They are understood by all the family members. When a foster child is placed with a family these rules may have to be reviewed and new elements added to take into account the particular needs of the foster child. There are a number of basic rules that should be adhered to regarding rights to privacy, appropriate behaviour and dress. In addition there are a number of other good practice precautions that should be taken such as:

- Reporting inappropriate or strange behaviour immediately to the child's social worker;

- Seeking immediate medical attention for any medical concerns;
- Reporting any unlawful behaviour in the home or the community to the child's social worker;
- Reporting problems at school;
- Maintaining a safe environment in the home;
- Agreeing arrangements with the health board on babysitting, child minding, holidays and moving house.

7.17 Under the Regulations foster carers have to inform the health board of any significant event affecting the foster child or any change of circumstances which affect their ability to care for the child[3]. *The Irish Foster Care Association* has produced a *Diary and Planner*, in which foster carers can keep a written record of information on the foster placement. The record should include positive as well as negative situations that the foster child and foster family have encountered. Keeping a daily record of this nature would help foster carers to review situations, provide the child and family social worker and the link worker with valuable information in decision making and allow the foster carer show how they dealt with difficult situations. The Working Group recommends that health boards in assisting foster carers to meet their responsibilities should encourage and train them to use the Diary or some similar means to maintain a record of the placement.

7.18 A crucial aspect of the training programme for foster carers is the issue of discipline. All children and young persons have to learn the boundaries in relation to behaviour. This is part of the process of them developing their self-discipline and self-confidence. Discipline is therefore a critically important part of the parent child relationship and is inevitably a critically important part of the relationship between foster carers and foster children. Given the problems that many foster children can have it is the issue that has the greatest potential for disruption in the placement. It is vital therefore that the issue of acceptable and unacceptable discipline procedures is addressed in the context of the initial training of foster carers. It must be emphasised that corporal punishment is not acceptable in any circumstances.

## Dealing with Allegations of Abuse

7.19 Once an allegation of abuse is made against a foster carer or member of their family it must be assessed and investigated immediately by the health board, in accordance with the *Children First - National Guidelines for the Protection and Welfare of Children* and the law. **The primary responsibility of a health board in this situation is to ensure the safety and well being of any child who is alleged to have been abused.**

3. Section 16 The Child Care (Placement of Children in Foster Care) Regulations 1995 and The Child Care Regulations 1995 (Placement of Children with Relatives) 1995

7.20 The child's account of the alleged abuse must be assessed. During this process it is the role of the child and family social worker to give the child the support they need. The child should be given the opportunity to discuss all of the issues concerning the investigation with them. Where the child has been abused there will be a need for support and possibly therapy. It may be the case that the allegation is proven, ultimately, to be false. Children and adolescents do sometimes make false allegations. This can occur for a wide variety of reasons. In these circumstances it is just as necessary to support the child or young person in coming to an understanding of their behaviour.

7.21 Health Boards must also assess the risk to all the other children in the foster home. They also have an obligation in such situations to ensure that the parents or guardians are informed of allegations and of the results of assessments and investigations. If there is a risk to other foster children in the home their parents or guardians should also be kept informed.

7.22 The experience of being investigated for alleged abuse is very traumatic for foster carers and their families. It can lead to feelings of betrayal, powerlessness and anger. These feelings often influence their subsequent attitudes towards health board personnel particularly the social worker dealing with them. They often feel a sense of humiliation, particularly if they are living in small communities, which affect their self-confidence. Difficulties can arise between carers and the health boards from the carers perception of how they were treated when the boards were assessing allegations of this nature. The approach of the boards in these matters can make a significant difference to subsequent relationships. The stress can be further aggravated by the fact that investigations can take a number of weeks, months or years to complete.

7.23 The boards should ensure that at all times the carers are treated with dignity and respect. They should be informed of their rights in the situation and the investigation should always be carried out with the strictest confidentiality. The investigation should be carried out by a social worker other than the foster family's link worker or the child and family worker.

7.24 When undertaking an investigation into any allegation the board's primary concern must be the safety and well-being of the child. However, it is crucial that proper support is provided for the foster family during this process. When a complaint of this nature is made it can cause carers to become withdrawn. They should be encouraged to maintain contact with relatives and friends. It is also vital that appropriate counselling and support services are provided. This support should be made available to the family as a whole as allegations of this nature can have an adverse impact on carers as well as on children or other foster children in their care. The Group recommends that the link worker have the primary responsibility to provide or organise this support.

7.25 The Group noted that there is independent support available to foster families in this situation from the Irish Foster Care Association. The Association is also putting in place a legal expenses insurance cover for foster carers and their families.

## Completing the Investigation Process

7.26 The investigation of an allegation can have one of three outcomes. The allegation may be supported by evidence and therefore confirmed as true. The evidence may show that the allegation is false. It may be that the evidence is such that it cannot be proved to be either true or false and is therefore inconclusive. Depending on the conclusion there could be a decision to remove the child, if he or she has not already been removed. If the allegation is found to be false or the health board deems that there is not a risk to the child, the child may be left with or returned to the carers. If the board considers the matter to be serious enough it may terminate the carers approval as foster carers. This decision could lead to child protection procedures being invoked in respect of the carers' own children and the matter referred to the Garda Síochána.

7.27 It may be the case that the board concludes that there is a need for further training or that the foster carers need to be given clearer guidelines on safe care practices. In any event, the Working Group recommends that health boards have clear procedures for investigating allegations and reviewing foster carers once an investigation is completed. The foster carers should be informed in writing as to the outcome of the investigation and the appropriate support provided. If the allegation is sufficiently serious there should also be a formal review undertaken with the carers and the matter referred to the approval committee.

7.28 In addition, it is recommended that each board put in place an appeals mechanism to deal with situations that carers consider unsatisfactory. The health boards should keep a record of the allegation and the outcome of the investigation.

## Conclusion

7.29 Ensuring the safe care of children in foster care can pose challenges for boards and foster carers. Given that children, who can have severe problems of their own, are being placed with other families with all the problems that can create, it will always be difficult to guarantee fully safe care and avoid false allegations. The promotion of high quality care allied to appropriate training and support for carers and children will greatly assist in achieving this objective.

7.30 The Working Group recommends that the issues raised in this chapter be considered as part of a review of practices and procedures in foster care. It also recommends that a framework of procedures required to deal with the issue of allegations of abuse in the foster care setting be

drawn up. This framework should have regard to the range of existing procedures set out in the *Children First – National Guidelines for the Protection and Welfare of Children* and other provisions in law. Such a review should incorporate a preventative approach including a description of appropriate training and support for foster carers in relation to this issue.

## Recommendations

### Ensuring Safe Care

1. The issue of safe care should be explored in the assessment procedure, prior to the approval of applicants as foster carers, and it should continue to be addressed in training (paragraph 7.10).

2. Training and support needs should be complemented by other service developments such as a sufficiency of carers, to ensure that foster carers are not overloaded with multiple or too frequent placements; and respite care, counselling and basic support services should be provided (paragraph 7.10).

### Pre-Placement Issues

3. The option for a family to refuse to accept a child in circumstances where it feels unhappy about the placement should be a clearly agreed part of the contract between foster carers and the health boards (paragraph 7.13).

4. Health boards should not place any more than two foster children in any one home at any one time except in the interests of keeping a sibling group together and such groups should not be placed with other foster children (paragraph 7.14).

5. Foster carers should be given all the essential information in relation to the child's background when the child is being placed with them (paragraph 7.15).

### When the Placement Begins

6. The good practice precautions should be advised to carers prior to the placement (paragraph 7.16).

7. Health Boards should train foster carers to maintain detailed records of the foster placement (paragraph 7.17).

8. The issue of acceptable and unacceptable discipline procedures should be addressed in the context of the initial training of foster carers emphasising that corporal punishment is not acceptable in any circumstances (paragraph 7.18).

### Dealing with Allegations of Abuse

9. Allegations of abuse must be assessed and investigated immediately by the health board, in accordance with the *National Guidelines for the Protection and Welfare of Children* and the law (paragraph 7.19).

10. The child's account of the alleged abuse must be assessed and the child and family social worker should provide the child the necessary support during the investigation (paragraph 7.20).
11. Health Boards must also assess the risk to all the other children in the foster home (paragraph 7.21).
12. The health boards must ensure that parents or guardians are informed of allegations and of the results of assessments and investigations and if there is a risk to other foster children in the home their parents or guardians must also be kept informed (paragraph 7.21).
13. When investigations are undertaken foster carers should be informed of their rights in the situation and be treated with dignity and respect (paragraph 7.23).
14. The investigation should always be carried out by a social worker, other than the foster family's link worker or the child and family worker, with the strictest confidentiality (paragraph 7.23).
15. Health boards should provide appropriate counselling and support for foster carers and their children when investigations are being undertaken and when they are completed (paragraph 7.24).
16. Health boards should have clear procedures for investigating allegations and reviewing cases once an investigation is completed (paragraph 7.27).
17. Each board should put in place an appeals mechanism to deal with situations that foster carers consider unsatisfactory (paragraph 7.28).
18. The health boards should keep a record of all allegations and the outcome of the investigations (paragraph 7.28).
19. Comprehensive guidance of safe care practices and procedure in relation to allegations of abuse in foster care should be addressed in the proposed National Standards on Practices and Procedures (paragraph 7.30).
20. The procedures should have regard to the existing procedures set out in the Children First – *National Guidelines for the Protection and Welfare of Children* and other provisions in law (paragraph 7.30).

# PART 4

CHAPTER 8

# Future Organisation and Management of the Foster Care Service

# Chapter 8
# Future Organisation and Management of the Foster Care Service

8.1 This Report addresses a wide range of issues with a view to improving the services for children in foster care and those caring for them. Another aspect of strengthening the services is the need to further develop the management and support structures of the health boards to enable them to deliver more effective services for the children in their care, their families and foster carers. Foster carers make a critical contribution to the child welfare alternative care services. It is however costly both financially and in terms of human resources to recruit and train them. This will always be the case as it is necessary to ensure that children being placed in foster care are given the protection and level of care they need. Health boards therefore need to look at their foster carers as a resource that needs to be properly supported, developed and monitored and have in place the management and service structures necessary to provide that level of support.

8.2 Foster care must be seen as part of the continuum of care for children at risk and the management strategies adopted by health boards must therefore link the foster care service into the wider child care services such as residential care and family support services. As a corollary to the overall strategic requirements of the managing the services there is also a need to ensure that mechanisms are in place to deal effectively with the routine issues that arise with children, their parents and foster carers, such as complaints or disagreements.

## Child Care Services Three-year Development Plan

8.3 The foster care service needs to be part of a co-ordinated and integrated service built around the needs of these children and its development planned on that basis. The Group recognises that health boards do not have all the necessary range of services in place to meet these needs, though major progress has been made in the area of child welfare provision. Since the introduction of the Child Care Act in 1991, the Department of Health and Children has invested an additional £135 million (€171m) in revenue in the development of services. However it is acknowledged that it was starting from a low base and that the pressures on the system continue to increase.

8.4 As preparation for the planning of these services there is a need to develop a national set of standard planning and key performance indicators so as to ensure consistent application of national standards to the development of the services and quality of services across all boards. The Department of Health and Children, as part of the process of allocating funding to health boards, has already started the development of key performance indicators, some of which applied to the child care area.[1] This planning process must however be extended

1. Butler.M, Performance Measurement in the Health Sector, IPA, pg. 89

and deepened so as to ensure the development of effective services, delivered in a timely and efficient manner. The Group therefore recommends that as a priority that the Department of Health and Children, in conjunction with the health boards, develop the necessary planning indicators and continue the development of performance indicators. Critical to the success of this process will be the provision of accurate and timely information. This issue is being addressed by the use of the Minimum Interim Data Set and the Steering Group on Child Care Management Information Systems.

8.5 Following on from the development of national indicators, the boards should plan for the further development of a comprehensive integrated child care service for children at risk and their families. The plans should identify the demands on services, the gaps in the services and put forward proposals to meet those gaps. The Plans should cover a three-year period and should be approved by the Minister for Health and Children, who will continue to make the ultimate decision in relation to the allocation of additional resources, in the context of Government policy in relation to public expenditure. It should be noted that such a planning process would be of major assistance to the Department of Health and Children in formulating the service's requirements in the context of the three year Multi-Annual Budget process which is now being operated by the Department of Finance.

## Monitoring and Evaluation

8.6 The process of planning will be of little value unless there is provision for ensuring that plans are implemented and reviewed. Planning has to be a continuous process with necessary changes being made in the light of new information. The health boards are already obliged to submit reports on the adequacy of their services under section 8 of the *Child Care Act, 1991*. However, these reports are often out of date by the time they are published and are therefore of limited use in the planning and evaluation of services. In addition each board presents its report in different ways thus making comparative evaluations difficult. The Working Group understands that the health boards are currently engaged in an initiative to standardise the presentation of these reports and welcomes this initiative.

8.7 The Working Group acknowledges that, through the service plans, the Department of Health and Children and the health boards have in place a mechanism that can ensure that development plans are implemented in a timely manner and that there is a continuous review and evaluation.

## Consultation

8.8 Each health board will be responsible for developing its own plan in line with the policies and planning parameters set out nationally by the Department. However in recognition of the need to develop a partnership approach to the provision of services, the boards in

developing the plan should consult, in so far as is practical, with as wide a range of interested parties as possible before finalising the plans. This process should involve voluntary bodies involved at a local level in the provision of services.

8.9 It is also vital in developing the plan that to the maximum extent possible the staff providing the service are consulted regarding the future of the service in their area. This might be done by way of establishing formal staff committees, or a more informal approach may be useful depending on local circumstances. The participation of staff in the early stages of planning will ensure that their knowledge and experience is be taken into account.

## Management Structures

8.10 In reviewing the issues concerning the management and organisation of the foster care services the Working Group is anxious to ensure that the appropriate management structures are in place with clear lines of responsibility and authority. The Working Group see the main responsibilities of health board management in terms of foster care as:

- Implementing national policies and those of the health board;
- Ensuring compliance with statutory requirements;
- Supervision and support of personnel delivering the services;
- Ensuring adherence to best practice and procedures;
- Monitoring and reviewing the implementation of foster care arrangements;
- Ensuring multi-disciplinary co-operation in relation the foster care service;
- Identifying and addressing the training needs of staff and foster carers;
- Ensuring the delivery of high quality services.

8.11 The management and organisation structures within the health board foster care services also need to be viewed within the context of the *Report of the Expert Group on Various Health Professions*, in 2000. This Report reviewed a wide range of issues effecting various professions within the health sector, including social workers and child care workers. The Report makes a number of key recommendations, which will have a direct bearing on future work practices and management structures in the health service generally. A number of these recommendations relate to:

- career structures;
- recruitment and retention of staff;
- training and education of staff;
- management structures within the health service;

- interaction with other disciplines;
- development plans for the delivery of services.

8.12 The *Expert Group Report* makes a number of specific recommendations in relation to Child Care Workers and Social Workers who are the main health board personnel interacting with the foster care service and these are listed in Appendix 8. The Working Group fully endorses these recommendations and acknowledges the work already underway towards implementation in consultation with the various stakeholders.

8.13 However, while acknowledging the existing career development structures and the recommendations contained in the *Report of the Expert* Group, the Working Group is concerned in relation to the operational practices of a number of key managerial posts. One of these concerns relates to the position of Child Care Manager. The post was introduced in 1995 and every health board now has Child Care Managers to co-ordinate child protection services. The Child Care Managers assist and report to the General Manager in each community care area. Some of their more important tasks include:

- receiving all notifications of child abuse;
- taking decisions relating to the holding of case conferences;
- ensuring inter-agency co-operation on child protection and welfare;
- ensuring inter-professional and inter-programme co-operation on child protection and welfare;
- overseeing staff training programmes;
- negotiating service agreements with voluntary service providers.[2]

8.14 Health board services must be organised in a co-ordinated and integrated manner in order to provide the continuum of care for vulnerable children. The roles of Child Care Manager and General Manager are crucial to ensuring a high degree of co-ordination and integration of services at community care area level. It is also crucial to developing the linkages with the other health services that may be required such as disability services or child and adolescent psychiatric services.

8.15 The Working Group is concerned the role of Child Care Manager appears to have evolved in different ways in across the health boards and that there appears to be no standard operational job description for Child Care Managers, particularly in relation to their wider role in relation to the services. The Group feels that there is a specific need to define roles and functions of the Child Care Managers and General Managers in the delivery of co-ordinated and integrated services and their position within the health board management structure. Another role that needs to be more clearly defined is that of Director of Child Care Services. Eight of the health boards have Directors of Child Care in

2. Children First, National Guidelines for the Protection and Welfare of Children, The Stationery Office Dublin, pg. 48

place and in the case of one board there are now two Directors of Child Care. The role, relationship and functions of Director of Child Care, Child Care Manager and General Manager need to be reviewed.

8.16 The Working Group therefore recommends that a comprehensive review of the roles, responsibilities and functions of Child Care Managers, General Managers in relation to child care services and Directors of Child Care should be carried out. The purpose of this review would be to establish common reporting structures and job descriptions across boards.

## Foster Care Teams

8.17 In addition to strengthening management structures, the Working Group considers it is necessary to strengthen the structures for delivering the services at community care area level. This can best be achieved by establishing dedicated Foster Care Teams at local level. One team would focus on meeting the needs of the children and their families while the other team would carry out assessments and provide the necessary support for foster carers and their families.

8.18 One of the primary functions of the Foster Care Teams will be to link in with other disciplines, in order to ensure prompt access to other relevant health services for children in foster care. Implementation of the recommendations in this Report will also mean that there will be a requirement for more sophisticated measurement of services and tracking of outcomes for children in care. It is therefore vital that the Foster Care Teams are adequately resourced in terms of management and administrative support.

## Foster Care Committees

8.19 In the area of foster care there is a need for a close working relationship between social workers, other health professionals involved with the children, teachers and other relevant staff. The Working Group acknowledges that only qualified social workers can be responsible for the placement and supervision of children placed in foster care and that the accountability for recommendations, decisions and reviews must be kept in line with the management structure.

8.20 The Working Group however feels that there is a need for a wider input into the process of maintaining standards particularly in relation to long-term placements. The Working Group therefore recommends that local foster care committees be established in each community care area. These principal tasks of the committees would be:

- To approve long-term planned placements expected to be for a duration greater than six months
- To approve applications to become foster carers
- To review the status of foster carers.

8.21 The Working Group acknowledges that health boards already use foster care committees to consider applications from prospective foster carers, in accordance with *The Child Care (Placement of Children in Foster Care) Regulations, 1995.* However the majority of these committees are made up exclusively of health board personnel. The Working Group recommends that membership of these committees be reviewed. Future membership of these committees should include representatives from social workers, other appropriately qualified and experienced health board staff, an experienced foster carer and where appropriate a person who had the experience of being in foster care. Consideration should also be given to having a representative from the education sector.

8.22 Each committee member, who is not an officer of the health board, should be subject to the appropriate Garda and health board checks before they are appointed and undertake to carry out their functions in complete confidentiality. On appointment each member should be acquainted with the health board's policies and standards in relation to its child welfare services. The members should be appointed by the health board chief executive officer. Appropriate training should be provided for non-health board members. It is envisaged that the committees would meet on a monthly basis.

## Use of Non-Statutory Agencies to supply Foster Care Services

8.23 Under the provisions of the Child Care Act, 1991 a health board may, subject to any general directions given by the Minister for Health and Children and on any such terms or conditions as he or she thinks fit, assist a voluntary body or any other person who provides or proposes to provide a child care or family support service, similar or ancillary to a service which the health board may provide under the Act. This provides for the possibility of non-statutory organisations undertaking the management of a foster care service and such services are already in operation in some health board areas. Where a board does contract such a service or places a child with it the board is still the statutory body with responsibility for the children in that service.

8.24 The Working Group recommends that each board should have clear policies and procedures in place regarding the contracting out of any service or part of the service. The boards should be satisfied as to the non-statutory agency's status, its management structures, finances, procedures, staffing levels and qualifications, policies and practices. The board must ensure that the service provided is of the same standard that would be expected of the board itself. All such contracts should be agreed in writing and the board should have representation on the management committees overseeing the service.

## Staffing Levels

8.25 A factor affecting the delivery of foster care services is the manpower levels in the child care service. The health service generally is experiencing severe difficulties in recruiting and retaining staff and the child protection and welfare service is no different. This can lead to social workers experiencing extremely heavy case loads, which effects their ability to provide a full service to foster children and their families. The health boards have endeavoured to address this issue and have undertaken recruitment campaigns abroad in order to fill the vacant posts. It is however extremely important that every effort is made to tackle this problem in as innovative a manner as possible.

8.26 The *National Social Work Qualifications Board* (NSWQB) has undertaken a Survey on Social Work Posts in Ireland and has identified key areas for further research[3]. The Department of Health and Children is currently in discussion with the *National Social Work Qualifications Board* in order to address these issues. One of the main outcomes of these discussions to date has been a proposal to provide additional training places for social workers over the next four years.

8.27 A major issue in improving the quality of the service is the level of support provided for the child and family and the link workers, including supervision by social work management. Allied to this is the need to ensure proper case management in order to avoid overloading of cases on individual workers. The issue of case loads is part of the wider issue of planning the services and staffing levels for other personnel involved in the delivery of services. This should be addressed in the context of the service planning and key performance indicators, which have already been discussed earlier.

8.28 The Working Group is concerned that promotional opportunities often leads to the loss of an experienced social worker '*on the ground*' due the present organisational structures. This has also been identified as an issue by people involved in the child welfare service. Staff representatives have made an argument in favour of a new post of *Senior Social Work Practitioner* in submissions to the *Expert Group on Various Health Professions.* It was suggested that this should be a promotional post for qualified social workers with three years post qualification experience and a proven effectiveness as a professional social worker. The Senior Social Work Practitioner would be responsible for an assigned workload involving complex cases or might perform specialist tasks.

8.29 The Working Group has examined the proposal and given the current difficulties in recruiting and retention of experienced staff recommends it should receive favourable consideration. The creation of such a post may help develop career structures that retain experienced staff in direct service delivery, which is an important consideration if the quality of the service is to be maintained and improved. At the time of

3. National Social Work Qualifications Board, Report No.1, Social Work Posts in Ireland

publication the Working Group understood that the Department of Health and Children had agreed to this proposal in principle. The Group welcomes the Department's decision.

8.30 The Working Group has also identified a linkage between current staff recruitment shortages and recognition of professional qualifications. The *National Social Work Qualifications Board (NSWQB*) is the responsible organisation for maintaining and promoting the quality of social work education in Ireland. One of the *NSWQB*'s main functions is to accredit the qualifications of social workers those who have studied abroad. The *NSWQB* has set criteria by which it judges international social work qualifications. These criteria directly relate to the *National Qualification in Social Work*, which is the professional qualification in Ireland. To become a qualified social worker requires obtaining a degree and the *National Qualification in Social Work*. This will take at least four years of full-time education to complete. Social work training in other European Union countries can take less time. For example, some social worker courses in the United Kingdom are of two-year duration. However the *NSWQB* does not consider the two-year course qualifications to be adequate. At present it advises applicants with these qualifications to obtain a relevant and accredited Irish qualification.

8.31 The Working Group notes *EU Directive 89/48*, which was designed to promote mobility of people with certain qualifications within the European Union. The Directive applies to a wide range of professions, including social workers. The Working Group considers that some initiative is needed to ensure that social workers, with insufficient qualifications, seeking employment in Ireland can obtain the necessary qualifications with the minimum delay. The Working Group therefore recommends that that in recognition of the current difficulties in recruiting qualified social workers that the *NSWQB* should explore the possibility, with the appropriate university authorities, of establishing a transition course to enable these applicants to bring their qualifications to the Irish standards

## Training and Education of Service Providers

8.32 Ongoing support and training for those involved in the delivery of the foster care service is also vitally important and has already been discussed in detail in this report. The *Expert Group on Various Health Professions* has also made a number of recommendations in relation to training and education mainly in respect of social workers entering the service. As part of those recommendations it proposed that the employers' and staff representatives explore the scope for drawing up agreed '*best practice*' recommendations for the providing and making available of resources for vocational training for serving social workers, with advice and input of the *National Social Work Qualifications Board*. The Working Group fully endorses this approach. However the issue of vocational training is inextricably linked with developments in improving

professional practices and the delivery of services. The Working Group therefore recommends that the Social Services Inspectorate should be involved and have a major input into the development and design of such training programmes.

8.33 The Working group strongly feels that the importance of foster care has to be highlighted in the professional training of social workers and other workers in the child care area. It feels that there is a need for a postgraduate course that specifically addresses the issues involved in foster care. Such a course would be invaluable to social work managers, social workers and other child care workers involved with foster care. The course could be based on the Advanced Diploma in Child Protection and Welfare run by University of Dublin since 1990. The Working Group recommends therefore that the health boards discuss with the appropriate academic authorities and the *National Social Work Qualifications Board*, the possibility of establishing a multi-disciplinary postgraduate course in foster care.

## Introduction of a Complaints Procedure

8.34 Complaints arise for a variety of reasons. It may be a result of poor communication between the social worker and foster carer, or a misunderstanding of what the process involved in foster care placement is about. When someone has a complaint, be it a major or minor complaint, there are a number of basic points to remember. Most people making a complaint want:

- To be listened to;
- To have the problem accepted as important;
- To be offered an apology and/or a solution;
- To be reassured that the same thing will not happen again.

8.35 The Working Group feels that in general minor problems relating to day-to-day issues in foster care should be resolved in a partnership spirit between the parties involved. Unfortunately, the reality is that not all problems will have ready solutions and there will always be situations where it will not be possible to deal with complaints at that level. A complaints system should therefore be introduced in relation to foster care in all health boards. For a complaint procedure to operate effectively, children, their parents, their foster carer and staff need to know how a complaint is made. It is important that the introduction of a formal complaint procedure should not be seen the introduction of a 'blame culture' by staff. A staff member or foster carer, about whom a complaint is made, should be regularly appraised in writing of the progress made in the investigation of a complaint in order to minimise their natural anxieties.

8.36 A formal complaints system should be introduced across all health boards and health boards should provide procedures and guidelines for dealing with complaints and representations and incorporate guidance on:

- Who can complain;
- What the complaint can be about;
- How the complaints system works (e.g. who will investigate the complaint and how will the outcome of the investigation be made known);
- Outline the Steps to be followed in the Complaints Procedure.

8.37 These procedures should be readily available and copies supplied to all children and young people in foster care, their parents and their foster carers. All parties involved should be informed that they have the right to complain about the quality of care or service they are receiving. All parties involved in the complaint should have the right to be heard and all of them should receive in writing a copy of any complaint made in respect of them and decisions taken in relation to the complaint. As part of the management of the complaint procedure each board should monitor and evaluate complaints and their outcome with a view to assessing if the service can be improved. Annual reports on the operation of the complaint procedure should be made to senior management in each board to help evaluation and assessment of the complaints process.

## Record Keeping and Management Information

8.38 Under the *Child Care Regulations, 1995* a health board is obliged to compile detailed case records of every child placed in foster care and to keep it up to date[4]. Part IV of the *Child Care Regulations, 1995* deals with the monitoring of placements and obliges health boards to maintain a register in relation to children placed in foster care. Whereas the register records salient objective facts about the child, such as his name, original home address, foster home address, and so forth, the case records consists of a number of detailed and personal documents relating to each child's case. Such documentation may include:

- medical and social reports on the child, including background information on the child's family,
- a copy of any court order relating to the child or of parental consent to the child's admission to the care of the board, as appropriate,
- the birth certificate of the child,
- a copy of the contract between the board and the foster parents,
- a copy of the plan for the care and upbringing of the child prepared by the board under article 11 of these Regulations,
- reports on the child's progress at school, where applicable,
- a note of every visit to the child and the foster parents in accordance with article 17 of the Regulations,

4. Section 13, The Child Care, (Placement of Children in Foster Care) Regulations and The Child Care (Placement of Children with Relatives) Regulations 1995

- a note of every review of the child's case pursuant to article 18, 19 or 20 of the Regulations, together with particulars of any action taken as a result of such review and a note of every significant event affecting the child.

## Confidentiality

8.39 Confidential, effective and efficient record keeping is therefore of critical importance. If a health board's record keeping is consistent and efficient then the likelihood of an unsuccessful or harmful placement escaping the notice of the board is reduced. The Working Group therefore recommends that the management of records held by the health board social worker or other designated key worker should be standardised in each health board area. Records should be factual, accurate and legible and should be dated and signed after each entry. If an assessment or evaluation is made, an explanation for its basis must be offered. Records should be accessible at all times during a key worker's absence. It is the responsibility of line managers to ensure that files are kept up to date and good recording practices are maintained.

8.40 Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. It is important to note that they are not intended to limit or prevent the exchange of information between different professional staff who have a responsibility for the care and welfare of foster children. Notwithstanding the requirement of all professionals involved in child care to share relevant information, records are nevertheless confidential. The issue of confidentiality should be part of the training plan for staff working in this area and the health boards should have a written policy in this regard.

8.41 Everyone involved in foster care should also be aware of the provisions of the *Freedom of Information Act, 1997.* This Act enables members of the public to obtain access, to the greatest extent possible consistent with the public interest and the right to privacy, to information in the possession of public bodies. The specific provisions of the Act include the following:

- to provide for a right of access to records held by such bodies, for necessary exceptions to that right and for assistance to persons to enable them to exercise it;
- to enable persons to have corrected any personal information relating to them in the possession of such bodies;
- to provide for independent review by an Information Commissioner both of decisions of such bodies relating to that right and of the operation of the Act generally;
- to provide for the publication by public bodies of guides to their functions and guidelines for assistance of the public.

8.42 Under the Act, a person about whom a pubic body holds personal information has:

- right of access to this information subject to certain conditions;
- right to correct this information if it is inaccurate;

8.43 Where a public body makes a decision, which affects an individual, that person has a right to access to the reasons and findings on the part of the body reaching that decision. The Act is also designed to protect the privacy of individuals and, in general, requires the prior consent of an individual before releasing personal information about them. Where the release of social work or medical records contains information that would be harmful to a person's well-being, the release may be made to a health professional who acts on the person's behalf. Under the Act, there are regulations and guidelines relating to access by parents to their children's records; these emphasise that the over-riding concern is the best interests of the child.

8.44 The exemptions and exclusions which are relevant to child protection and welfare include the following:

- protecting records covered by legal professional privilege;
- protecting records which would facilitate the commission of a crime;
- protecting records which would reveal a confidential source of information.

8.45 Clear guidance and training should be provided by the health boards to all staff and foster carers regarding the implications of the Act for access to records they maintain on children in foster care.

## Management Information Systems

8.46 The Working Group notes the lack of a national management information system for child and welfare services as a serious deficiency in the service. Such a management system would assist policy makers, managers and professionals in their respective roles and would also assist research on the child care services in Ireland. In addition to providing management information such a system should enable the boards to track children coming into care, their assessments, child care plan reviews and the outcome of the placements.

8.47 The Working Group is aware that the Department of Health and Children has introduced the Interim Minimum Data Set to address these issues in the short-term. However it is recognised that this is only a temporary measure. The absence of a fully developed management system hinders the introduction of key performance indicators for child and welfare services, including foster care, which are crucial to the measurement of the efficiency and effectiveness of services. The Working Group welcomes the initiative undertaken by the Department of Health and Children and the health boards in 2000, in establishing the Steering Group on Child Care Management Information Systems.

The Group's remit is to draw up proposals for the introduction of a standardised integrated and national child care information system.

## Research

8.48 In the preparation of this report, experience of foster care on a national and international level was researched. Whilst a great deal of the research carried out internationally is useful, there is a need for research in an Irish context. However, very little published work on the operation of foster care services in Ireland is available. This also detracts from our ability to analyse the efficiency and effectiveness of the Irish foster care service.

8.49 The Working Group acknowledges that some valuable research has been carried out in this country. There is a need to address a wider agenda, particularly in relation to the outcomes of the services. The Working Group therefore recommends that the Department of Health and Children, in consultation with the health boards, should encourage independent research on the operation of the Irish foster care service. The investment in this research will be quickly repaid through the added benefit it will bring to development plans and evaluation of services in terms of their stated objectives. This then helps ensure that scarce resources are allocated wisely.

## Recommendations

1. The Department of Health and Children in consultation with the health boards should develop national standard planning and key performance indicators for the service (paragraph 8.4).

2. Based on the planning and key performance indicators, health boards should draw up three-year plans for the development of co-ordinated and integrated child welfare services (paragraph 8.5).

3. In drawing up the plans the health boards should consult widely with staff and voluntary bodies involved in the provision of services (paragraphs 8.8 and 8.9).

4. A comprehensive review of the roles, responsibilities and functions of Child Care Managers, General Managers in relation to child care services and Directors of Child Care should be carried out (paragraph 8.16).

5. Dedicated foster care teams should be established to deliver services at local level (paragraph 8.17).

6. These teams should link into other disciplines and services to ensure prompt access to other relevant health services for children in foster care (paragraph 8.18).

7. The health boards should establish foster care committees in each community care area, made up of up of senior social work staff, other appropriately qualified and experienced staff, an experienced foster carer and possibly a person who had the experience of being in foster

care, to approve the placement of children in placements planned for a duration of six months or more, approve foster carers and review their status. (paragraphs 8.20 and 8.21).

8. The health boards should have clear policies and procedures in place regarding the contracting out of any foster care service or part of the service to non-statutory agencies. (paragraph 8.24).

9. The *NSWQB* should explore the possibility, with the appropriate university authorities, of establishing a transition course to enable social workers with qualifications from abroad, which do not meet current national standards, to bring their qualifications up to Irish standards (paragraph 8.31).

10. The Social Services Inspectorate should have a major input into the development of continuing training for personnel in child protection and welfare services (paragraph 8.32).

11. The health boards should discuss with the appropriate academic authorities and the National Social Work Qualifications Board, the possibility of establishing a multi-disciplinary postgraduate course in foster care (paragraph 8.33).

12. The health boards should develop procedures and guidelines for dealing with complaints and representations and copies of these procedures should be given to children and young people, their parents and foster carers (paragraph 8.36).

13. The procedures and guidelines should set out that all parties involved in the service should be informed that they have a to the right to complain about the quality of care or service they are receiving (paragraph 8.37).

14. The procedures and guidelines should ensure that all parties involved in a complaint have the right to be heard and should receive in writing a copy of any decisions taken in relation to the complaints (paragraph 8.37).

15. The management of the service in each board should monitor and evaluate complaints and their outcome (paragraph 8.37).

16. The management of records held by health board should be standardised in each health board area (paragraph 8.39).

17. Guidance and training should be provided by the health boards to all staff and foster carers regarding the implications of the Freedom of Information Act for access to records they maintain on children in foster care (paragraph 8.45).

18. That the Department of Health and Children should draw up in consultation with the health boards and other interested parties a programme of research in relation to children in care (paragraph 8.49).

## Signed

Eamon Corcoran (Chairman)

Mary Collins

Jim Gibson

Rio Hogarty

Grace Lynam

Roisin Maguire

Michael McGinley

Pat Whelan

Joan McLoughlin

Alice Parkinson

Ann McWilliams

Marie Smith

David Smith (Secretary)

Published by The Stationery Office
To be purchased directly from:
Government Publications Sales Office,
Sun Alliance House,
Molesworth Street, Dublin 2.
Or by mail order from:
Government Publications, Postal Trade Section,
4-5 Harcourt Road, Dublin 2.
Tel: 01-647 6834/5 Fax: 01-475 2760
Or through any bookseller.

**Price: £5.00 €6.35**

© 2001 Government of Ireland

LANGLEY FREEMAN
design group limited
Tel: +353 1 822 8970
www.langleyfreeman.ie