Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

REVIEW OF ADEQUACY FOR HSE CHILDREN AND FAMILIES SERVICES 2010

April 2012

TABLE OF CONTENTS

1 Foreword 1

2 Executive Summary 2

3 Introduction 3

4 Strategic Change, Governance, and Structure 4
4.1 Strategic Change 4
4.2 Governance and Structure 5
4.2.1 Governance and Accountability within the HSE 5
4.2.2 Budget and Expenditure 7
4.2.3 Structure of Service Provision 7
4.2.4 Staffing 8
4.2.5 Resource Allocation Model 8
4.2.6 Performance Management 8
4.2.7 Infrastructure 8
4.3 Inspection and Monitoring 9
4.3.1 HIQA Inspections 9
4.3.2 Inspections by the HSE 10

5 Indicators of Need 12
5.1 Children's Population 12
5.2 Other Demographic Factors 14
5.2.1 Poverty 14
5.2.2 Lone Parent Families 14
5.2.3 Ethnicity 14

6 Family Support Services 15
6.1 Introduction to Family Support Services 15
6.2 Issues Raised in the 2009 Review of Adequacy 15
6.2.1 Children's Services Committees 16
6.2.2 Development of Service Models to Address the Balance between Family Support and Child Protection 16
6.2.3 Commissioning of Family Support Services 17
6.3 Child Welfare Reports 17
6.4 Family Welfare Conferences 21
6.5 Springboard 22
6.6 Teen Parent Support Programme 23

7 Child Protection Services 26
7.1 Introduction to Child Protection Services 26
7.2 Review of *Children First* Implementation 26
7.3 Response to Child Care Inquiries 30
7.3.1 Ryan Implementation Plan 30
7.3.2 Implementation of Ferns 4 and Ferns 5 Report Recommendations 31

7.3.3 Roscommon Child Care Inquiry 32
7.4 National Review Panel 34
7.5 Child Protection Data 36
7.5.1 Child Protection Reports 36
7.5.2 Rates of Child Protection Reports per Local Population 36
7.5.3 Initial Assessments 38
7.5.4 Balance between Child Protection and Welfare Cases 39
7.5.5 Confirmed Abuse 41

8 Alternative Care Services 42
8.1 Introduction to Alternative Care Services 42
8.2 Issues Raised in the 2009 Review of Adequacy 43
8.2.1 Multi-Disciplinary Assessment Services for Children and Young People at Risk 43
8.2.2 Ensuring that Appropriate Placements are Available for Children In Care 43
8.2.3 Care Planning for Children in Children Detention Schools 43
8.2.4 Placement of Sibling Groups 44
8.3 Children in Alternative Care Data 44
8.3.1 Children in Care 44
8.3.2 Rates of Children in Care per Local Population 45
8.3.3 Admissions to Care 47
8.3.4 Placement Type for Children In Care 49
8.3.5 Age and Gender of Children in Care 51
8.3.6 Placement of Children Aged 12 or Under in Residential Care 51
8.3.7 Length of Time in Care 52
8.3.8 Placement Abroad 54
8.3.9 Discharges from Care 55
8.3.10 Aftercare 55
8.4 Key Statutory Responsibilities 57
8.4.1 Allocated Social Workers for Children In Care 57
8.4.2 Written Care Plans for Children In Care 58
8.4.3 Performance Indicators for Key Statutory Responsibilities for 2011 58
8.5 Special Care and High Support 58
8.5.1 Definition of Special Care 58
8.5.2 Definition of High Support 59
8.5.3 Reports on Special Care 59
8.5.4 HSE Children and Families Services Capacity Review of Special Care and High Support 60
8.5.5 Special Care and High Support Data 61
8.6 Foster Carers 63
8.6.1 Approved Foster Carers with Allocated Social Workers 63
8.6.2 National Audit of Foster Care Services 63
8.7 Residential Units 65
8.8 Supported Lodgings 65
8.9 Out of Hours Services 67
8.9.1 Crisis Intervention Service 67
8.9.2 Emergency Place of Safety Service 68
8.9.3 Homeless Young People 69
8.10 Separated Children Seeking Asylum 71

8.10.1 Equity of Care Policy....71
8.10.2 Trends in Numbers of Separated Children Seeking Asylum....71
8.11 Adoption Services....72
8.11.1 Adoption Act, 2010....72
8.11.2 Adoption Data....72

9 Education, Training, Research and Policy (ETRP)....74
9.1 Introduction to Education, Training, Research and Policy....74
9.2 Strategy and National Framework for Education, Training, Research and Policy....74
9.3 Development of Training Courses....75
9.3.1 Leadership and Management....75
9.3.2 Supporting Children First....76
9.3.3 Other Training....76
9.4 Social Work Practice Placements....76
9.5 Research....77
9.5.1 Management of Postgraduate Courses and Research Contracts Funded by Children and Families Services and the Establishment of Service Level Agreements with Academic Providers....77
9.5.2 Retention of Social Workers....77
9.5.3 North South Child Protection Hub (NSPCH)....77

10 Summary of Data....78

11 Conclusions....80

12 Bibliography....81

1 Foreword

The statutory requirement to review the adequacy of our child care and family support services on an annual basis is a welcome opportunity to take stock of our performance. It provides a means for us, not only to reflect upon what went well, but also to highlight and address areas where improvements are required.

I was appointed National Director, Children and Families Services in January 2011. It is evident that there were significant demands and challenges during 2010: for example, the report of the Roscommon Child Care Inquiry highlighted a number of deficiencies at organisational, management and practice level which are now the subject of a detailed action plan. The Ombudsman for Children criticised a lack of consistency in the implementation of Children First, the national guidelines for child welfare and protection. Therefore improvements in this area were a priority during 2010. Also in 2010 the Health Information and Quality Authority (HIQA) published Guidance of the HSE for the Review of Serious Incidents including Deaths of Children in Care. As a result the HSE established a National Review Panel, with an independent chair, to conduct objective and consistent reviews of such incidents and to make recommendations for service improvement.

Against this background the core business of child welfare and protection was conducted by a dedicated and professional staff group. In a climate of economic constraint, where opportunities for service development are curtailed, the emphasis must be placed on greater efficiencies. We have begun a process whereby service delivery will be measured in terms of the quality of service provision and the outcomes that are achieved for children and their families.

Gordon Jeyes

National Director

2 Executive Summary

The Review of Adequacy is not an end in itself; rather it is a process of review and reflection upon how services might be improved. In recent years a number of reports have highlighted the need for structural reform and more consistency in the way in which services are delivered. Meeting this challenge was a priority throughout 2010 and into 2011. The Government decision, late in 2010, to appoint a National Director for Children and Families Services reflected the commitment to address these issues in a meaningful way. Despite the financial constraints additional staff were recruited in key areas during the year. Greater emphasis was also placed on the efficient management of resources and on the management of performance.

The **first** and **second sections** of this report provide a **foreword** and **executive summary.**

The **third section** provides an **introduction** which sets out the statutory provisions governing the Review of Adequacy 2010.

The **fourth section** addresses **strategic change, governance and structure**. It provides an overview of budget and expenditure, the structure of service provision and performance management arrangements.

Section five provides an analysis of **indicators of need**. Ireland's growing child population is highlighted. Other demographic factors are considered, such as poverty, lone parent families and ethnicity.

Section six deals with **family support services**. There is an emphasis on the development of Children's Services Committees as a means of integrating family support services across a range of key stakeholders. Welfare reports to social work departments continued to outnumber reports concerning child protection.

In **section seven** trends in **child protection services** are analysed. Figures show a year-on-year increase in the number of reports being made. Neglect remained the consistently the most prominent reason for a child protection report to be made. Planned service improvements continued to be rolled out in the light of the *Ryan Report* (Commission of the Inquiry into Child Abuse 2009), report of the OCO on Children First (OCO 2010) and the Roscommon Child Care Inquiry report (Roscommon Child Care Inquiry Team 2010).

Section seven describes **alternative care services**. The numbers of children in care has increased by 13.7% since 2006 from 5,247 to 5,965. However, the rate of children in care remains lower than those in neighbouring countries. Admissions to care were slightly down on the previous year. By the end of December the percentage of children in care with an allocated social worker exceeded 93%.

In **section eight** services for **education, training, research and policy** are examined. During the year a National Advisory Group was established to provide advice on these internal services.

Finally **section nine** draws broad overall **conclusions**.

3 Introduction

Section 8 of the *Child Care Act, 1991* states that the Health Service Executive (HSE) should prepare an annual report on the adequacy of child care and family support services, making this available to the Minister and other stakeholder bodies. Up until 2005, individual Health Boards produced their own local reviews of adequacy but since 2005, when the Boards were replaced by the national Health Service Executive, there has been a single annual document covering the whole of HSE Children and Families Services.

The determination of the adequacy is an ongoing process of review and reflection in order to determine the planning, development and delivery of effective services. There are a range of methods by which this is achieved, such as:

- internal and external review of policies, services and processes;
- findings from inquiries;
- findings from inspections;
- research commissioned by HSE Children and Families;
- academic research;
- comparability with international best practice.

The Review of Adequacy is not an end in itself nor a once-a-year process. It is critical to ensuring that HSE Children and Families Services is a 'learning organisation' underpinned by a robust evidence-base. The processes employed ensure that staff are involved in research, design and delivery, either through consultation on specific themes/topics or via involvement in task forces or working groups. Service user involvement in these processes, however, is less strong: while children and families are routinely involved in the creation of plans to meet their specific needs, they are not involved in the design and implementation of services.

The last few years have been difficult for HSE Children and Families Services with the publication of a number of reports that have indicated a need to improve governance, accountability, management of performance and transparency in processes and systems. Many of the reviews of services over the last few years have identified issues relating to inconsistency of policies and processes throughout the country. Such inconsistencies can create:

- inequities in the service delivered to different service users in different parts of the country;
- difficulties for partner agencies in both statutory and voluntary sectors in working with services in different geographical areas where there may be differences in policy and practice;
- difficulties in analysing performance and describing best practice in different parts of the country.

The key focus, therefore, has been to address these inconsistencies by:

- reforming the structure of HSE Children and Families Services to strengthen linkages across both national-regional-local and welfare-protection-care continuums;
- developing national policies to replace legacy health board policies;
- promoting standardised processes as part of the task of developing a National Child Care Information System.

4 Strategic Change, Governance, and Structure

Children and Families Services form a part of the national Health Service Executive (HSE) structure. The HSE itself is a relatively young organisation, having come into existence in 2005. Services aim to promote and protect the health and well-being of children and families, particularly those who are at risk of abuse and neglect. In this regard, the HSE has a responsibility under the *Child Care Act, 1991* and other legislation to promote the welfare of children who are not receiving adequate care and protection. Child protection and welfare services are also provided in accordance with the *Children Act, 2001* and the *UN Convention on the Rights of the Child, 1989, ratified in 1992*.

HSE Children and Families Services provide a wide range of services including early years, family support, child protection, alternative care, services for homeless youth, search and reunion (post adoption) services, registration and inspection of children's residential centres in the voluntary sector and monitoring of children's residential centres in the voluntary and statutory sectors. These services are provided directly by the HSE, or indirectly on the HSE's behalf under Section 38 of the *Health Act, 2004*, or by agencies grant-aided to provide similar or ancillary services under Section 39 of the *Health Act, 2004*.

4.1 Strategic Change

The strategic review of the delivery and management of HSE Children and Families Services (HSE/PA Consulting 2009) provided useful analysis to influence strategic direction for the future, with services more integrated both across a continuum of services (family support, child protection, alternative care) and geographically (local-regional-national). The National Office was strengthened in order to manage this change process. At operational level, the need to promote standardisation to develop a coherent national service was well recognised. Variations in policy and practice across the country began to be addressed. A range of working groups and task forces were employed to help progress a range of initiatives, to ensure that staff were involved in developing and implementing solutions.

There were several key drivers of strategic change for Children and Families Services in 2010, including:

- The *Agenda for Children's Services 2007* (OMCYA 2007).
- *Inspiring Confidence in Children and Family Services (2010) - the Strategy Review of Children and Families Services* (HSE/PA Consulting 2009);
- OMCYA's *National Review of Compliance with Children First* (OMCYA 2008); work of the HSE Task Force established in February 2009 that aimed to 'accelerate the development of a national, unified and standardised approach to the delivery of Child Protection Services' (HSE 2010h); and the *Ombudsman for Children's investigation into the implementation of Children First* (OCO 2010);
- The *Report of the Commission to Inquire into Child Abuse 2009* (Ryan Report) (Commission of the Inquiry into Child Abuse 2009) and subsequent *Implementation Plan* (OMCYA 2009b);
- The *HSE National Service Plan 2010* (HSE 2010c);

The Strategy Review defined the key elements of the strategic response to be:

- simplifying and streamlining the organisational structure for the delivery of the service to make

it clearer and more accountable;
- developing an evidenced based service delivery system;
- the implementation of formal child protection protocols to ensure standardised and consistent practice across the country;
- the implementation of the National Child Care Information System;
- the recruitment of 200 additional social work staff and 65 related child care staff; and
- the implementation of the recommendations of the National Foster Care Audit.

Given the significant breadth and depth of this change programme, it will be rolled out in a measured and planned way over the coming years.

4.2 Governance and Structure

4.2.1 Governance and Accountability within the HSE

Section 3 of the *Child Care Act, 1991* provided that 'It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection.' Under Section 56 of the *Health Act, 2004*, the existing ten health boards and the Eastern Regional Health Authority, were dissolved and all of their functions and employees, including those related to child care, were transferred to the HSE. The HSE came into existence formally in January 2005, with Children and Families Services coming under the remit of the Director of Primary Community and Continuing Care Services.

The structure of delivery of children and families services in 2005 followed legacy health board boundaries. The HSE was subdivided operationally into four Regions; the previous 32 Community Care Offices (CCOs) under the health boards became 32 Local Health Offices under the HSE, each with a Local Health Manager, with the same geographical remit as their predecessor CCOs.

Table 1: HSE Regions, former Health Boards and Local Health Offices

HSE Region	Former Health Board	LHOs		
Dublin Mid-Leinster	East Coast Area	Dublin South East	Dun Laoghaire	Wicklow
	Midland	Laois/Offaly	Longford/Westmeath	
	South Western Area	Dublin South City Dublin West	Dublin South West Kildare/West Wicklow	
Dublin North East	Northern Area	Dublin North Central	Dublin North West	North Dublin
	North Eastern	Cavan/Monaghan	Louth	Meath
South	Southern	Kerry South Lee	North Cork West Cork	North Lee
	South Eastern	Carlow/Kilkenny Wexford	Tipperary South	Waterford
West	Mid-Western	Clare	Limerick	Tipperary North
	North Western	Donegal	Sligo/Leitrim/West Cavan	
	Western	Galway	Mayo	Roscommon

The structures that were inherited did not provide sufficient clarity about governance, accountability and responsibilities for HSE Children and Families Services. The *Ryan Implementation Plan* (OMCYA 2009b) noted:

> *'It is difficult at present to locate responsibility for services delivered to children at risk or in care. There is no single management post at local health office level with clinical and executive authority for child and family social services. In the past, there has been a lack of leadership and accountability for self-reported failings in implementing legislation, regulations and national standards. Those managers with responsibility for risk (principal social workers) do not have direct access to resources, including care placements. Child care managers have an advisory role rather than a service management function in 28 of the 32 HSE areas. Local health offices have different management systems, frequently allocating decisions on sensitive gate-keeping or admissions to services to committees. Although the local health manager has overall responsibility, the layers and decision-making arrangements make it difficult to identify where authority and responsibility lie, and leads to a system that is administered rather than managed.*
>
> *'The HSE recognises that its current management structure needs to be reformed and has recently engaged in a process to review the structure, management and organisation of children and family services.'*

Similarly, the Strategy Review (HSE/PA Consulting 2009) found that 'the structure needs to be leaner, more transparent with clear lines of responsibility and accountability.' The structure had not changed fundamentally since the HSE had been established, with changes 'grafted' on 'as needs arose.' Findings in this area included:

- The absence of a 'clear line of sight' from senior management to front-line delivery 'makes delivery complex. It can also undermine confidence between different layers of the service.'
- Authority for managing financial resources was unclear.
- It was not clear to external agencies or other HSE agencies who was responsible for child protection. 'This is a basic requirement for interagency collaboration.'
- There were weak performance structures.

The HSE revised its senior management structure in late 2009 and this provided the opportunity to strengthen governance of Children and Families Services. Under the National Director of Integrated Services, an Assistant National Director (AND) for Children and Families Services was appointed. Reporting to the National Director, the AND had overall responsibility for the policy and strategy, while line management remained under the auspices of regional and local integrated management. The AND's responsibilities included assuring that:

- the national priorities for HSE Children and Families Services were delivered across the country;
- the provision of the National Corporate and Service Plans and Key Results areas were being implemented;
- The delivery of services for Children and Families were in line with policies agreed by the Government and within the agreed targets and resources of the HSE.

Alongside this post, four National Specialists were appointed for: Family Support; Child Protection; Alternative Care Services; and Education, Training, Research and Policy. Some administrative posts

were also introduced. All of these developments represented, for the first time, the establishment of a full time National Office for HSE Children and Families Services. Key priorities for the National Office were to provide consistency in the way services were managed and delivered throughout the country and to develop an overall strategic plan for the service.

The National Office was further strengthened by a decision in late 2010 at Government level to appoint a National Director for Children and Families Services; the post was filled in early 2011. It was felt that the issues facing child care were so important, urgent and unique as to warrant a separate directorate that was not overshadowed by medically dominated services.

At Regional level, one Local Health Manager per Region was given strategic responsibility for child care services for that Region. They were assisted by Regional Child Care Specialists who provided day to day leadership. At local level, Child Care Managers continued to hold responsibility for strategic management and overall responsibility for the child protection system. The Strategy Review (HSE/PA Consulting 2009) felt that this structure needed further revision and included as an option a clearer management structure at local level via a single Manager of Children and Family Services assisted by Principal Social Workers (PSWs) with responsibilities for family support, child protection and alternative care.

A report by the Ombudsman for Children Office into the implementation of Children First (OCO 2010) urged that consideration should be given to 'whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.' The Minister for Children rejected the option of separating Children and Families Services from the HSE into a separate executive agency but the Opposition Fine Gael's 'Reinventing Government' agenda was more supportive of this type of approach and has promoted this since the General Election in 2011.

4.2.2 Budget and Expenditure

In 2010, Children and Families Services was allocated a budget of €601m (HSE 2011b). Budget and expenditure for Children and Families Services were not easy to extract from existing financial systems, where there are around 12,000 cost centres across 11 legacy health board systems. There was no national standardisation as to what specifically constitutes a care group: eg in some health boards, Child and Adolescent Mental Health Services were classed as child care, whereas in others they were classed as mental health. The HSE built the business case for a single financial system but did not receive permission from Government to implement this. Nevertheless, during 2011 area accountants reviewed the care group mappings to identify improvements that could be made.

4.2.3 Structure of Service Provision

The vast majority of services were planned and delivered at LHO level in 2010. This included core social work services such as duty and assessment, child protection, children in care teams, and fostering assessment/support services.

Some services were provided on a joint-LHO basis, often reflecting inherited structures from the former health boards. This included, for example, some fostering teams in the South and West, Aftercare, Family Welfare Conference Services, and monitoring and inspection. In the greater Dublin area, both family welfare conference services and the emergency out of hours service (Crisis Intervention Service) followed the boundaries of the former Eastern Regional Health Authority, covering ten LHOs that under the HSE were divided between Dublin Mid-Leinster and Dublin North East. Management and gatekeeping for residential provision was still often conducted along former health board boundaries although the patterns of that provision sometimes had an even older historic basis, reflecting

voluntary/religious order provision prior to the religious orders reducing their involvement. Assessment of Separated Children Seeking Asylum was primarily undertaken by one LHO in Dublin Mid-Leinster, as it had been prior to the establishment of the HSE. Special Care and the two national High Support units began to be planned and delivered on a national basis, with the three special care units and the two national high support units coming under a single national manager and operating with a common national admission and discharges committee.

4.2.4 Staffing

The number of whole-time equivalent staff for Children and Families Services in November 2009 was 1,527 (HSE 2010c). Action 58 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: 'It has already been decided that the HSE will fill up to 270 social work posts currently vacant. This initiative will be targeted at the area of child protection and children in care in order to fulfil its statutory obligations. The need to recruit further additional social workers will be considered in the light of progress made in delivering necessary reforms in the area of child welfare and protection.' A deliverable output was set in the *HSE National Service Plan 2010* (HSE 2010c) to recruit 200 social workers and child care staff and this was achieved: by December 2010, the annual increase in the number of social workers was 246 (HSE 2010g).

The cost coding inherited from the former Health Boards is complex, with staff being categorised in different ways in different parts of the country, so HSE Children and Families was unable to obtain routinely and easily figures on its workforce, either as a total figure or broken down into staff types. As the separate Directorate for Children and Families developed, it was increasingly important to have improved information on the numbers and composition of the workforce.

4.2.5 Resource Allocation Model

Action 44 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: 'The HSE will direct resources equitably on the basis of need and level of deprivation, irrespective of geographical area or organisation. It will report progress on this action to the OMCYA annually.' Within the ongoing reform programme for Children and Families Services, there is a commitment to establish a funding formula based on child population, deprivation and sparsity.

Action 43 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: 'The HSE will carry out an audit of all resources, financial and staff, directed at child and family services and at children in care services across regions and statutory and non-statutory agencies.' This was included in the *HSE National Service Plan 2010* (HSE 2010c): no action was taken on it in 2010 because of resource constraints

4.2.6 Performance Management

The *HSE National Service Plan 2010* (HSE 2010c) set as a Deliverable Outcome for 2010 'Collection of new and existing performance measures as agreed.' HSE Children and Families worked with the OMCYA during 2010 to define a range of new performance indicators (PIs).

Much of the data in previous Reviews of Adequacy has derived from an annual data collection from LHOs known as the Child Care Dataset (known in the past as the Interim Minimum Dataset). This data has not been of consistently reliable quality. With the development of new PIs, the scope and frequency of data collected began to be revised from 2011 onwards, to provide a more rationalised and focussed data set.

4.2.7 Infrastructure

The HSE has been preparing for several years for the introduction of an integrated IT-based National Child Care Information System, to support clinical practice and provide management information, by

way of intensive and extensive consultation with stakeholders. An essential aspect of this is the development of standardised business processes for all the core activities of Children and Families Services. The standardised business processes are essential to underpin the design of the ICT system.

The definition of standardised business processes was completed in late 2009: this included the development of a suite of forms and operating procedures to be used throughout Ireland. Roll-out of the new processes was to be carried out in three phases. The first phase involved the briefing and training of ten sites in the standardised business processes for referral, initial assessment and further assessment. This commenced in mid-2010, with the aim for these sites to go live in January 2011. The sites included in Phase 1 were: Cavan/Monaghan, Donegal, Kerry, Louth, Mayo, North Cork, Sligo/Leitrim/West Cavan, South Lee, and West Cork. Other sites and business processes will be implemented from 2011 onwards.

The business case for the National Child Care Information System (NCCIS) was signed off and sent to peer review in late 2009. The project received approval to proceed and work began on the preparation of the Request For Tender (RFT) in January 2010. During the first half of 2010, the RFT pack was developed, including a statement of requirements, Invitation To Tender and a scoring/evaluation document. The statement of requirements was closely linked to standardised business processes. The RFT went to peer review in June 2010. The peer review was still in progress at the end of 2010.

The *HSE National Service Plan 2010* (HSE 2010c) had as Deliverable Outcomes:

- standardised child protection referral and assessment processes implemented across all LHOs in line with Task Force outputs;
- standardised Care Planning Template rolled out across LHOs in 2010.

These processes were finalised under the standardised business processes initiative in 2010, in preparation for roll-out in 2011.

4.3 Inspection and Monitoring

4.3.1 HIQA Inspections

The Health Information and Quality Authority (HIQA) inspects HSE-run children's centres and foster care services against *National Standards for Children's Residential Centres* (DoHC 2000b) and *National Standards for Foster Care Services* (DoHC 2003). The HSE inspects children's residential centres in the private and voluntary sectors. A Government decision was taken in July 2010 to prioritise the inspection of community based child protection services ahead of the commencement of HIQA regulating all children's residential services. Action 87 of the *Ryan Implementation Plan* (OMCYA 2009b) was for HIQA to develop outcome-based standards for child protection services.

In addition to individual inspection reports, publications by HIQA in 2010 included:

- *Draft National Quality Standards for Residential and Foster Care Services for Children and Young People* (HIQA 2010a);
- *Guidance for the HSE for the Review of Serious Incidents including Deaths of Children In Care* (HIQA 2010b);
- *National Overview Report of Special Care Services Provided by the Health Service Executive* (HIQA 2010c).

Inspection of the HSE's provision of foster care services in seven LHOs commenced in late 2009 and was concluded in 2010. Detailed findings were published for Dublin North, Dublin North Central LHOs and for HSE South (North Lee, South Lee, North Cork and West Cork). All three special care units were also inspected.

Table 2: HIQA Inspections of children's services in 2010 (HIQA 2011a)

Type	Public announced	Public unannounced	Total
Full inspections			
Children's detention schools	0	3	3
Special care units	3	2	5
Children's community residential centres	9	11	20
Foster care	4	0	4
Follow-up inspections			
Special care units	3	2	5
Fostering	2	1	3
Children's community residential services	11	25	36
Total	**32**	**44**	**76**

4.3.2 Inspections by the HSE

HSE Children and Families Services has a responsibility to conduct inspection and monitoring visits of voluntary and private sector providers under Part VIII of the *Children Act, 1991*. Inspections are in accordance with the *Child Care (Placement of Children in Residential Centres) Regulations, 1995* and the *Child Care (Standards in Children's Residential Centres) Regulations, 1996*.

In 2010 there were five HSE Children and Families Services monitoring and inspection teams throughout country: two in the South (one for the area of the former Southern Health board, one for the area of the former South Eastern Health Board), two in the West (one for the area of the former North Western and Western Health Boards, one for area of the former Mid-Western Health Board) and the largest one in the East (former Eastern Region area, former North Eastern Heath Board area, former Midland Health Board area).

During 2010 progress was made on standardising approaches across the teams, with an initial focus on developing a similar structure for inspection reports, followed by the development of standardised business processes. The development of national standardised business processes for pre-school inspections and for fostering were identified as priorities for 2011.

By November 2010, a national Registration and Inspection Database was being developed. This will enable HSE Children and Families Services to track registration and inspections over the coming years.

Pre-School Inspections

HSE Children and Families Services undertake pre-school inspections under Part VII of the *Child Care Act, 1991* and the *Child Care (Pre-School Services) Regulations, 2006*. The HSE is responsible for inspecting pre-schools, play groups, nurseries, crèches, day-care and similar services which cater for children aged 0-6.

In 2010 there were 3,628 inspections undertaken, of which 3,016 were annual inspections.

The HSE inspected 59.3% of all notified services (notification is the procedure by which a person proposing to carry on a pre-school service gives notice in writing to the HSE at least 28 days before the

commencement of the service).

Some 612 review/follow up inspections were required. Such inspections are undertaken to assess where necessary that pre-school childcare services have rectified the areas of non-compliance with the pre-school regulations as detailed on the Inspection report or to investigate where a complaint on a childcare service is received.

In addition in there were 774 advisory visits carried out to a combination of potential and existing pre-school childcare providers. The introduction of the Early Childhood Care and Education Scheme (free pre-school year) by the Office of the Minister for Children and Youth Affairs in January 2010 was the main reason for requests for this service.

At the end of 2010 there were 4,804 notified pre-school services:

- 1,309 (27.2%) in Dublin Mid-Leinster;
- 1,065 (22.2%) in Dublin North East;
- 1,100 (27.7%) in South;
- 1,330 (22.9%) in West.

5 Indicators of Need

5.1 Children's Population

The most recent population data for the 0-17 age group that is available by LHO is from the 2006 Census (CSO 2007). At that time, the total population aged 0-17 was 1,036,034, distributed across the four HSE regions as shown in table 3.

Table 3: Population aged 0-17 (2006 Census) x Region

Region	0-17 ppn (2006 Census)	% of 0-17 ppn
Dublin Mid-Leinster	294,344	28.4%
Dublin North East	241,088	23.3%
South	283,473	27.4%
West	217,129	21.0%
National	**1,036,034**	**100%**

Data from the Census 2011 has not yet been reported by age group by the Central Statistics Office (CSO). The most recent population estimates by the CSO that showed age were made in September 2010, showing estimated populations for April 2010 (CSO 2010a). These figures showed a mixed pattern by age group (table 4): the 0-4 age group has increased the most significantly, and is the largest of the four age groups shown, while the 15-17 age group has declined.

Table 4: Population Estimates by Age Group (000s), April 2010

Year / Age Group	2006	2007	2008	2009	2010	% Change
0-4	302.3	312.3	327.9	341.6	353.8	+17.0%
5-9	288.5	295.9	303.4	308.0	311.6	+8.0%
10-14	274.2	275.6	281.0	288.1	293.6	+7.1%
15-17[1]	174.5	171.6	170.3	167.2	164.0	-6.1%
Total	**1039.5**	**1055.4**	**1082.6**	**1104.9**	**1123.0**	**+8.0%**

To project forward, we can age those children by five years (for simplicity, as they are in five-year age bands), with an assumption that there is no change from immigration/emigration, birth rates or infant mortality. In other words, in five years' time the 0-4 age group will become the 5-9 age group, the 5-9 will become the 10-14, and three-fifths of the 10-14 will become the 15-17 age group. Let us then assume a number of scenarios for the new 0-4 age group over that period – 6% decline, 3% decline, same rate, 3% increase, 6% increase, 9% increase. Remember that, with a larger population for the country overall, there is more likelihood of the 0-4 age group increasing than decreasing. As the table below shows, even with a decline of 0-4s by 6%, the overall 0-17 population would still increase by 4.6%.

[11] Note that the CSO reports data in five-year age bands: the figure here for the 15-17 group derives from multiplying the CSOs 15-19 figures by three-fifths. This calculation produces a slightly higher figure for the 0-17 population in 2006 than reported census figures but is only marginally different.

Table 5: Possible population projections for 0-17 age-group 2010-2015

Year / Age group	2010	2015 - 6% for 0-4s	2015 -3% for 0-4s	2015 Same for 0-4s	2015 +3% for 0-4s	2015 +6% for 0-4s	2015 +9% for 0-4s
0-4	353.8	332.6	343.2	353.8	364.4	375.0	385.6
5-9	311.6	353.8	353.8	353.8	353.8	353.8	353.8
10-14	293.6	311.6	311.6	311.6	311.6	311.6	311.6
15-17	164.0	176.2	176.2	176.2	176.2	176.2	176.2
Total	**1123.0**	**1174.1**	**1184.7**	**1195.4**	**1206.0**	**1216.6**	**1227.2**
Rise		4.6%	5.5%	6.4%	7.4%	8.3%	9.3%

Estimates by the CSO (CSO 2010a) suggested that that the rate of population growth was very high in 2006 and 2007 but has since declined: the birth rate has increased over this period, but immigration has slowed and emigration has increased. Table 6 shows the changes in the numbers of births year-on-year. Changes in patterns of immigration are shown in table 7.

Table 6: Births per year (000s)

Year	Births
2005	61.4
2006	61.2
2007*	65.8
2008*	72.3
2009*	74.5
2010*	74.1

* Preliminary data

Table 7: Estimated immigration x Nationality, all age groups (000s), April 2010

Year / Nationality	2006	2010
Irish	18.9	13.3
UK	9.9	2.4
Rest of EU15 (EU before enlargement in 2004)	12.7	4.3
EU12 (accession countries)	49.9	5.8
USA	1.7	0.3
Rest of world	14.7	4.6
Total	**107.8**	**30.8**

5.2 Other Demographic Factors

5.2.1 Poverty

People defined as being 'at risk of poverty' have an income below 60% of median disposable income. In 2009, some 18.6% of children aged 0-17 were 'at risk of poverty', an increase from the 2008 figure (18.0%) and higher than the figure for the national population covering all age groups (14.1%) (CSO 2010b, figures not yet available for 2010).

The 'individual consistent poverty rate' is the proportion of people, from those with an income below a certain threshold (less than 60% of median income), who are deprived of two or more goods or services considered essential for a basic standard of living. The 'individual consistent poverty rate' for children aged 0-17 was 8.7%, a rise from the 6.3% for 2008 and higher than the national average (for all age groups) of 5.3%.

5.2.2 Lone Parent Families

The *State of the Nation's Children* (OMCYA 2010b) reported that in 2006 around 17.8% (n=183,744) of children were living in lone-parent households, drawing from Census 2006 data (table 8).

Table 8: Number and percentage of children under 18 living in a lone-parent household, by population groups (2006)

	Number	% of all children
All children	183,744	17.8%
• Traveller children	2,698	24.7%
• Foreign national children	11,631	18.5%
• Children with a disability	9,694	23.1%

5.2.3 Ethnicity

Data on ethnicity in the 2006 census (CSO 2007) is shown in table 9, with 88.4% of the population aged 0-19 being White Irish. In other words, only 11.6% of the 0-19 population was of a different ethnicity to White Irish.

Table 9: Census 2006: Population aged 0-19 by Ethnicity

Census 2006	White Irish	White Irish Traveller	White Other	Black and Black Irish	Other (incl Mixed)	Not Stated	Total
0-4	252,499	3,298	12,100	10,214	9,748	12,824	300,683
5-9	253,369	3,019	12,126	5,255	7,109	6,435	287,313
10-14	245,903	2,954	11,196	2,672	5,379	4,396	272,500
14-19	262,505	2,529	11,709	2,132	4,883	3,363	287,121
Total	**1,014,276**	**11,800**	**47,131**	**20,273**	**27,119**	**27,018**	**1,147,617**
%	88.4%	1.0%	4.1%	1.8%	2.4%	2.4%	100%

6 Family Support Services

6.1 Introduction to Family Support Services

The HSE has a statutory responsibility to provide Family Support Services to the families of children who may be at risk of abuse or neglect. The HSE is committed to the development of childcare services which are located within the overarching framework of comprehensive child care services. Requests for HSE Family Support Services are received from a wide range of agencies outside of the HSE (e.g. school, probation, An Garda Síochána) and inter-departmentally within the HSE. Families can also self-refer directly to all HSE community-based Family Support Services.

The *Child Care Act, 1991* led to a number of new initiatives in the late 1990s and early 2000s across child protection and family support services. Key publications on child care policy and practice with a strong focus on the importance of supporting families and investing in preventative services were published including:

- *Final Report to the Minister for Social, Community and Family Affairs: Strengthening Families for Life.* (Commission on the Family 1998);
- *Children First, National Guidelines for the Protection and Welfare of Children* (DoHC 1999a);
- *The National Children's Strategy* (DoHC 2001a);
- *Best Health for Children: Developing a partnership with Families* (Denyer et al. 1999) and *Best Health Revisited* (National Core Child Health Programme Review Group 2005)

National policies and guidelines, which inform the provision of Family Support Services, include:

- The Springboard Initiative 1998;
- The Revitalising Areas by Planning, Investment and Development (RAPID) Programme 2001;
- The CLÁR programme, 2001, aimed at addressing depopulation and deficits in infrastructure and services in rural areas;
- *Quality and Fairness, A Health System for You* (DoHC 2001b);
- *Building an Inclusive Society* (Office for Social Inclusion 2002);
- *National Action Plan Against Poverty and Social Exclusion 2003-05* (Office for Social Inclusion 2003);
- *Agenda for Children's Services* (OMCYA 2007);
- National Childcare Investment Programme 2006-2010.

6.2 Issues Raised in the 2009 Review of Adequacy

The *HSE National Service Plan 2010* (HSE 2010c) set the following two Deliverable Outputs for 2010:

1. Implementation of the Strategy in line with Task Force outputs to support Agenda for Children's Services.
2. Ensure agencies providing services for HSE to children and families develop and implement an operational plan based on Agenda for Children.

These actions were embraced the Strategy Review (HSE/PA Consulting 2010), which provided a wider strategic vision for the development of Children and Families Services, embracing *Agenda for Children*.

The five recommendations of the *Review of Adequacy 2009* for the further development of Family Support Services reflected this thinking:

1. The development of a shared HSE understanding of family support within the Hardiker framework (Hardiker *et al.* 1991) using the *Agenda for Children's Services* (OMCYA 2007);
2. The development of more localised integrated models of family support aligned to Primary Care;
3. The re-organisation of local HSE infrastructure to support the integration and management of Family Support at local level;
4. Improved understanding and commissioning of services at local level;
5. Strengthening of the mandate for and roll-out of the Children's Services Committee initiative.

The first three of these recommendations will be addressed by the implementation of the Strategy Review. There is further commentary below on Children's Services Committees, the development of service models to address the balance between Family Support and Child Protection, and the commissioning of Family Support Services.

6.2.1 Children's Services Committees

The *Agenda for Children's Services* (OMCYA 2007) stated 'the achievement of the 7 National Service Outcomes for Children requires an even wider and deeper engagement by all Departments, Agencies and services with responsibility, however limited, for children. To support the achievement of whole system delivery, new interdepartmental, cross agency and multidisciplinary ways of working are needed.'

Children's Services Committees (CSCs) are an important vehicle for achieving this. CSCs aim to assist in the integration of Family Support with external stakeholders. The CSCs offer a common strategic platform for the development of priority actions in relation to youth services and child care services across the family support continuum.

Action 56 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: 'The HSE and local authorities will continue to establish and implement Children's Services Committees in each county nationwide.' *Towards 2016* (Department of the Taoiseach 2006) expected that these committees would be chaired by the HSE 'who are best placed to drive this initiative to achieve coordinated and integrated services.'

CSCs have been piloted in four areas since 2007: Dublin City, South Dublin, Donegal and Limerick City. The OMCYA and the HSE invited applications for new CSCs from all HSE Local Health Managers in 2008 and six new committees (Carlow, Fingal, Kerry, Kildare, Longford/Westmeath, and Louth) were operational in 2010. Invitations for further applications were made in December 2010.

6.2.2 Development of Service Models to Address the Balance between Family Support and Child Protection

During 2010 there were a number of pilots underway that were exploring alternative pathways and responses to reports made to social work departments, to reduce the need to initiate child protection processes. These include the Differential Response Model (DRM) in Dublin North LHO, the Identification of Need model in Limerick LHO, and the Identification of Need (ION) process in Donegal LHO and Sligo/Leitrim/West Cavan LHO. During the summer of 2010, the Child and Family Research Centre, NUI Galway, was appointed as the external evaluator of the Identification of Need (ION) process, to report back in 2011.

6.2.3 Commissioning of Family Support Services

As part of an HSE-wide initiative to improve governance arrangements for the funding of non-statutory agencies, a national framework has been developed which will ensure a consistent approach, operated by the HSE's National Business Support Unit. This Framework seeks to provide a level of governance, which will link funding provided to a quantum of service, and provides for these services to be linked to quality standards, with continuous monitoring to ensure equity, efficiency and effective use of available resources.

Data on funding and services from non-statutory agencies is held on a central reporting database. The primary purpose of the database is to monitor compliance with SLAs and grant-aid processes but it also holds information on service provision that would be useful in mapping family support services. During 2010, Children and Families Services began the process of exploring what information might be obtained from this database on the type of services being funded and the quantum.

As well as services that are categorised as oriented towards Children and Families on the database, there are services under other headings that will also have elements of focus on children and families (eg mental health, disabilities). During 2011, these were also explored to develop a fuller picture of family support services.

The data on the central reporting database will be used to assist Children and Families Services to understand current commissioning patterns as a basis for developing a commissioning strategy for Family Support Services, based on the New Children and Families' Service Delivery Model, "What Works" and local needs analysis. The rationale for developing a commissioning strategy is that there is a need to maximise the current resource bank to deliver on the new Service Delivery Model, using evidence based/informed practice. There is a need to further develop the continuum of service provision to children and families in each locality through more integrated partnership arrangements between statutory and voluntary/community sector providers.

6.3 Child Welfare Reports

Social work services received 29,277 of reports in 2010, 56.2% (n=16,452) of which were welfare reports and 43.8% (n=12,825) of which were protection reports. The profile of reports per Region and Local Health Office is shown in table 10. The *HSE Social Work and Family Support Survey 2008* (HSE 2009b) had noted that welfare reports consistently exceeded abuse reports, and had been rising since 2006 as a proportion of all reports: as in that survey, the 2010 data showed that a much higher proportion of reports in the West are classed as welfare compared to other Regions (see table 10).

Table 10: Reports to Social Work Departments x Report Type x HSE Region (2010)

Report type / Region	Number of welfare reports	Number of protection reports	Total	% welfare
Dublin Mid-Leinster	2,804	3,573	6,377	44.0%
Dublin North East	3,147	3,410	6,557	48.0%
South	4,360	3,766	8,126	53.7%
West	6,141	2,076	8,217	74.7%
National	**16,452**	**12,825**	**29,277**	**56.2%**

A critique of the *HSE Social Work and Family Support Survey 2008* that was commissioned by HSE Children and Families Services from Dr Helen Buckley of Trinity College Dublin (Buckley 2009) noted that variations were related not simply to disadvantage in an area but also to other factors such as:

- the accessibility of social work services;
- how well publicised they are;
- how established they are;
- the availability of duty social workers;
- the quality of interagency relationships and the reputation of the child protection services in the locality (which impacts on the willingness of reporters to make contact);
- the attractiveness of child protection social work services to service users, some of whom may prefer to engage with voluntary or community organisations;
- the range of other community based/NGO child and family services available in an area that deal with the consequences of disadvantage (which could mean that families have other optional ways of getting services and reporters have a choice of services with which they can link people).

In addition, the critique noted that:

- 'The decision to classify cases as abuse or welfare is a complex one.' An increase in the number of reports classified as welfare might indicate a re-focusing away from investigation/blame towards strengths/support based approaches. Inconsistency might reflect a tendency to classify reports in terms of eligibility for services (and capacity of services to respond) so that 'classifying a case as welfare could be another way of signifying low priority status.'
- The boundary between 'neglect' and 'welfare' is quite permeable with a discernible, but not altogether consistent, pattern whereby if the number of welfare cases is high, the number categorised as neglect is low, and vice versa. 'The reality is that abuse cases and welfare cases often need and receive precisely the same type of intervention, the difference being that in the former case, intervention may have to be coercive because it needs to take place even if caretakers are not immediately willing to engage. However, good practice in both categories should be based on the same principles ie focus on strengths, negotiation of agreement on the child's needs for safety and welfare and the best means of attaining them, respect, empathy and child centeredness and based on evidence of the most appropriate way forward.'
- It is important that the cases are responded to according to identified needs and risks rather than classification as welfare or abuse.
- Classifying a report by 'type' of abuse ie physical abuse, sexual abuse, does not give any indication of the range or nature of services required to address it, other than assessment services.

Table 11: Reports to Social Work Departments x Report Type x LHO (2010)

Report type / LHO	Number of welfare reports	Number of protection reports	Total	% welfare
Carlow/Kilkenny	712	398	1,110	64.1%
Cavan/Monaghan	691	878	1,569	44.0%
Clare	616	219	835	73.8%
Donegal	565	404	969	58.3%
Dublin North Central	233	327	560	41.6%
Dublin North West	561	420	981	57.2%
Dublin South City	153	253	406	37.7%
Dublin South East	67	126	193	34.7%
Dublin South West	485	475	960	50.5%
Dublin West	146	382	528	27.7%
Dun Laoghaire	137	116	253	54.2%
Galway	1,897	184	2,081	91.2%
Kerry	369	282	651	56.7%
Kildare/W Wicklow	298	309	607	49.1%
Laois/Offaly	634	511	1,145	55.4%
Limerick	800	286	1,086	73.7%
Longford/Westmeath	711	1,188	1,899	37.4%
Louth	633	704	1,337	47.3%
Mayo	422	277	699	60.4%
Meath	497	575	1,072	46.4%
North Cork	147	349	496	29.6%
North Dublin	532	506	1,038	51.3%
North Lee	723	337	1,060	68.2%
Roscommon	503	251	754	66.7%
Sligo/Leitrim/W Cavan	724	211	935	77.4%
South Lee	203	495	698	29.1%
Tipperary North	614	244	858	71.6%
Tipperary South	214	271	485	44.1%
Waterford	688	601	1,289	53.4%
West Cork	192	198	390	49.2%
Wexford	1,112	835	1,947	57.1%
Wicklow	173	213	386	44.8%
National	**16,452**	**12,825**	**29,277**	**56.2%**

Caution needs to be exercised when considering the comparative data in the table above for the reasons mentioned on the previous page. In addition, until standardised business processes are fully implemented, there will continue to be variances as the result of variations in the processes employed in different LHOs.

Data was collected on the primary reason for a welfare concern (table 12). Buckley (2009) noted that such data items as '*parent unable to cope'* (a welfare report type) and '*neglect*' (a child protection report type) are broad terms that can lead to an underestimate of contextual factors such as domestic violence, substance misuse and other parenting factors. Buckley felt that information on the children who are subject of reports to HSE Children and Families social work teams would benefit from greater

specificity in terms of: the source of the report; the context (domestic violence etc.); greater clarity relating to the recording of repeat reports. HSE Children and Families will be revisiting the categories used for 'primary reason' in the future.

Table 12: Primary reason for welfare concern following initial assessment (2010)

	%
Child Problems	**30.2%**
• Child with emotional/behavioural problems	14.7%
• Child abusing drugs/alcohol	2.0%
• Child involved in crime	0.3%
• Child pregnancy	0.5%
• Physical Illness/disability in child	0.3%
• Mental health problem/intellectual disability in child	1.3%
• Other	11.0%
Family Problems	**69.8%**
• Parent unable to cope	8.4%
• Family member abusing drugs/alcohol	15.9%
• Family member involved in crime	0.5%
• Domestic violence	4.6%
• Physical illness/disability in other family member	1.1%
• Mental health problem/intellectual disability in other family member	5.8%
• Family difficulty re: housing/finance	4.7%
• Parent separation/absence/other disharmony in home	13.6%
• Other	15.2%
National	**100%**

There were weaknesses in the recording of responses to welfare concerns. The child care dataset prompted social work departments to report the 'primary welfare service offered to support the child/family following an initial assessment.' Options available included: Springboard; social work interventions; family support worker; community child worker; family centre; community mother; home help; referred to other professional; pre-schools; NYP/community groups; other HSE services; other services outside HSE. This was not always completed and, where it was, often only 'social work interventions' was chosen, meaning that the range of services offered to children and families is difficult to ascertain. This is not going to change in the future: under the Standardised Business Processes, there will be a requirement for a Family Support Plan to be completed after the initial assessment for children who require a service from social work and are not child protection cases, but the service options to choose from will be the same. The capacity to extract such information will exist in the National Child Care Information System but more accurate recording of the details of services provided has not been made a high priority. Equally, such information would never capture range of family support services provided by other agencies, only those by HSE Children and Families Services, so it would only provide a partial picture.

However, the initiative to extract information from the SLA and Grant-Aid databases (see section 6.2.3 on Commissioning of Family Support Services) will provide a useful picture of the range of family support services that the HSE makes use of. Data is also collected separately for a range of specific family support services (family welfare conferences, Springboard projects, teen parent support programme), as shown in the next few sections.

6.4 Family Welfare Conferences

Family Welfare Conference (FWC) Services offer families and professionals the opportunity to meet together in an equitable manner, sharing responsibility in planning and decision-making in the best interest of the welfare and protection of children and in support of families in need. Family Welfare Conferences might be used at any time but are specifically required to be considered as part of the Special Care application process (see section 8.5 for a definition of Special Care).

Family Welfare Conference Services are structured on legacy health board boundaries primarily. For example, services in the greater Dublin area provided across the area of the former Eastern Regional Health Authority. Some services are provided directly by the HSE and some are sub-contracted (eg Barnardos provide the service under an SLA on the HSE's behalf in areas such as Cavan/Monaghan, Meath, Tipperary South, Waterford and Wexford). The development of standardised business processes for FWC will assist in promoting consistency. Prior to 2009, the FWC managers met a number of times a year in order to co-ordinate policy and practice but this has not been possible since then because of financial constraints: meetings were curtailed, with the exception of meetings related to national business processes. This was an issue of concern to FWC Service co-ordinators.

HSE policy and practice on FWCs adheres to the internationally established best practice 'Family Group Conference' model. The model facilitates and empowers extended family networks to come together to devise safe family plans that seek to address concerns. The conference itself is the culmination of a process of effective, meaningful consultation and preparation of all family participants and is a complex and often time-consuming process in order to achieve the most from bringing extended family members together in difficult, stressful circumstances to address a significant concern. Processes followed include:

- A referral meeting to establish the purpose of the FWC.
- Preparation of the participants in the process and in the conference. This requires significant input and time in terms of developing meaningful relationships and trust with immediate and extended family members so that there is unambiguous understanding and acceptance of what is required of each of them, coupled with a motivation to actually wish to change the circumstances the family find themselves in.
- Convening of a family meeting. A Family Plan is devised and agreed. It is then presented to the referrers for approval and the family, in conjunction with the referrer, implement the terms of the Family Plan. A review conference is usually scheduled within a three month timeframe to review what is working and what is not working in the Family Plan and make any changes necessary.

The *HSE National Service Plan 2010* set a target for 2010 of 477 referrals to Family Welfare Conference Services. The actual number of 461 was around 3% below this (figure 1). The *HSE National Service Plan 2010* also set a target for 2010 of 268 Family Welfare Conferences convened. The actual number of 282 was around 5% above this (figure 2). Performance indicators for family welfare conferences were removed from the *HSE National Service Plan 2011.*

Figure 1: Referrals to Family Welfare Conferences 2010

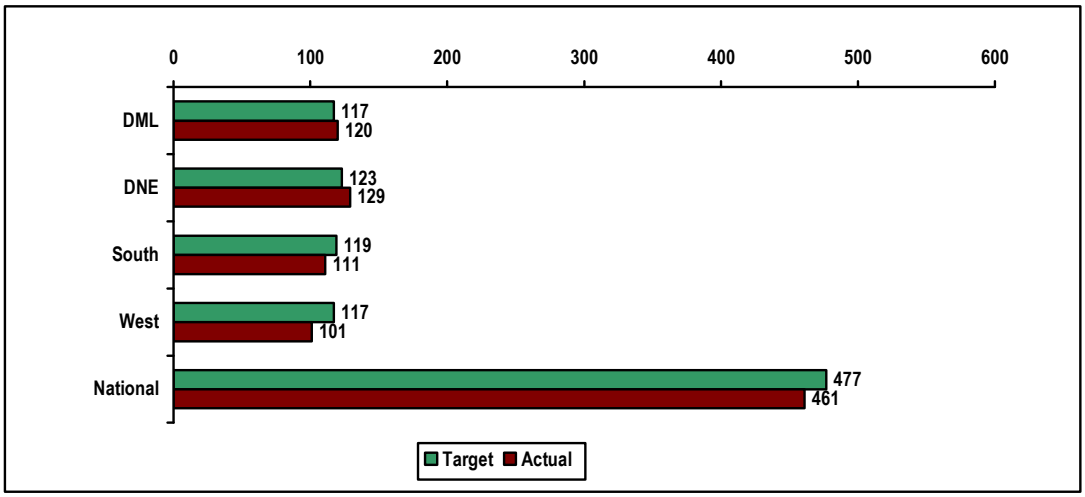
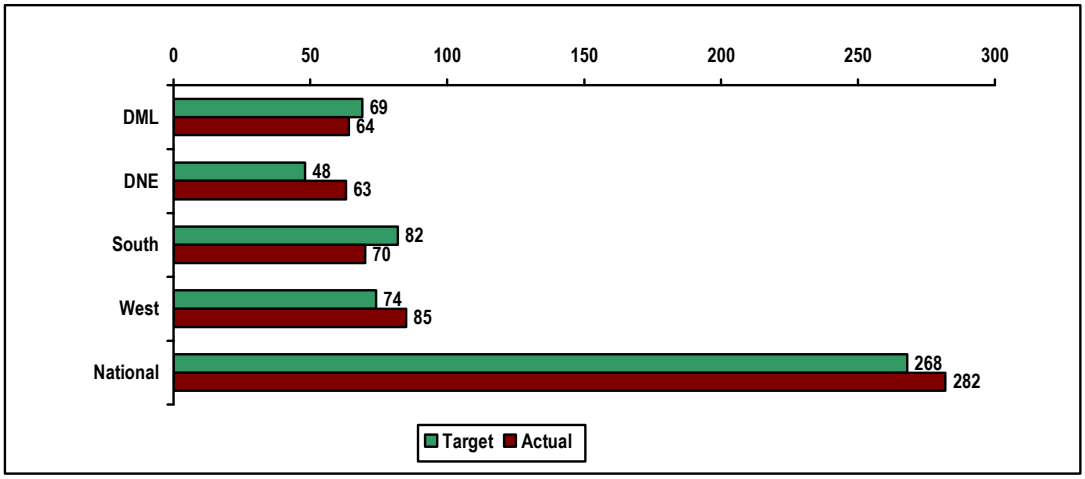


Figure 2: Family Welfare Conferences convened 2010



6.5 Springboard

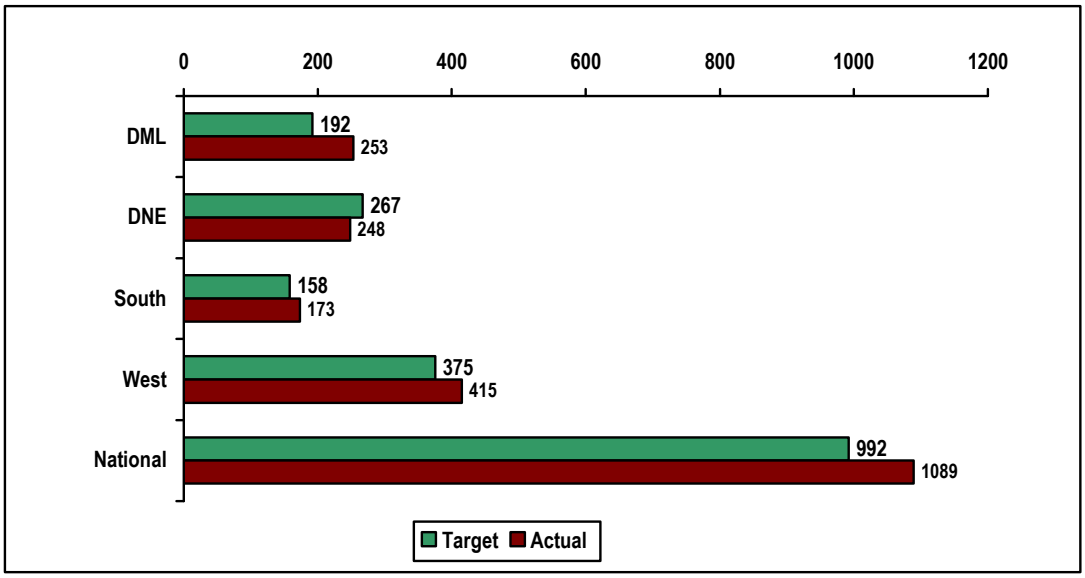
Springboard is a national family support initiative designed to improve the well-being of families, parents and children and to improve the organisation and delivery of services. Springboard is a resource for all families providing non-stigmatising support to those who are most vulnerable. The objectives of Springboard (DoHC 1998) are:

- To identify the needs of parents and children in the proposed area. Specific attention given to those families where child protection concerns exist, to families with on-going health and welfare problems and/or families in once-off crisis situations.
- To target the most disadvantaged and vulnerable families in the area specifically focusing on improving parenting skills and child-parent relationships.
- To work in partnership with other agencies, key groups and individuals in the community and with families to develop programmes of family support services.
- To provide a direct service through a structured package of care, intervention, support and

counselling to the targeted families and children, and to families within the wider community.

The *HSE National Service Plan 2010* set a target for 2010 of 992 family referrals to Springboard. The actual number of 1,089 was around 10% above this (figure 3). The service was provided to families that included 1,307 parents and 1,651 children.

Figure 3: Springboard Referrals 2010



The performance indicator for Springboard referrals has been removed from the *HSE National Service Plan 2011.*

6.6 Teen Parent Support Programme

The Teen Parents Support Programme (TPSP) supports young people who become parents when they are aged 19 years or under and generally supports them until their child is two years of age. Support is offered on topics such as: health, relationships, parenting, childcare, accommodation, social welfare entitlements, education, training and any other areas about which the young person is concerned. In 2010, there were 2,019 births registered to mothers aged under 20 (2009 n=2,223) (CSO 2011). CSO data showed that around 28% of teen mothers were living at the same address as the father of their child when the birth was registered (33% for 18/19 year olds).

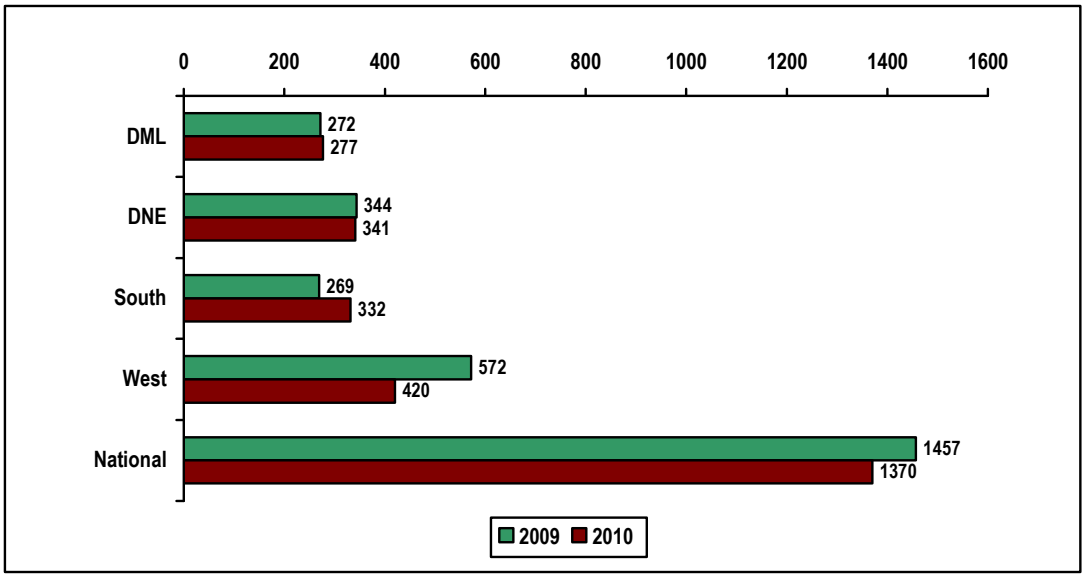
In 2010 the TPSP received €1.78m in HSE funding. There were 11 TPSPs throughout the country each based in an employing organisation from either the statutory or voluntary sector. Nationally, the TPSP structure consisted of a National Co-ordinator who is based in Treoir and a National Advisory Committee which provided a forum for information sharing and interagency collaboration. The 11 TPSPs were as follows:

- Dublin:
    - Ballyfermot, Bluebell, Inchicore
    - Dublin 5, 13, 17 and parts of Dublin 3 and 9
    - Dublin: Drimnagh, Crumlin, Dublin 24, parts of Dublin 8
    - Finglas
- Carlow/Kilkenny

- Cork
- Donegal
- Galway
- Limerick
- Louth
- North Wexford

A total of 1,370 cases were supported by TPSP in 2010, down from the 1,457 in 2009 (figure 4). The West had a substantial decline in numbers. However, this was primarily linked to a change in practice relating to case closure: the three original TPSPs, including Limerick and Galway in the West, had kept cases open until the youngest child was at least two years of age, regardless of the level of activity; this practice was reviewed in 2010 and all TPSPs closed cases when presenting needs were met, with the option of reviewing them at a later date if necessary. This was the primary reason for the decline in the number of cases in the West.

Figure 4: Cases supported by the TPSP in 2009 and 2010



During 2010, there were 401 new service users (367 mothers, 32 fathers who engaged separately from the mother of their child and two others). For 68% (n=244) of the new service users, they came to the service at the antenatal stage for their first child, for 30% (n=110) they were postnatal for their first child, eight were repeat pregnancies and the pregnancy status of three was unknown. Around 53% of the mothers (n=179) were not in education/training and around 43% (n=13) of the fathers. Some 83% of the mothers were either in their family home (n=244), their own home (n=5) or private rented accommodation (n=51), with ten in care and 27 in temporary accommodation. Some 82% (n=301) of the mothers were White Irish, 4% (n=13) were White Irish Travellers, 6% (n=21) were African and 4% (n=15) were Eastern European.

During 2010 462 service users ceased contact with the service (397 mothers, 34 fathers, where data was available at case closure). For the mothers who ceased contact with the TPSP in 2010, the reasons were:

- needs met (34%, n=136);
- child older than two years of age (12%, n=43);

- referred to other support (8%, n=33);
- moved out of area (13%, n=53);
- parent ceased contact (22%, n=88);
- did not avail of service (10%, n=41);
- other (1%, n=3).

The *HSE National Service Plan 2010* set a target for 2010 of 1,147 Teen Parent Support Programme Cases at December 31st 2010. The actual number of 878 was around 24% below this, the majority of the fall being in the West: however, as already mentioned, this was caused by a more rigorous approach to case closure rather than a fall in demand. This performance indicator was removed from the *HSE National Service Plan 2011.*

7 Child Protection Services

7.1 Introduction to Child Protection Services

Child protection and welfare services are provided by the HSE through a range of professional disciplines and interventions, in accordance with legislative obligations, policy documents and national and HSE guidance. Section 3 of the *Children Act, 2001* places a statutory duty on the HSE to identify children who are not receiving adequate care and protection, and to then provide appropriate family support and child care services, which is understood to include child protection services if required.

Set out below are the key legislative provisions for Child Protection Services. Other related provisions are covered in the Alternative Care and Family Support Sections of this report.

- Data Protection Act, 1988 & Amendment Act 2003;
- Child Abduction and Enforcement of Custody Orders Act, 1991;
- Child Care Act, 1991;
- Family Law Act ,1995;
- Domestic Violence Act, 1996;
- The Refugee Act, 1996;
- Freedom of Information Act, 1997 & Amendment Act 2003;
- The Non-Fatal Offences Against the Person Act, 1997;
- The Education Act, 1998;
- The Protection for Persons Reporting Child Abuse Act, 1998;
- Protection of Children (Hague Convention) Act, 2000;
- Children Act, 2001;
- Mental Health Act, 2001;
- Ombudsman for Children Act, 2002.
- Disability Act, 2006.

Underpinning the legislative framework are the Irish Constitution and the United Nations Convention on the Rights of the Child (ratified by Ireland in 1992). The *Ombudsman for Children Act, 2002* applies in relation to complaints being referred to the Ombudsman for Children. The *Children Act, 2001* provides a framework for the development of the juvenile justice system and makes provision for addressing the needs of out-of-control or non-offending children who may come before the courts. The Act provides for two distinct pathways for these children, one of which is a welfare route through the HSE.

7.2 Review of *Children First* Implementation

Children First National Guidelines for the Protection and Welfare of Children (DoHC 1999a) is intended to assist in the identification and reporting of child abuse and to clarify and promote mutual understanding among statutory and voluntary organisations regarding the contributions of different disciplines and professions to child protection. The importance of consistency between policies and procedures across HSE areas and other statutory organisations is also emphasised, as is the development of a partnership approach in service delivery.

The *HSE National Service Plan 2010* included the following Deliverable Outcomes for 2010:

- plan in place to implement revised Children First Guidelines and roll-out of implementation plan commenced;
- monitoring compliance with *Children First*.

With regards to revised Children First Guidelines, the Minister for Children initiated a revision of the *Children First* document to take account of changes that have happened in the ten years since it was first published, such as the creation of the HSE, and to address issues arising from various inquiries. Significant work was undertaken during 2010 by the OMCYA, with the involvement of HSE Children and Families Services, in revising the Guidelines, although the revisions had not been finalised by the end of 2010.

With regards to monitoring compliance with Children First, there had been significant activity over the last few years within HSE Children and Families Services and partner agencies in reviewing its implementation. This has included:

- The *HSE Social Work and Family Support Survey 2008* (HSE 2009b). This noted that development of children and family services within the previous health board structures lacked national direction and coordination. Compliance with national child protection procedures had not been uniform.
- The OMCYA's *National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children* (OMCYA 2008). The review made recommendations in five areas: protection; access; standards; integration; implementation and monitoring. It recommended that the *Children First Guidelines* be applied in a consistent manner across the HSE and the HSE develops good practice guidelines, standards and protocols, underpinned by appropriate management and quality assurance, to enable this to happen.
- Work of the HSE Children and Families Task Force that sought to address the issues raised by the above. The final report of the Task Force was published in June 2010 (HSE 2010h). There were eight Task Groups under the Task Force that focussed on:
    - completion of the National Social Work and Family Support Survey; and examination of HSE compliance with Children First;
    - development of formal child protection protocols to ensure standardised and consistent practice by HSE staff;
    - development of standardised business processes for Family Support Services, Family Welfare Conferences and Children in Care;
    - undertake a due diligence examination of existing child protection systems in order to develop a self-assessment framework to manage risk and to provide early warning of difficulties;
    - clarification of governance arrangements in child protection, including the roles and responsibilities of staff;
    - standardise and disseminate approved HSE National Policies for children and families services, and identify additional policies required;
    - review existing performance measures and outcome measures, and identify changes required;
    - develop a standardised approach to statutory care planning.
- The *Strategic Review of the Delivery and Management of Children and Families Services* (HSE/PA Consulting 2009).

In addition, during 2009 the Ombudsman for Children conducted its own review of compliance with *Children First* and its findings were published in April 2010 (OCO 2010). The report found that, up until the establishment of the HSE Taskforce in February 2009, insufficient efforts were made to drive forward implementation of *Children First* by the HSE. Other findings included:

- failure to put in place appropriate quality assurance through internal audit of case files;
- failure to ensure that LHOs all have local procedures;
- the effects of industrial relations issues in certain LHO areas on implementation;
- absence of consistent definitions of abuse in local procedures;
- absence of clarity and consistency regarding the basis for reporting child abuse concerns;
- failure to ensure 24-hour external access to the Child Protection Notification System in most of the State.

Some 21 recommendations were made, relating to HSE Children and Families Services, the OMCYA and An Garda Síochána. The report also included the response from HSE Children and Families Services: the recommendations, and the response of HSE Children and Families Services at that time, are shown in table 13.

Table 13: Recommendations of the OCO Investigation into Children First implementation and the response of HSE Children and Families Services (OCO 2010)

OCO Recommendation	HSE Children and Families Response
That resources be better matched to need around the State in social work departments to ensure equitable service provision through evidence based resource allocation.	Equitable services provision through evidenced based resource allocation was very much the focus and one of the key outcomes of the HSE Task Force Subgroup: National Social Work and Family Support Survey Report and in conjunction with the Ryan Report Implementation Plan will address deficits in relation to social work resources being better matched to need. The HSE National Service Plan 2010 also commits to an audit of resources targeted at children and families across the statutory and non-statutory sector and the recruitment of an additional 200 social workers for Child Protection and Alternative Care Services will be targeted at areas of greatest need.
It is important that family support services, locally and nationally, are properly planned for with appropriate strategies in place and it is recommended that all necessary steps be taken to this end, whether under the auspices of the revised Children First Guidelines or not.	An HSE specific action under the Ryan Implementation Plan commits to 'all agencies that provide services to children and families develop and implement an operational plan based on the Agenda for Children's Services.' The HSE Strategy to support the Agenda for Children's Services was completed in 2009 and the *National Service Plan 2010* advances implementation of the strategy in line with Task Force outputs. An operational plan is currently being finalised by the HSE in relation to the development of Family Support Services incorporating an action plan to improve our engagement with children and young people and we are in the process of finalising the Investing in Parents and Children's Strategy which will clearly outline the targeting of prevention and early intervention services. There will also be a requirement built into all local Service Level Agreements with all community and voluntary agencies that are funded and provide services to children and families of the necessity to develop and implement an operational plan based on the Agenda for Children's Services.

OCO Recommendation	HSE Children and Families Response
This Office is aware that the HSE is undertaking a Strategic Review of the Delivery and Management of Child Protection Services. It is important that this review considers all options and asks new questions. That should include whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.	Focus on the delivery and management of Child Protection Services is underpinned by the creation of the Children and Families Care Group and the appointment of the Assistant National Director. This is enhanced by the Ryan Implementation Plan. The HSE will act to reform its management structures following the review it commissioned in July 2009 to ensure a transparent and accountable management system, confirmed in the 2010 Service Plan, with the implementation of the *Strategic Review of Child Protection Services*.
It is strongly recommended that work to standardise processes and improve datasets by the HSE be continued as a priority. This should include clarity on screening and initial assessments, clarity on when to accept to the Child Protection Notification System and when to close a case to the Child Protection Notification System, as well as clarity on the non-removal of cases from the Child Protection Notification System.	The National Child Care Information System with concomitant Standardised Business Processes has been prioritised by the HSE for implementation subject to approval by the Department of Finance and is included in the *HSE National Service Plan 2010.*
It is recommended that all necessary steps be taken to ensure that information be stored and searchable otherwise than solely on grounds of alleged victim, at least prospectively if it is not feasible to do so retrospectively.	The HSE commits to address information retrieval systems to include the Ombudsman's recommendations in addition to development of a National Archive managed professionally for the records of all children in care including records from non-statutory agencies.
While this is not a requirement of Children First, given the reality that families and children can move between counties, it is recommended that consideration be given to the creation of a national Child Protection Notification System, rather than only a local one.	The HSE will give consideration to the creation of a National Child Protection Notification System. In addition a cross border working party under the auspices of the North / South Ministerial Conference is currently devising a protocol in relation to the movement of vulnerable children and families across jurisdictions.
While not a requirement of Children First, this Office strongly recommends the rolling out of an out of hours service throughout the State and that all necessary funding be given priority to this end.	Subject to funding, the HSE is putting in place a national Out of Hours Social Work Crisis Intervention Service built into the existing HSE Out of Hours Service. This will be piloted initially in two areas of the country.
It is noted that the current role of CCMs is under review and it is recommended that issues of access to information by the CCM or designate and ability to direct be fully considered in that context.	The role of Child Care Managers is actively under review and is a key management reform component of the structural management and accountability process.
It is strongly recommended that joint liaison structures be established between the HSE and the Garda Síochána in all areas where they are outstanding.	In order to advance and enhance joint working arrangements between the HSE and An Garda Síochána a recent high level meeting was convened by the Assistant National Director, Children and Families Social Services, with Gardaí at Assistant Commissioner level identifying key areas including joint liaison structures to address deficits. This work is ongoing.

OCO Recommendation	HSE Children and Families Response
It is recommended that the HSE provide further training to professionals on their duty to report abuse, including regarding retrospective cases.	The HSE is committed to the ongoing professional development of staff including training for professionals moving into management positions. A National Steering Group representing the Health, Education and Justice sectors to strategically plan for the training needs of staff working with children and families is being established and will target priority areas under the auspices of the National Steering Group. A National Specialist with responsibility for training has been designated to lead out on this process and child protection has been designated as a key priority.

The key focus for the future will be to promote effective national implementation of *Children First* through a range of structural and process changes to create a national, unified, standardised approach. This was reflected in the *HSE National Service Plan 2011,* which included the following Deliverable Outcomes for 2011:

- Cross Sectoral Implementation Plan developed with supplementary HSE implementation plans across all four regions;
- dedicated national and regional units to implement and monitor compliance with *Children First;*
- national audit of child protection policies, practices and procedures in Catholic Church Dioceses completed and report submitted to Minister;
- national audit of child protection policies, practices and procedures in Religious Orders completed and report submitted to Minister.

7.3 Response to Child Care Inquiries

7.3.1 Ryan Implementation Plan

The *Report of the Commission to Inquire into Child Abuse*, commonly referred to as the Ryan Report, was published in May 2009 (Commission of the Inquiry into Child Abuse 2009) and an Implementation Plan was published by the OMCYA in July 2009 (OMCYA 2009b). Priorities within the *HSE National Service Plan 2010* made explicit references to actions in the *Ryan Implementation Plan* and comment is made on progress against individual actions at relevant points in this Review of Adequacy.

The *Ryan Report* contained 20 recommendations and these were responded to in the implementation plan in the form of 99 actions. These actions were grouped into six categories:

- addressing the effects of past abuse;
- developing and strengthening national child care policy and evaluating its implementation;
- strengthening the regulation and inspection function;
- improving the management of children's services;
- giving greater effect to the voice of the child;
- revising *Children First*, the national guidance on the protection and welfare of children and underpinning the guidance by way of legislation.

Implementation of the Plan is being overseen by a high level group chaired by the Minister for Children and Youth Affairs. The Group includes representatives from the OMCYA, the HSE, HIQA, the Irish Youth Justice Service (IYJS), the Department of Education and Skills and An Garda Síochána. The

first annual progress report was published by the OMCYA in July 2010 (OMCYA 2010a).

7.3.2 Implementation of Ferns 4 and Ferns 5 Report Recommendations

The *Ferns Enquiry Report* (Francis *et al.* 2005) identified over 100 allegations of child sexual abuse made between 1962 and 2002 against 21 priests operating under the aegis of the Diocese of Ferns. A number of Working Groups were established to address the recommendations.

The **Ferns 4 (Children) Working Group** was tasked with examining the needs of children and young persons and their families who had been affected by sexual abuse. The terms of reference of this Working Group were:

- to examine the assessment, therapy and counselling needs of children who have been sexually abused and their families;
- to make recommendations concerning service requirements.

The report of the Ferns 4 (Children) Working Group, *Assessment, therapy and counselling needs of children who have been sexually abused, and their families* was completed in November 2009 (HSE 2009c). Key findings included:

- The absence of a standardised approach to assessment services, with these having developed locally following legacy health board boundaries.
- The absence of designated therapy services outside the two Dublin hospital-based units (St. Clare's and St. Louise). Elsewhere some HSE staff provided different types of therapy services or there was a reliance on Child and Adolescent Mental Health Services, most of which had significant waiting lists.
- These variations raised issues in relation to equity of access for children and families.
- The need for a framework of services spanning the entire country. In the first instance current services should be amalgamated cohesively at Regional level, incorporating HSE, hospital and NGO services.
- Some 16 recommendations for action were made.

A new Ferns 4 Working Group[2] was convened in June 2010 to progress the recommendations of the report, with the following five recommendations prioritised:

- The establishment of a National Steering Committee to manage and co-ordinate assessment and therapy services throughout the country**;** and to have governance oversight of these services (recommendation 1).
- Children who may have been sexually abused should not be subjected to repeat interviewing in the interests of the children themselves and in the interest of successful prosecution. Therefore**,** a co-ordinated management structure, including experts in this field, needs to be put in place between the HSE and the Gardaí, in relation to the interviewing of children, that reflects a positive, child-centred, inter-agency approach (recommendation 7).
- The establishment of more assessment services in the community to cater for ease of access (recommendation 8).
- All children who require access to therapeutic services should be linked to a free therapeutic service as soon as possible after assessment. It should be recognised that children may need to access therapeutic inputs at different stages (recommendation 9).
- The establishment of an integrated dataset for sexual abuse covering all HSE services. There

[2] Membership was refreshed as many of the original members no longer held the same posts.

should be a link to the Gardaí, the Court Service, the Prison Service and Probation, with a unique case identifier where a case could be tracked from the point of entry to the final outcome (recommendation 14).

The Children and Family Research Centre NUIG was commissioned to conduct a literature review on international best practice in assessment and therapy for children who have been sexually abused. A review was also commissioned by the Director of the Integrated Services Directorate into sexual assault treatment services for children and young people, with Mott MacDonald Consultants undertaking the work. Both these reviews were ongoing at the end of 2010.

In line with the *HSE National Service Plan 2010,* the HSE provided funding to NGOs to provide additional counselling services to the victims of child abuse.

The **Ferns 5 Working Group** had as its terms of reference 'To advise the Forum of the needs and strategic direction of the HSE in the treatment of sexual abusers; adults, teenagers and children.' Its report, *Treatment Services for Persons who have Exhibited Sexually Harmful Behaviour* was published in March 2007 (HSE 2007), with 30 recommendations clustered under the headings of:

- philosophy;
- prevention, assessment and treatment;
- strategic direction; and
- model for service delivery.

The *HSE National Service Plan 2010* included as a Deliverable Outcome implementation of the recommendations of this report. The primary focus related to the model of service delivery, with job descriptions and job specifications drawn up for two Regional Co-ordinators per Region (one for adults, one for children and young people), providing a remit to develop and manage a regional assessment and treatment service. The HSE moratorium on recruitment meant that these posts were not advertised in 2010.

The process of establishing National Steering Committees to implement both Ferns 4 and Ferns 5 was begun in 2010. These committees were tasked with implementing the recommendations arising from the findings of the Ferns 4 and 5 reports, and agreeing on plans of action for each, with identified targets, to be achieved over the next two years.

7.3.3 Roscommon Child Care Inquiry

In 2009, the HSE established an independent inquiry into a specific well-publicised case in Roscommon for which the presiding Judge felt that there had been failures on the part of the HSE and Western Health Board, particularly in relation to not taking the children into care soon enough. The terms of reference for the inquiry were to: examine the entire management of the case from a care perspective; identify any shortcomings or deficits to the care management process; make a report on the findings and any learning arising from the investigation.

The *Roscommon Child Care Case: Report of the Inquiry Team to the Health Service Executive* was published in October 2010 (Roscommon Child Care Inquiry Team 2010), with a series of recommendations under the broad headings of: organisation change; policy change; practice; the development of services; and management. A summary of the main recommendations follows:

- **Victim impact statements:** Engagement of HSE with the offices of the Director of Public Prosecutions to determine how best the identities and personal information of children involved

in child protection cases can be better protected, particularly where victim impact statements are supplied in relation to court processes.

- **Quality assuring the child protection system:**
  - develop and implement a national policy of audit and review of neglect cases;
  - implement a nationally appropriate quality assurance system;
  - review procedures for the reporting up of escalating risks and cases of public importance to ensure they are fully understood and that they are applicable in the wide range of possible situations.
- **Court processes:**
  - ensure specialist legal services in child care matters are available at all times;
  - law agents/legal advisors consulted regarding any possible legal remedies at an early stage, when there are serious concerns around child welfare and protection;
  - the likelihood of success should not be used as a criterion for determining whether legal remedies should be pursued;
  - wider consultation within the HSE when a legal matter arises that is unfamiliar to the personnel involved.
- **Staff roles:**
  - greater clarity where there are child protection concerns, so that everyone is clear on the exact concerns for each child and understands their role both in terms of their professional expertise but also as part of the team;
  - social workers should see and speak directly to every child where there is a concern about their welfare;
  - contact with children should appear on the agenda for every professional supervision meeting and form part of every report for a Case Conference.
- **Assessment:** Urgent requirement for a national common framework for assessment for all child welfare and protection cases.
- **Chronic neglect cases:** identify explicit outcomes for each family member and each child, short-term and long-term; case management plan should include how progress will be measured; workers should be mindful of the need to consider alternative plans where desired outcomes are not achieved, with case files recording reflective thinking, planning and consideration of outcomes; consideration of each episode in the context of previous concerns; key designated worker should meet regularly with all personnel who are visiting the home to ensure that all are fully aware of the key concerns for the children.
- **Concerns of relatives and others:** Third parties who express concerns should be interviewed as part of the assessment.
- **Working with parents who seek to distract workers:** the views of parents should be taken into account and checked against the facts and the views of concerned others; all personnel be alert to parents and carers who consistently try to divert attention.
- **The development of services:**
  - a system should be devised and implemented for the equitable distribution of HSE resources based on assessed need;
  - a targeted family support service for families with young children should be developed for this part of County Roscommon;
  - full involvement of the HSE Speech and Language Department in the development of services for children and families where this is an issue, including a review of the effectiveness of the Home Management Service where chronic neglect is an issue;
  - a specialised Child Sexual Abuse Unit/Team to be put in place in each HSE region.
- **Decision-making**
  - systems of decision making are well linked and provide for the decisions to be fully carried through and reviewed for effectiveness;

- the chair of case conferences should be trained for, and alert to, the demands of this role; the purpose of each case conference and review should be clear; the record of each case conference should be clear and easily accessible;
- standardised file recording/file management systems to be devised and introduced;
- review of Public Health Nursing records in respect of children where there are child protection concerns to ensure their adequacy.

- **Staffing:** a range of recommendations relating to, for example, recruitment and retention, accreditation, supervision, caseloads, staff welfare.
- **Continuous professional development:** a range of recommendations relating to sharing learning, training needs analysis and areas for training.

A detailed action plan was put in place to implement the recommendations from late 2010 onwards.

7.4 National Review Panel

In 2009 the publication of the *Ryan Report* (Commission of the Inquiry into Child Abuse 2009) and the Dublin Archdiocese Commission of Investigation Report (Murphy Report) created considerable public and political concern about the treatment of vulnerable children and the need for transparency and accountability. At that time there was no national standardised way of reviewing serious incidents, including the deaths of children in care. This posed a difficulty for the HSE in providing timely and accurate information, particularly at a time when public accountability was being demanded. The high numbers of deaths which subsequently were put into the public domain caused considerable disquiet, reinforcing demands for greater transparency. Minister of State, Mr Barry Andrews, T.D., established an Independent Review Group to examine the circumstances concerning children who died while in care, children who were known to the child protection services and young people who had been in care as children and died after their 18th birthday between 2000 and 2010. This review is ongoing.

In January 2010 HIQA published *Guidance for the HSE for the Review of Serious Incidents including Deaths of Children In Care* (HIQA 2010b). This was followed by the establishment of a National Review Panel (NRP) in June 2010, comprising 21 members supported by HSE management. As per HIQA Guidance, the panel had an independent chair and deputy chair and professionals from a wide range of disciplines appointed for their professional expertise. Allowing for the necessary lead in time for the induction of panel members, the establishment of an office and the development of protocols, the core function of conducting reviews commenced in August 2010.

At an early stage, a priority system was agreed with HIQA to determine the speed of response required in the light of higher than anticipated notifications to the NRP (National Review Panel 2011). In addition, it was agreed with HIQA that different levels of review would be undertaken, on a pilot basis, depending on the circumstances of each case:

- **Major review:** where contact with HSE Services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex (eg multiple placements), and where a child protection issue is likely to be of public concern.
- **Comprehensive review:** where involvement of HSE Services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period.
- **Concise review:** Where the involvement of HSE Services is either of a short duration or of low intensity over a longer period.
- **Desktop review:** Where involvement of HSE Services has been brief, the facts of the case

including the circumstances leading up to the death or serious incident are clearly recorded, and there is no evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent.

- **Internal review:** Where the notification refers to a serious incident that has more local than national implications eg where a child is regularly absconding from a placement.

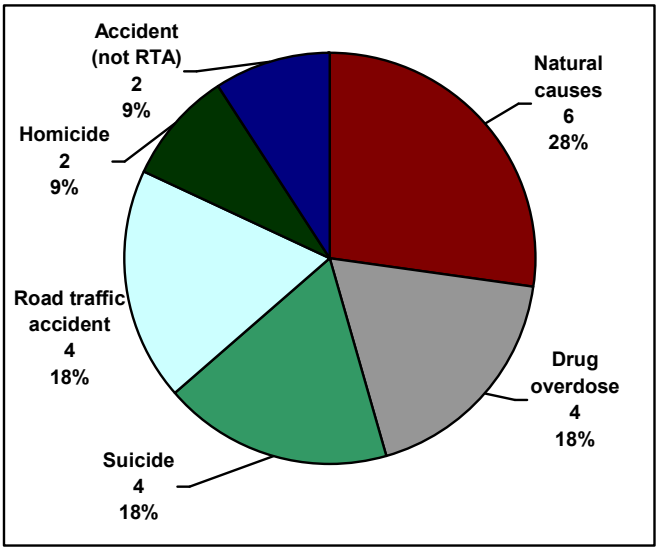
Between March 10th 2010, when the HIQA guidance went live, and December 30th 2010, 30 cases were notified to the NRP by HSE Children and Families Services (table 14).

Table 14: Cases notified to the National Review Panel (Mar-Dec 2010)

Category of case notified	Deaths	Serious incidents	No.	%
Cases open to the child protection service	11	2	13	43%
In care at the time of the incident	2	5	7	23%
In care immediately prior to 18th birthday and still under 21 years of age	7	0	7	23%
In aftercare at the time of the incident	2	1	3	10%
Total	**22**	**8**	**30**	**100%**

Causes of death are summarised in figure 5. None of the deaths were related to familial child abuse, while the two homicides can be categorised as extra-familial child abuse. In contrast, in England Ofsted reported that during 2009-10, ten of 15 homicides were classified as murder by a parent or guardian (Ofsted 2010).

Figure 5: Causes of death for cases notified to the National Review Panel (Mar-Dec 2010)



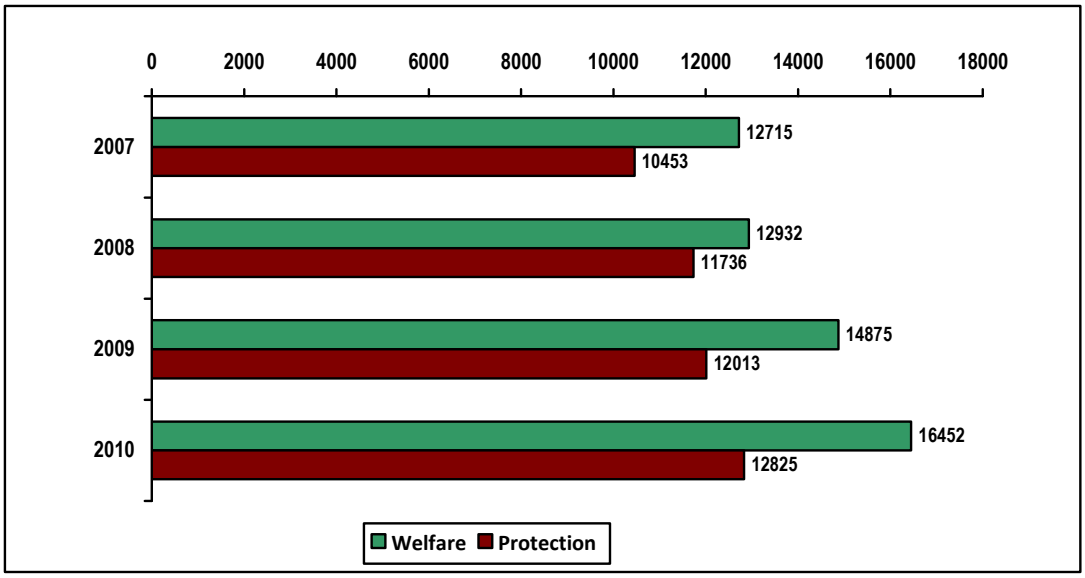
7.5 Child Protection Data

7.5.1 Child Protection Reports

A Report to a social work department includes all information received where there are concerns about the safety or wellbeing of a child. These might come from professionals in other agencies, the public, or a request for help and support directly from the family. The HSE is obliged to treat seriously all child welfare and protections concerns, whatever their source, and consider carefully and fairly the nature of the information reported. A balance needs to be struck between protecting the child and avoiding unnecessary and distressing intervention.

The figures for 2007-2010 (figure 6) show a year-on-year rise in Reports received by social work departments for both child protection and welfare reports. This in part reflected a growing 0-17 population but also was influenced by more difficult economic conditions over the previous years which in turn place strains upon families. This presented a very substantial demand on limited social work resources. This trend is likely to continue in the future unless more resources are provided for early intervention, to help families before the concerns escalate. Since 2007, the number of Reports overall has risen by 26.4% (n=29,277/23,168). Child protection Reports have risen by 22.7% (n=12,825/10,453) while welfare Reports have risen by 29.4% (n=16,452/12,715).

Figure 6: Number of child protection and welfare reports to HSE 2007-2010



7.5.2 Rates of Child Protection Reports per Local Population

Table 15 shows the rate of child protection reports per 10,000 population for the four HSE regions and table 16 shows it for the 32 LHOs. Note that, pending actual figures for the 0-17 populations in each Region and LHO, the estimated 2010 0-17 population (see table 4) has been distributed amongst the Regions and LHOs in exactly the same proportions as the 0-17 population in Census 2006. Clearly this does not take into account underlying socio-economic factors but it at least provides some degree of comparability. In section 6.3 a range of factors that influence the number of Reports received, in addition to levels disadvantage, were noted. In addition, some LHOs in 2010 counted a 'case' as a family, others a child: this is being addressed under the Standardised Business Process initiative so that, when fully implemented, all LHOs will count a case as a child. The data here should therefore be treated with some caution.

Table 15: Children protection reports (2010) x Children's population (April 2010 Estimated) [3] x Region

Region	% of population (2006)	Est ppn (2010) on same distribution	Child Protection Reports (2010)	Rate per 10,000 ppn
Dublin Mid-Leinster	28.4%	319,052	3,573	112.0
Dublin North East	23.3%	261,325	3,410	130.5
South	27.4%	307,268	3,766	122.6
West	21.0%	235,355	2,076	88.2
National	**100.0%**	**1,123,000**	**12,825**	**114.2**

Table 16: Children protection reports (2010) x Children's population (April 2010 Estimated) x LHO

LHO	% of population (2006)	Est ppn (2010) on same distribution	Child Protection Reports (2010)	Rate per 10,000 ppn
Longford/Westmeath	2.9%	32,577	1188	364.7
Cavan/Monaghan	3.0%	33,915	878	258.9
Louth	2.8%	31,687	704	222.2
Wexford	3.4%	37,776	835	221.0
Waterford	2.9%	32,788	601	183.3
North Cork	1.9%	21,330	349	163.6
Roscommon	1.4%	15,720	251	159.7
West Cork	1.3%	14,667	198	135.0
Dublin North Central	2.2%	24,805	327	131.8
Laois/Offaly	3.6%	40,303	511	126.8
Dublin South West	3.4%	38,167	475	124.5
Meath	4.3%	48,367	575	118.9
Carlow/Kilkenny	3.0%	33,512	398	118.8
Tipperary South	2.2%	24,448	271	110.8
South Lee	4.0%	45,097	495	109.8
Dublin South City	2.1%	24,106	253	105.0
Dublin West	3.3%	37,296	382	102.4
Donegal	3.9%	43,670	404	92.5
Tipperary North	2.4%	26,524	244	92.0
Dublin North West	4.1%	46,289	420	90.7
Sligo/Leitrim/W Cavan	2.1%	23,886	211	88.3
North Dublin	5.3%	59,636	506	84.8
Mayo	3.0%	33,569	277	82.5
Kerry	3.2%	35,809	282	78.8
North Lee	4.0%	44,904	337	75.0
Limerick	3.5%	38,812	286	73.7
Clare	2.8%	30,963	219	70.7
Wicklow	2.7%	30,168	213	70.6
Dublin South East	2.0%	22,156	126	56.9
Kildare/West Wicklow	5.3%	59,541	309	51.9
Dun Laoghaire	2.7%	30,564	116	38.0
Galway	5.3%	59,948	184	30.7

[3] Using 0-17 population as calculated in table 4.

It is important to treat the above figures with caution as explained in the paragraph preceding the table.

7.5.3 Initial Assessments

In previous years, Reviews of Adequacy provided data on the number of Initial Assessments that proceeded from Reports to HSE Children and Families. This tended to show a substantial fall between the number of Reports received and the number of Initial Assessments undertaken. For example, in 2009 there were 26,888 Reports with only 15,611 (58%) receiving an Initial Assessment.

A major part of the explanation of the difference between these two figures derived from inconsistent definitions: expectations of what an 'Initial Assessment' is or 'preliminary enquiries' and when they should be triggered varied across the country. This has been addressed by the development of Standardised Business Processes, which began to be implemented in 2010. Under the Standardised Business Process:

- A screening process will take place that will identify which Reports do not belong within the remit of HSE Children and Families Services and divert these away. Many of these enquiries will be diverted to a more appropriate agency.
- For other Reports, preliminary enquiries will be made to confirm key information (eg verify reporter's contact details, child's address, nature of the concern, checks whether already known to the department). A preliminary enquiry is not an assessment. The aim of this process is to support and help the social worker to make a decision on the actions to take in response to information reported to determine the best outcome for the child who is the subject of the Report. Normally that decision or action will be an assessment or assessment plus action. The screening and preliminary enquiry process should take no more than 24 hours.
- The Initial Assessment is defined as a time-limited process to allow sufficient information to be gathered on the needs and risks within a case so that informed decisions, recommendations and actions can be taken. They are expected to be carried out within a specific time frame (up to 20 working days although they may be completed much sooner), using standardised procedures and approved templates and forms. The Initial Assessment is normally centred on interviews and home or site visits, sometimes defined as direct work. Objectives of the Initial Assessment are to determine whether a further or more comprehensive assessment may be required and to enable if necessary a plan to be put in plan for continued intervention or support.

The expectation is that implementation of the Standardised Business Processes for Reports and Initial Assessments will lead to substantial increase in the number of Reports that have an associated Initial Assessment in the future. This is not to say that children without an Initial Assessment currently are not having their needs assessed and receiving the support that they need: the opposite is likely to be true, the difference is that the *formal* process of applying a national standardised approach may not be happening. Changing this is seen both as good practice and an effective method to promote the consistency that has been found to be lacking in the various reviews of the implementation of *Children First*.

As such, reporting on the number of Initial Assessments undertaken in 2010 is not particularly helpful, given the inconsistency in approach, and a figure for this has not been included in this year's Review of Adequacy, pending the full implementation of standardised business processes in this area.

7.5.4 Balance between Child Protection and Welfare Cases

Table 17 also shows that the primary reason for a Report to social work in 2010 was for *welfare* reasons (56.2% of Reports, n=16,452/29,277). *Neglect* is the second highest primary report type at 16.2% (n=4,755). *Sexual abuse* accounted for 10.1% (n=2,962), *physical abuse* for 8.9% (n=2,608) and *emotional abuse* for 8.5% (n=2,500). Apart from *physical abuse,* all figures were higher than in 2009.

Table 17: Child welfare and protection Reports received x Category of Report 2007-2010

Year Report type	2007	2008	2009	2010	% of Reports in 2010
Welfare	12,715	12,932	14,875	16,452	**56.2%**
Physical abuse	2,152	2,399	2,617	2,608	**8.9%**
Sexual abuse	2,306	2,379	2,594	2,962	**10.1%**
Emotional abuse	1,981	2,192	2,125	2,500	**8.5%**
Neglect	4,114	4,766	4,677	4,755	**16.2%**
National	**23,268**	**24,668**	**26,888**	**29,277**	**100%**

However, there were differences in the distribution of Report types between Regions (figure 7). There appears to be an inverse relationship between the distribution of *Welfare* and *Neglect* Report types (eg West has the highest percentage of its Reports as Welfare cases and the lowest percentage of its Reports as Neglect, while Dublin North East and Dublin Mid-Leinster's figures are close to being the opposite). This might reflect differences in perceptions of when a case can trigger a welfare or protection response but equally might reflect other factors such as differences in the accessibility of resources.

Figure 7: Distribution of Report types x Region (Dec 31 2010)

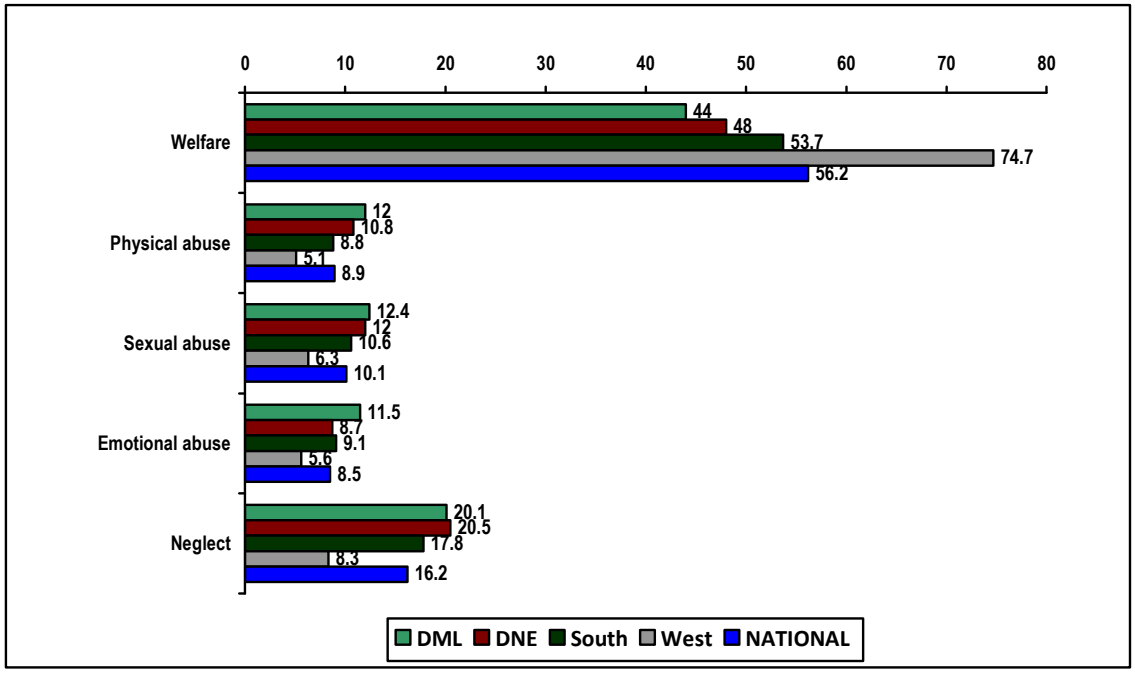


Table 18: Distribution of Report types by LHO – Dublin Mid-Leinster (Dec 31 2010)

DML	% Welfare	% Physical abuse	% Sexual abuse	% Emotional abuse	% Neglect	Total
Dublin South City	37.7%	13.8%	18.5%	4.7%	25.4%	100%
Dublin South East	34.7%	5.7%	28.0%	10.4%	21.2%	100%
Dublin South West	50.5%	12.5%	15.8%	3.8%	17.4%	100%
Dublin West	27.7%	19.3%	18.8%	5.1%	29.2%	100%
Dun Laoghaire	54.2%	13.4%	13.4%	4.3%	14.6%	100%
Kildare/W Wicklow	49.1%	9.6%	16.8%	7.7%	16.8%	100%
Laois/Offaly	55.4%	10.9%	7.0%	14.2%	12.5%	100%
Longford/Westmeath	37.4%	11.0%	6.3%	20.1%	25.1%	100%
Wicklow	44.8%	13.2%	18.9%	7.5%	15.5%	100%
Total DML	**44.0%**	**12.0%**	**12.4%**	**11.5%**	**20.1%**	**100%**

Table 19: Distribution of Report types by LHO – Dublin North East (Dec 31 2010)

DNE	% Welfare	% Physical abuse	% Sexual abuse	% Emotional abuse	% Neglect	Total
Cavan/Monaghan	44.0%	9.1%	11.6%	8.6%	26.7%	100%
Dublin North Central	41.6%	9.6%	15.9%	7.3%	25.5%	100%
Dublin North West	57.2%	11.7%	13.4%	3.3%	14.5%	100%
Louth	47.3%	11.1%	6.7%	11.8%	23.0%	100%
Meath	46.4%	12.1%	12.1%	14.4%	15.0%	100%
North Dublin	51.3%	11.3%	16.1%	5.0%	16.4%	100%
Total DNE	**48.0%**	**10.8%**	**12.0%**	**8.7%**	**20.5%**	**100%**

Table 20: Distribution of Report types by LHO – South (Dec 31 2010)

South	% Welfare	% Physical abuse	% Sexual abuse	% Emotional abuse	% Neglect	Total
Carlow/Kilkenny	64.1%	6.7%	9.7%	5.3%	14.1%	100%
Kerry	56.7%	7.2%	9.4%	8.6%	18.1%	100%
North Cork	29.6%	12.5%	10.7%	26.8%	20.4%	100%
North Lee	68.2%	6.5%	7.8%	4.0%	13.5%	100%
South Lee	29.1%	16.0%	13.3%	19.8%	21,8%	
Tipperary South	44.1%	8.2%	10.1%	7.2%	30.3%	100%
Waterford	53.4%	8.5%	10.9%	9.4%	17.8%	100%
West Cork	49.2%	7.9%	7.9%	8.7%	26.2%	100%
Wexford	57.1%	8.9%	12.5%	6.1%	15.4%	100%
Total South	**53.7%**	**8.8%**	**10.6%**	**9.1%**	**17.8%**	**100%**

Table 21: Distribution of Report types by LHO – West (Dec 31 2010)

West	% Welfare	% Physical abuse	% Sexual abuse	% Emotional abuse	% Neglect	Total
Clare	73.8%	5.4%	6.7%	3.7%	10.4%	100%
Donegal	58.3%	9.0%	13.0%	11.2%	8.5%	100%
Galway	91.2%	1.5%	1.2%	2.4%	3.8%	100%
Limerick	73.7%	4.4%	9.4%	3.1%	9.4%	100%
Mayo	60.4%	11.4%	7.3%	6.3%	14.6%	100%
Roscommon	66.7%	3.8%	5.3%	11.1%	13.0%	100%
Sligo/Leitrim/W Cavan	77.4%	4.3%	8.2%	3.3%	6.7%	100%
Tipperary North	71.6%	6.9%	5.2%	8.7%	7.6%	100%
Total West	**74.7%**	**5.1%**	**6.3%**	**5.6%**	**8.3%**	**100%**

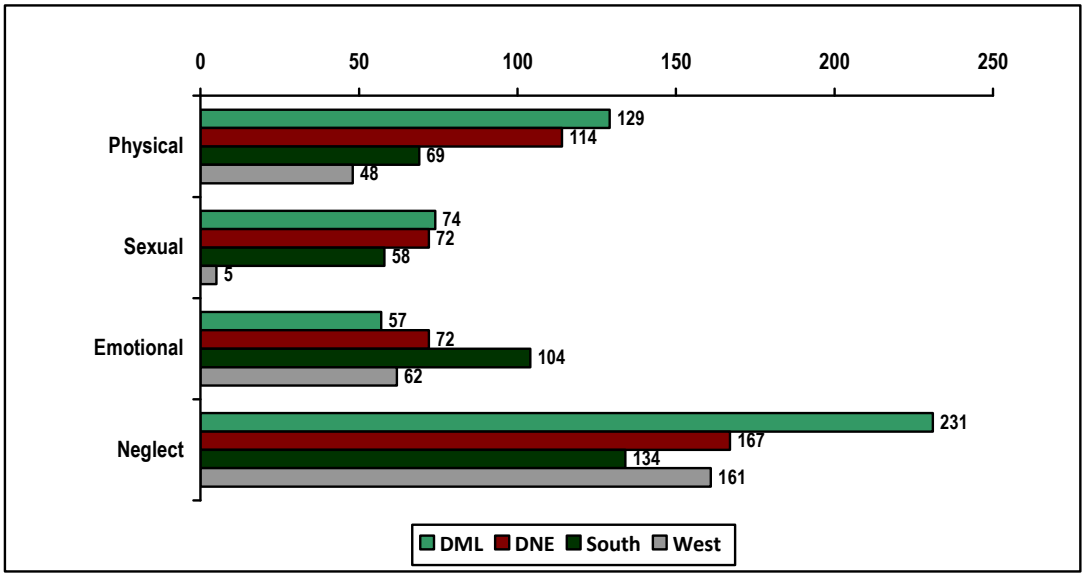
7.5.5 Confirmed Abuse

The critique of the *HSE Social Work and Family Support Survey 2008* (Buckley 2009) noted how small the number of cases of confirmed abuse was compared to the number of children protection Reports received. This is reflected once more in the figure for 2010, where only 1,556 cases had abuse confirmed as an outcome from notification to the Child Protection Notification Management Team/Child Care Manager compared to 12,825 child protection Reports (figure 8). The critique queried:

- whether too many Reports are classified as abuse at the point of entry to social work departments, placing additional time on social workers to process them and additional stress to families already under pressure;
- how many Reports that began as 'protection' Reports are re-classified as 'welfare' cases, given that there is no data on this;
- whether if too many resources are spent in investigating/assessing, that might leave fewer resources for welfare services.

The Standardised Business Process will, however, impact on this apparent 'attrition' between Reports for abuse and the number of confirmed abuse cases. Rather than focussing on whether abuse is confirmed or not, which has an historic focus, emphasis will be placed on *current* risks and needs. Guidance within the Standardised Business Process on child protection conferences (the meeting that brings together key people from different agencies and disciplines with the family to address the continuing protection needs of a child) states that: 'The main tasks of a child protection conference are to decide if a child continues to be at ongoing risk of significant harm as a result of risk of abuse or neglect and if so to formulate a child protection plan.' The fact or otherwise of historical abuse will be subordinated to the requirement to address the current needs of the child, but this will not reduce vigilance in determining whether a criminal route may need to be taken with the abuser, in conjunction with An Garda Síochána.

Figure 8: Profile of confirmed abuse for cases notified to CPNMT/CCM x Category of abuse x Region (2010)



8 Alternative Care Services

8.1 Introduction to Alternative Care Services

The HSE has a statutory responsibility to provide Alternative Care Services under the provisions the *Child Care Act, 1991*, *the Children Act, 2001* and the *Child Care (Amendment) Act, 2007*. Children who require admission to care are accommodated through placement in foster care, placement with relatives, or residential care. The HSE also has a responsibility to provide Aftercare services. In addition, services are provided for children who are homeless or who are separated children seeking asylum. The HSE also has certain responsibilities with regards to adoption processes.

Set out below are the key legislative provisions for Alternative Care Services. Other related provisions are covered under the Child Protection and Family Support Sections.

- Child Trafficking and Pornography Act, 1998;
- Child Care Act, 1991;
- Child Care (Placement of Children in Foster Care) Regulations, 1995;
- Child Care (Placement of Children with Relatives) Regulations, 1995;
- Child Care (Placement of Children in Residential Centres) Regulations, 1995;
- Child Care (Standards in Children's Residential Centres) Regulations, 1996;
- Refugee Act, 1996;
- Children Act, 2001;
- Ombudsman for Children Act, 2002*;*
- Children (Family Welfare Conference) Regulations, 2004;
- Child Care (Special Care) Regulations, 2004;
- Child Care (Amendment) Act, 2007;
- Health Act, 2007;
- Adoption Act, 2010.

National policies and guidelines include:

- *Child Care (Standards in Children's Residential Centres) Regulations 1996 and Guide to Good Practice in Children's Residential Centres* (DoHC 1997);
- *Standards and Criteria for the Inspection of Children's Residential Centre* (Fox and McTeigue 1999);
- *Children First, National Guidelines for the Protection and Welfare of Children* (DoHC 1999a);
- *National Standards for Special Care Units* (DoHC 1999b);
- *Towards a Standardised Framework for Inter-Country Adoption Assessment Procedures* (DoHC 1999c);
- *National Children's Strategy: Our Children – Their Lives* (DoHC 2000a);
- *National Standards for Children's Residential Centres* (DoHC 2000b);
- *Foster Care - A Child Centred Partnership* (DoHC 2001a);
- *Youth Homelessness Strategy* (DoHC 2001c);
- *Our Duty to Care: The principles of good practice for the protection of children and young people* (DoHC 2002);
- *National Standards for Foster Care* (DoHC 2003);
- *Statement of Good Practice: Separated Children in Europe Programme* (Separated Children in

Europe Programme 2009, 4th edition);
- *Draft National Quality Standards for Residential and Foster Care Services for Children and Young People* (HIQA 2010a);
- *Guidance for the HSE for the Review of Serious Incidents including Deaths of Children In Care* (HIQA 2010b).

8.2 Issues Raised in the 2009 Review of Adequacy

8.2.1 Multi-Disciplinary Assessment Services for Children and Young People at Risk

The HSE *National Service Plan 2010* included the following Deliverable Output: 'Establishment of multi-disciplinary assessment services for children and young people at risk and development of a multi-disciplinary team for children in care and detention (with Irish Youth Justice Service).'

A multidisciplinary Working Group representing the HSE and the Irish Youth Justice Service was established in May 2010 to progress this action. The Group reported in October 2010 and recommended the development of a four-pronged model comprising:

- a national assessment and intervention service for children at risk;
- on-site therapeutic services for high support and special care units;
- on-site therapeutic services for the children detention schools;
- a parallel development of a forensic child and adolescent mental health service (CAMHS) for children and young people with significant mental health needs requiring more specialist input.

The necessary and associated manpower requirements were approved during 2010 for implementation in 2011.

This will be a highly specialised service which offers multidisciplinary assessment and focused time-specific interventions to young people who have high risk behaviours associated with complex clinical needs. The team will also provide multidisciplinary assessment and therapeutic services to young people placed in high support, special care and detention and support residential care staff in their work with young people while promoting positive links with community based services.

8.2.2 Ensuring that Appropriate Placements are Available for Children In Care

Action 48 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: '*The HSE will systematically plan to ensure that appropriate placements are available for children in care.'* In late 2010 the HSE sought proposals from a range of external consultants to undertake a review of alternative care services: this work will be undertaken in 2011.

Action 73 of the Ryan Implementation Plan stated: 'The HSE will actively review the impact of placement distance from family and community on a child's ongoing relationship and contact with their family, and if the placement goes ahead, will put in place a specific plan to facilitate ongoing contact.' Distance will be an issue that is looked at in 2011 during the review of alternative care services.

8.2.3 Care Planning for Children in Children Detention Schools

Action 63 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: 'The HSE will ensure that social workers who are allocated to children whom the courts place in detention continue to work in partnership with the children detention schools in care planning.' During 2010 the HSE had begun meeting with the Irish Youth Justice Service on this issue with a view to developing an operational protocol in 2011.

8.2.4 Placement of Sibling Groups

Action 72 of the Ryan Implementation Plan stated: 'The HSE will ensure that where siblings have needs that cannot be met within the one placement at a particular time, the care plan should review on a regular basis current circumstances to see if a joint placement is in the interests of all the children in the future. Siblings who live apart should have planned visits and holidays together other than in exceptional circumstances where it is not in the best interest of a child to do so and these reasons are formally recorded.' This was not progressed in 2010 because of resource constraints but was referred in 2011 to the HSE National Alternative Care Co-ordination Group for the development of a national protocol with regard to the placement of sibling groups.

8.3 Children in Alternative Care Data

Data for 2010 on the number of children in care, by LHO and Region, and their placement type, and key statutory duties derives from the HSE database on Quarter 4 2010 Performance Indicators. Data on admissions to care, the primary reason for admission to care, age and gender of children in care, the placement of children under 12 in residential care, length of time in care, placement abroad, and aftercare derives from the HSE's annual collection of Child Care information.

8.3.1 Children in Care

Between 2006 and 2010, the number of children in care rose from 5,247 to 5,965, an increase of 13.7% over that period (figure 9). The figure of 5,965 is 4.6% higher than the target set in the *HSE National Service Plan 2010* of 5,700. Perceptions of reasons for changes in the numbers and characteristics of children entering care will be explored in the capacity review for Alternative Care in 2011.

Figure 9: Number of Children in Care (Dec 2010)

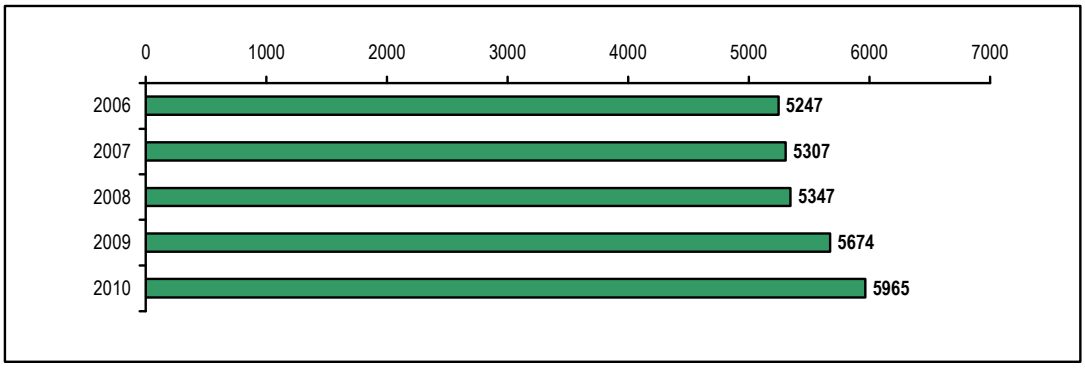
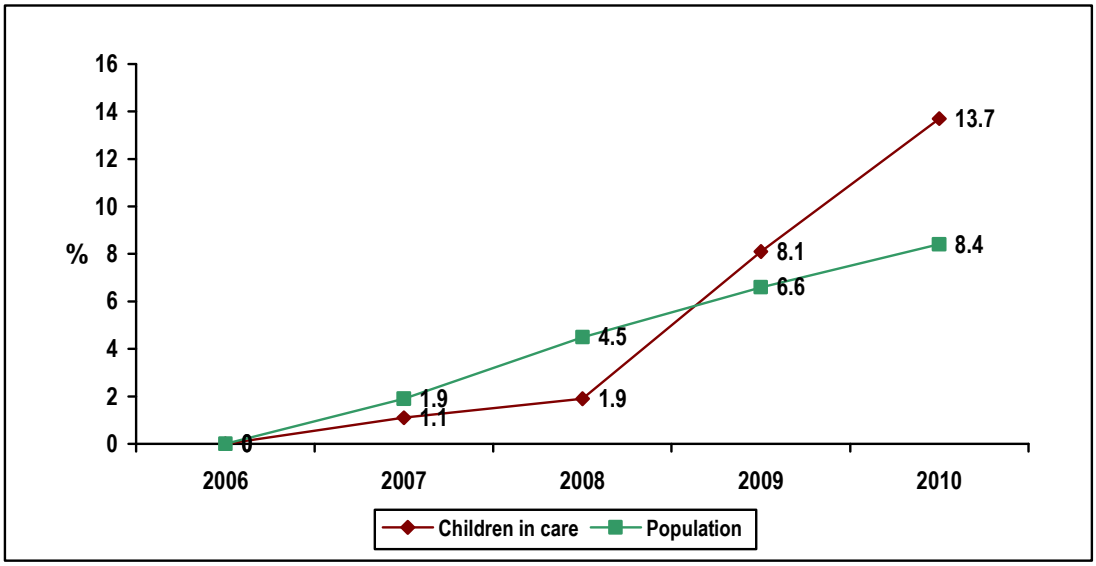


Figure 10 shows that the growth in the number of children in care from 2006-2008 was below the estimated growth of the 0-17 population, whereas for 2008-2010 it exceeded it.

Figure 10: Cumulative percentage rise in population 0-17 (estimated)[4] and children in care



8.3.2 Rates of Children in Care per Local Population

Table 22 shows the rate of children in care per 10,000 population for different jurisdictions. The rate of children in care in Ireland was lower than for these other jurisdictions.

Table 22: Children in care – comparative rates

	Children In Care	Rate per 10,000 ppn	Age-band of population used for calculating rate
Ireland (Dec 2010)[5]	**5,965**	**53.1**	**0-17**
Northern Ireland (Mar 2010)[6]	2,606	57.7	0-17
England (Mar 2010)[7]	64,400	58	0-17
Australia (June 2009)[8]	34,069	67.0	0-17
Wales (Mar 2010)[9]	5,162	82	0-17
Scotland (Jul 2010)[10]	15,892	143	0-18

Table 23 shows the rate of children in care per 10,000 population for the four HSE regions. Note that, pending actual figures for the 0-17 populations in each Region and LHO, the estimated 2010 under 18 population (see table 4) has been distributed amongst the Regions and LHOs in exactly the same proportions as the 0-17 population in Census 2006. The final column in this table shows what the number of children might be if children in care were distributed according to their underlying local populations alone. Reasons for these variations are not well understood at present, in many cases different levels of deprivation will be a substantial part of the explanation.

[4] Populations as calculated in table 4
[5] Using 0-17 population as calculated in table 4
[6] DHSSP, Northern Ireland (2010).
[7] Department for Education, England (2010).
[8] AIHW (2010).
[9] Statistics for Wales (2010).
[10] Scottish Government (2011).

Table 23: Children in care (December 2010) x Children's population (April 2010 Estimated) x Region

Region	% of population (2006)	Est ppn (2010) on same distribution	No. children in care (2010)	% of children in care (2010)	Rate per 10,000 ppn	No. of Children In Care if distributed by population alone
Dublin Mid-Leinster	28.4%	319,046	1,557	26.1%	48.8	1,695
Dublin North East	23.3%	261,321	1,440	24.1%	55.1	1,388
South	27.4%	307,263	1,758	29.5%	57.2	1,632
West	21.0%	235,351	1,210	20.3%	51.4	1,250
National	**100.0%**	**1,122,980**	**5,965**	**100.0%**	**53.1**	**5,965**

Table 24 shows the same information by LHO. There are major variations, with Dublin North Central having a substantially higher rate than other areas (156.8 per 10,000 population aged 0-17) while neighbouring North Dublin had a rate that was only around fifth of this (24.1 per 10,000 population aged 0-17). Again, the reasons for these variations are not well understood at present and socio-economic factors are likely to be part of the explanation.

Table 24: Children in care (December 2010) x Children's population (April 2010 Estimated) x LHO

LHO	% of population (2006)	Est ppn (2010) on same distribution	No. children in care (2010)	% of children in care 2010	Rate per 10,000 ppn	No. of Children In Care if distributed by population alone
Dublin North Central	2.2%	24,804	389	6.5%	156.8	132
North Lee	4.0%	44,904	442	7.4%	98.4	239
Dublin North West	4.1%	46,288	437	7.3%	94.4	246
Roscommon	1.4%	15,720	122	2.0%	77.6	84
Waterford	2.9%	32,788	226	3.8%	68.9	174
Dublin South City	2.1%	24,105	165	2.8%	68.4	128
Limerick	3.5%	38,811	257	4.3%	66.2	206
Tipperary South	2.2%	24,448	158	2.6%	64.6	130
Louth	2.8%	31,686	199	3.3%	62.8	168
Dublin South West	3.4%	38,166	229	3.8%	60.0	203
Dublin West	3.3%	37,296	220	3.7%	59.0	198
Wexford	3.4%	37,776	216	3.6%	57.2	201
Carlow/Kilkenny	3.0%	33,512	180	3.0%	53.7	178
National	**100.0%**	**1,122,980**	**5,965**	**100.0%**	**53.1**	**5,965**
Laois/Offaly	3.6%	40,302	210	3.5%	52.1	214
Wicklow	2.7%	30,168	154	2.6%	51.0	160
Clare	2.8%	30,962	156	2.6%	50.4	164
South Lee	4.0%	45,097	216	3.6%	47.9	240
Tipperary North	2.4%	26,524	123	2.1%	46.4	141
West Cork	1.3%	14,667	68	1.1%	46.4	78
North Cork	1.9%	21,329	97	1.6%	45.5	113
Dublin South East	2.0%	22,155	100	1.7%	45.1	118
Kerry	3.2%	35,808	155	2.6%	43.3	190
Dun Laoghaire	2.7%	30,563	127	2.1%	41.6	162
Longford/Westmeath	2.9%	32,576	135	2.3%	41.4	173
Galway	5.3%	59,947	229	3.8%	38.2	318
Cavan/Monaghan	3.0%	33,915	125	2.1%	36.9	180
Kildare/West Wicklow	5.3%	59,540	217	3.6%	36.4	316
Mayo	3.0%	33,568	112	1.9%	33.4	178

LHO	% of population (2006)	Est ppn (2010) on same distribution	No. children in care (2010)	% of children in care 2010	Rate per 10,000 ppn	No. of Children In Care if distributed by population alone
Donegal	3.9%	43,669	138	2.3%	31.6	232
Sligo/Leitrim/W Cavan	2.1%	23,885	73	1.2%	30.6	127
Meath	4.3%	48,366	146	2.4%	30.2	257
North Dublin	5.3%	59,635	144	2.4%	24.1	317

8.3.3 Admissions to Care

There were 2,291 children admitted to care in 2010 (figure 11). This represented a fall of 3.4% (n=81) on the previous year.

Figure 11: Admissions to Care x Year

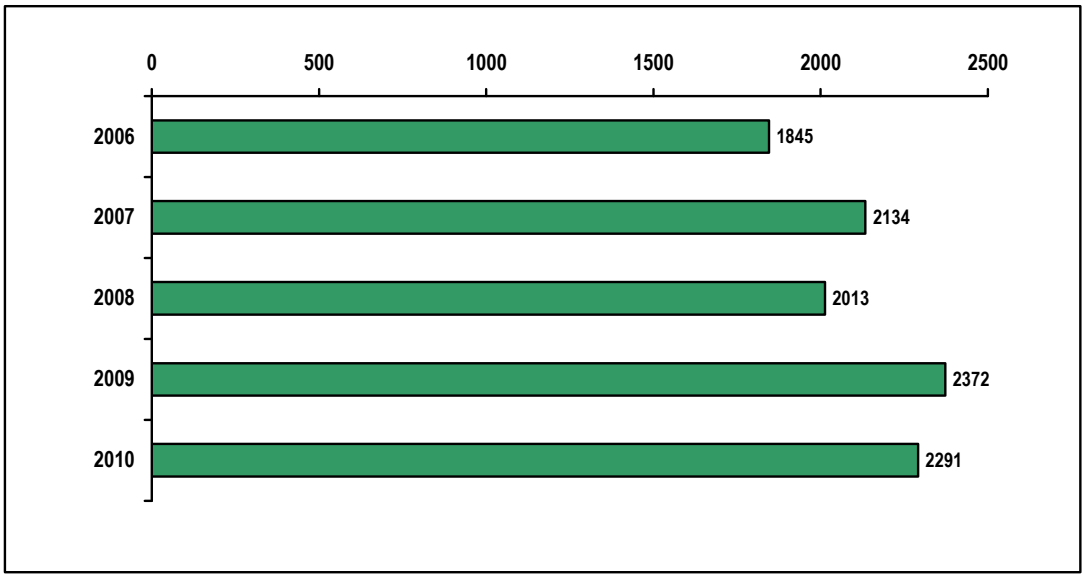


Table 25 shows that 67% (n=1,524/2,291) of children admitted to care in 2010 were admitted voluntarily and for 57% (n=1,316) the primary reason related to family problems. The largest individual primary categories were *Parent unable to cope/family difficulty re: housing/finance etc.* (26%, n=599), *Neglect* (17%, n=398), and *Family member abusing drugs/alcohol* (10%, n=231). These patterns are similar to previous years.

The HSE-commissioned critique of the *HSE Social Work and Family Support 2008* (Buckley 2009) noted that 'the data on reasons why children are in care are extremely broad, and possibly inaccurate, in that only the issues that were uppermost at the time that placements were decided upon were identified.' This is related to comments made within the same paper on primary reason for welfare reports (see section 6.3) which felt that contextual factors such as domestic violence, substance misuse and other parenting factors may be being under-represented. The critique stated that: 'The purpose of collecting this data should be considered; it is important for policy makers to know why children are in care, the sort of contexts in which decisions for removal to care are made and the sort of services they will require while in care, but an equally important objective of gathering this data should be to pinpoint factors that present high risk to children and target them for early intervention by either HSE child and family services, adult services (such as addiction, mental health and domestic violence) or, ideally, a combination of these services.'

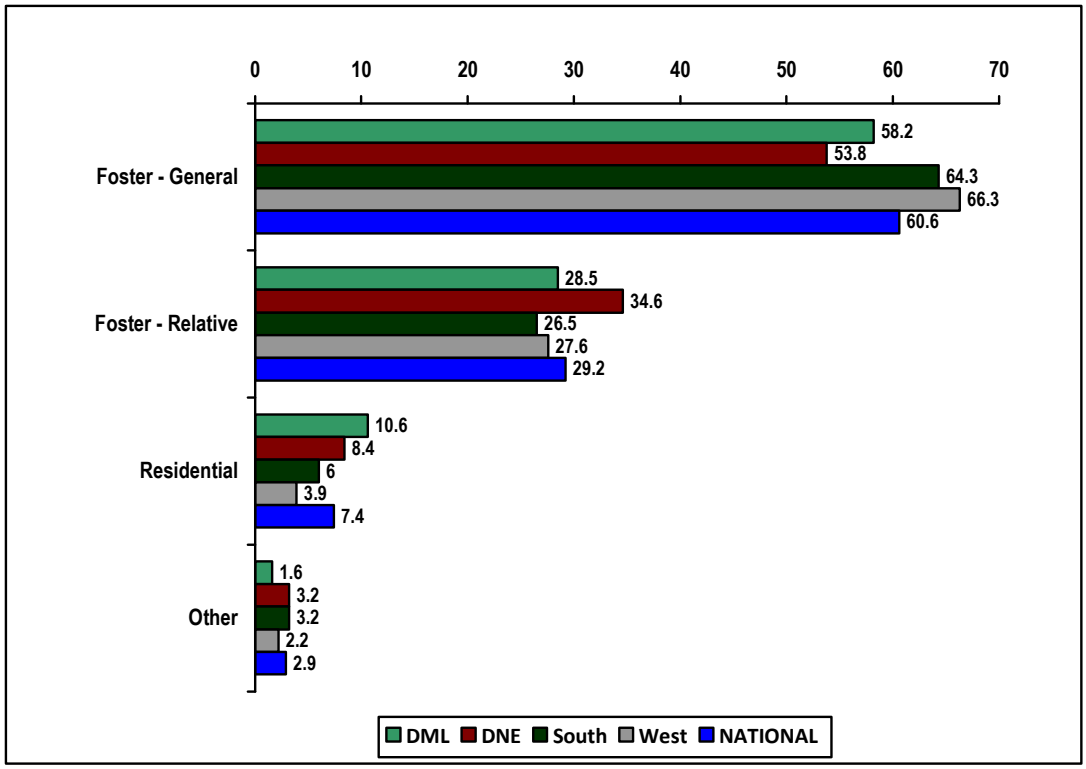
Table 25: Primary reason for admission x Care status (2010)

Care status / Primary reason for admission	Emergency Court Order	Other Court Order	Admitted Voluntarily	Total	%
Abuse	**190**	**230**	**267**	**687**	**30%**
Physical abuse	49	45	66	160	7%
Sexual abuse	17	22	24	63	3%
Emotional abuse	17	25	24	66	3%
Neglect	107	138	153	398	17%
Child Problems	**32**	**39**	**217**	**288**	**13%**
Child with emotional/behavioural problems	6	14	148	168	7%
Child abusing drugs/alcohol	7	4	12	23	1%
Child involved in crime	1	2	4	7	0%
Child pregnancy	1	0	0	1	0%
Physical illness/disability in child	0	1	6	7	0%
Mental health problem/intellectual disability in child	3	1	22	26	1%
Other	14	17	25	56	2%
Family Problems	**125**	**151**	**1,040**	**1,316**	**57%**
Parent unable to cope/family difficulty re: housing/finance etc.	22	38	539	599	26%
Family member abusing drugs/alcohol	36	49	146	231	10%
Domestic violence	12	11	11	34	1%
Physical Illness/disability in other family member	16	1	101	118	5%
Mental health problem/intellectual disability in other family member	28	21	82	131	6%
Separated children seeking asylum	2	9	1	12	1%
Other	9	22	160	191	8%
Total	**347**	**420**	**1,524**	**2291**	**100%**
%	15%	18%	67%	100%	

8.3.4 Placement Type for Children In Care

Performance indicators in the *HSE National Service Plan 2010* included targets that at least 61% of children in care would be placed in general foster care, 28% in relative foster care, and no more than 7% in residential care. These targets were met in 2010 for foster care and relative care, with 60.6% (n=3,612/5,965) of placements in Foster Care General and a further 29.2% (n=1,742) of children in Relative Foster Care (figure 12). Around 7.4% (n=440) of placements were in residential care, a rise from 6.8% (n=383) in December 2009. The HSE Corporate long term plan is for children in residential care to be 5% or less: on a total care population of 5,965, this would equate to 298 ie 142 fewer children in residential care than in 2010.

Figure 12: Placement type x percentage of placements in each Region (Dec 31 2010)



Percentages for LHOs are shown in table 26.

Table 26: Placement type x percentage of placements in each Region and LHO (Dec 31 2010)

Dublin Mid-Leinster	Foster	Relative	Resid	Other
Dublin South City	50.3%	36.4%	11.5%	1.8%
Dublin South East	51.0%	28.0%	14.0%	7.0%
Dublin South West	47.4%	40.1%	11.2%	1.3%
Dublin West	65.5%	21.8%	11.8%	0.9%
Dun Laoghaire	54.3%	31.5%	8.7%	5.5%
Kildare/W Wicklow	67.7%	17.5%	12.0%	2.8%
Laois/Offaly	63.8%	26.2%	8.6%	1.4%
Longford/Westmeath	71.1%	22.2%	5.2%	1.5%
Wicklow	48.1%	34.4%	12.3%	5.2%
DML total	**58.2%**	**28.5%**	**10.6%**	**2.6%**

Dublin North East	Foster	Relative	Resid	Other
Cavan/Monaghan	83.2%	12.8%	0.8%	3.2%
Dublin North Central	45.8%	38.6%	14.7%	1.0%
Dublin North West	43.5%	44.2%	9.2%	3.2%
Louth	65.3%	27.1%	4.0%	3.5%
Meath	70.5%	20.5%	4.1%	4.8%
North Dublin	48.6%	38.2%	6.3%	6.9%
DNE total	**53.8%**	**34.6%**	**8.4%**	**3.2%**

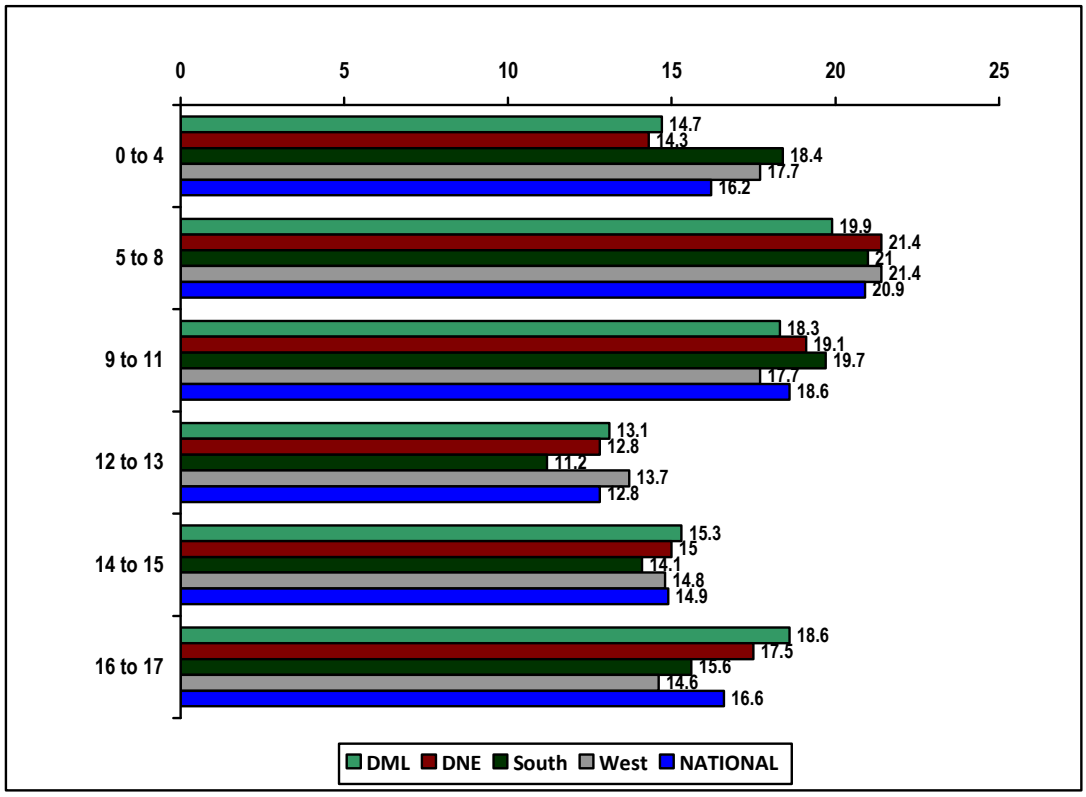
South	Foster	Relative	Resid	Other
Carlow/Kilkenny	58.3%	35.0%	6.1%	0.6%
Kerry	58.1%	34.2%	2.6%	5.2%
North Cork	49.5%	42.3%	7.2%	1.0%
North Lee	67.6%	26.9%	3.8%	1.6%
South Lee	51.4%	36.6%	4.2%	7.9%
Tipperary South	72.2%	15.2%	10.1%	2.5%
Waterford	68.1%	20.4%	8.4%	3.1%
West Cork	70.6%	19.1%	8.8%	1.5%
Wexford	74.5%	13.0%	7.9%	4.6%
South total	**66.3%**	**27.6%**	**3.9%**	**2.2%**

West	Foster	Relative	Resid	Other
Clare	67.3%	25.6%	4.5%	2.6%
Donegal	67.4%	22.5%	6.5%	3.6%
Galway	68.9%	29.3%	1.3%	0.4%
Limerick	58.8%	31.5%	5.8%	3.9%
Mayo	79.5%	18.8%	1.8%	0.0%
Roscommon	62.3%	34.4%	3.3%	0.0%
Sligo/Leitrim/W Cavan	71.2%	21.9%	1.4%	5.5%
Tipperary North	63.4%	29.3%	4.9%	2.4%
West Total	**64.3%**	**26.5%**	**6.0%**	**3.2%**

8.3.5 Age and Gender of Children in Care

There was a reasonably even balance in terms of gender for children in care in 2010, with 51.9% being male and 48.1% female. With regards to age, around 37.1% of children in care were aged 0-8, 31.4% were aged 9-13 and around 31.5% were aged 14-17. Figure 13 shows the distribution of children in care by age group across the Regions.

Figure 13: Children in care x Age, percentage in each Region (Dec 31 2010)



8.3.6 Placement of Children Aged 12 or Under in Residential Care

During 2009 the OMCYA drew up a *National Policy in Relation to the Placement of Children aged 12 Years and Under in the Care or Custody of the Health Service Executive* (OMCYA, 2009a). The intention here was to reduce the number and percentage of children aged under 12 who were in residential care, prompted by an SSI finding that from October 2006 to January 2007 children of this age comprised around 20% of the population of children in residential care. Family-based care such as foster care and relative care is felt to be more appropriate for children of this age. Table 27 shows the position in December 2010 with a national average of 8.9% of residential placements being for children aged under 12. This was a further improvement on 2009 when the figure was 12.6%.

Table 27: Number and percentage of children in residential care aged under 12 (Dec 2010)

Region	Number aged under 12 in residential care	Total in residential care	% in residential care aged under 12
Dublin Mid-Leinster	21	166	12.7%
Dublin North East	11	121	9.1%
South	5	106	4.7%
West	2	47	4.3%
National	**53**	**440**	**8.9%**

The *HSE National Service Plan 2011* introduced a new performance indicator on the Number of children in residential care aged 12 or under.

8.3.7 Length of Time in Care

Research suggests that the age of entry and the speed of action to either return the child home or find long term permanency options for the child are critical in achieving optimal outcomes for children in the care system. In general it is not good practice for a child to be in residential care for five years more. In 2010 some 52.7% of children in residential care had only been in that placement for less than a year, with 30 in residential care for five years or more.

Table 28: Number of children in care x Length of stay (Dec 2010)[11]

Length of stay / Placement type	Less than one year	One to five years	More than 5 years	Total
Foster care general	821	1,202	1,311	3,334
Children with special or extra supports	4	7	12	23
Foster care with relatives	290	738	618	1,646
Pre-adoptive foster placement	8	7	2	17
Residential general	195	145	30	370
Residential special	9	5	0	14
Residential high support	17	12	1	30
At home under a care order	10	15	4	29
Other	61	45	15	121
Total	**1,415**	**2,176**	**1,993**	**5,584**

Length of stay / Placement type	Less than one year	One to five years	More than 5 years	Total
Foster care general	24.6%	36.1%	39.3%	100%
Children with special or extra supports	17.4%	30.4%	52.2%	100%
Foster care with relatives	17.6%	44.8%	37.5%	100%
Pre-adoptive foster placement	47.1%	41.2%	11.8%	100%
Residential general	52.7%	39.2%	8.1%	100%
Residential special	64.3%	35.7%	0.0%	100%
Residential high support	56.7%	40.0%	3.3%	100%
At home under a care order	34.5%	51.7%	13.8%	100%
Other	50.4%	37.2%	12.4%	100%
Total	**25.3%**	**39.0%**	**35.7%**	**100%**

Figure 14 shows the length of time that children have been in foster care (mainstream foster care and relative foster care) by year. For example, in 2010 33.3% of children had been in foster care for less than a year.

[11] Note: this data was incomplete and covers 5,584 of the 5,965 children in care ie 93.6%

Figure 14: Length of time for children in foster care x Year (Dec 31)

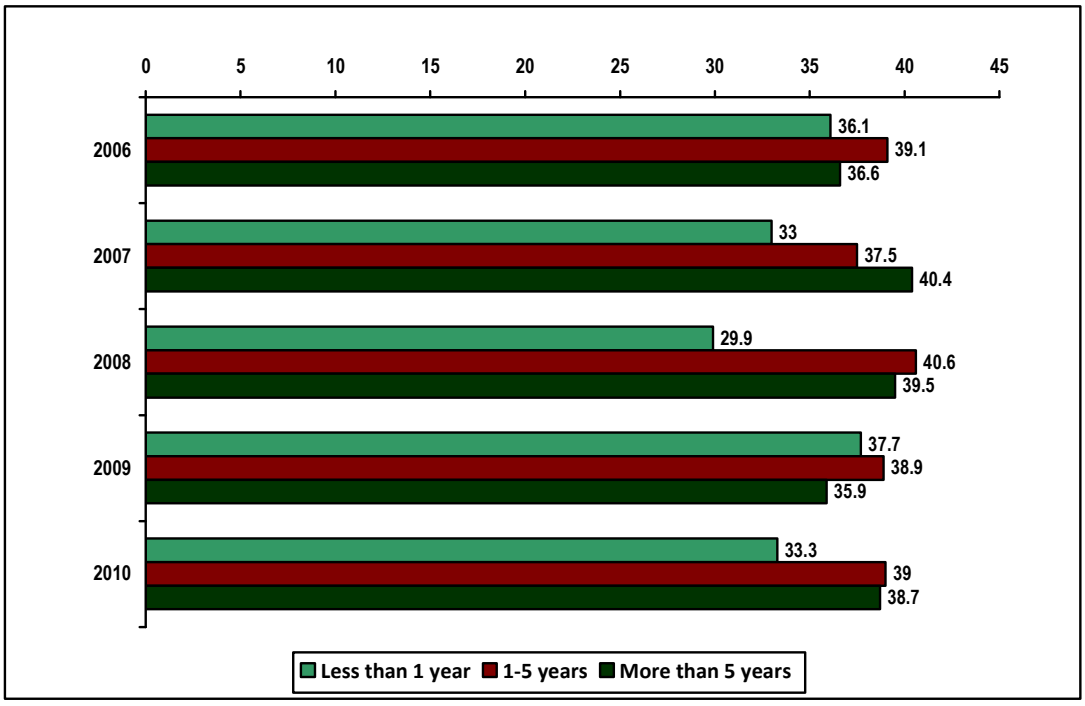
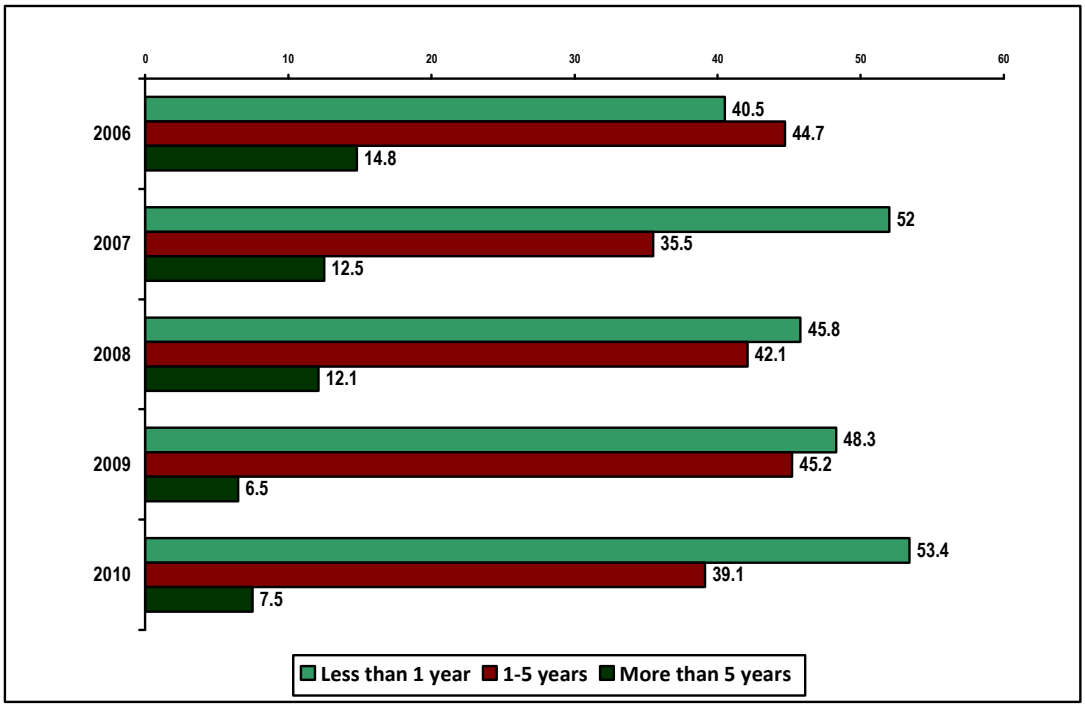


Figure 15 shows the length of time in care for children in residential care by year (mainstream residential care, special care and high support). Around 53.4% of children in residential care in 2010 had been in residential care for less than a year, higher than the four previous years. The percentage of children in residential care for more than five years has declined steadily from 14.8% in 2006 to 7.5% in 2010, a fall in numbers from 60 to 31.

Figure 15: Length of time for children in residential care x Year (Dec 31)



8.3.8 Placement Abroad

In some limited circumstances there is no suitable placement available for a child within the jurisdiction of Ireland. In those circumstances the *HSE National Protocol for Special Arrangements* applies.

In keeping with the principle of placing children with family members, a number of children in need of care are placed with relatives who live abroad, under the *Child Care (Placement of Children with Relatives) Regulations, 1995*. Children are also placed abroad whose care plan has outlined their need for specialised treatment and care. These children most commonly have severe behaviour difficulties, in some cases as a result of injury or accident, in others due to their childhood experiences. Some children require long term placements. These difficulties frequently manifest in ways that make the children a danger to themselves and others. HSE Children and Families Services seeks to place children with severe challenging behaviour in specialist foster care and high support and special care units within Ireland and in the majority of instances this is achieved. However, where HSE Children and Families Services is seeking a specialist placement to cater for a rare behavioural diagnosis, it prioritises the needs of the child over the location of the placement.

Where children are placed abroad they remain in the care of the State, they have an allocated social worker who visits them in their placement, they have a care plan and this is reviewed within the statutory framework. All units in which children are placed are subject to the regulatory and inspection framework of that jurisdiction and HSE Children and Families Services makes itself aware of any reports prior to placing a child abroad. HSE Children and Families Services supports visits from family members to children placed abroad by paying for travel and accommodation costs.

The HSE protocol provided for out of state placements for children in care other than for medical treatment. Decisions regarding 'special arrangements' were made by a Regional Panel comprising the Regional Specialist for Children and Family Social Services, a Principal Psychologist, General Manager and other professionals as required. The purpose of the Panel was to make decisions regarding applicants to ensure the proper utilisation of HSE resources, that placements are compliant with regulations, standards and best practice and support equity of access to placements across all HSE areas. Additionally, the Panel acts to ensure a standardised approach to special arrangements across HSE Children and Families Services.

All placements outside the jurisdiction are made in the best interests of the child. Funding for such placements is provided on a case by case basis as required.

On December 31st 2010 some 22 children were placed outside Ireland (2009 n=13), four of whom were in a relative placement, and eleven of whom were placed abroad because of specialised needs. Many of these placements were in Northern Ireland (n=4) or other parts of the UK (n=6), with four in other EU countries, two in the USA, one in a non-EU European country and five placed in 'Other' areas.

Table 29: Principal reason for placement of children in care outside HSE (Dec 2010)

Principal reason / Region	Relative placement	Specialised needs	Other	Total
Dublin Mid-Leinster	0	1	3	4
Dublin North East	1	4	0	5
South	1	0	2	3
West	2	6	2	10
National	**4**	**11**	**7**	**22**

8.3.9 Discharges from Care

HSE Children and Families Services was not in 2010 collecting data on the profile of children when they are discharged from care. Information such as the age of children at the point of discharge and the length of time that they had been in care would be useful to illustrate the success or otherwise of attempts to reunify families where this is regarded in the care plan as being in the best interests of the child. The development of a Standardised Business Process at the point of discharge from care, plus the National Child Care Information System will help to address this in the future.

It is possible to calculate basic numbers of children discharged from care, as shown in table 30.

Table 30: Changes in the Number of Children in Care in 2010

Items	No.
Children in care December 2009 (A)	5,674
New admissions (B)	2,291
Children in care December 2010 (C)	5,965

This means that during 2009 2,000 children must have been discharged from care (A+B-C). The figure of 5,965 at December 2010 therefore hides the considerable amount of work involved in either admitting a new child to care or discharging them.

Table 28 also shows that in December 2010 around 25.3% of children in care had been in care for less than a year. Extrapolated to the full care population of 5,965, this equates to around 1,512 children. This means that it is possible to estimate that, if only 1,512 of the 2,291 admitted to care during 2010 were still in care by December 2010, then 779 (34% of the new admissions) had been discharged from care within the year.

8.3.10 Aftercare

Aftercare is a process of preparation for leaving care, follow up and support in moving towards independence for all those young people who are eligible. Section 45 of the *Child Care Act, 1991* outlines how a care leaver may be supported. The HSE may assist a person under Section 45 in one or more of the following ways:

1. By causing him to be assisted or visited;
2. By arranging for the completion of his education and by contributing towards his maintenance while he is completing his education;
3. By placing him in a suitable trade, calling or business and paying such fee or sum as may be requisite for that purpose;
4. By arranging hostel or other forms of accommodation for him;
5. By co-operating with housing authorities in planning accommodation for children leaving care on reaching the age of 18 years.

The HSE can support young people who have been in care up to the age of 21, or, where they are involved in a course of education, until the young person completes that course.

The *Ryan Implementation Plan* (OMCYA 2009b) included a range of actions to be taken in relation to Aftercare, including:

64. The HSE will ensure the provision of aftercare services for children leaving care in all instances where the professional judgement of the allocated social worker determines it is required.

65. The HSE will, with their consent, conduct a longitudinal study to follow young people who leave care for 10 years, to map their transition to adulthood.
66. The HSE and the Department of the Environment, Heritage and Local Government will review the approach to prioritizing identified 'at risk' young people leaving care and requiring local authority housing.
67. The HSE will ensure that care plans include aftercare planning for all young people of 16 years and older.
68. The HSE will ensure that aftercare planning identifies key workers in other health services to which a young person is referred, for example, disability and mental health services.
69. The OMCYA, in conjunction with the HSE, will consider how best to provide necessary once-off supports for care leavers to gain practical lifelong skills.

Leaving and Aftercare Policy and Procedures

In June 2010 the Minister for Children wrote to HSE Children and Families with regards to S.45: 'I understand that there may be a view within the HSE that the provision of such services is discretionary and the evidence is that such an approach is being adopted within some areas of the HSE. However, my Office has clear legal advice to the effect that this provision places a statutory duty on the HSE to form a view in relation to each person leaving care as to whether there is a "need for assistance" and if it forms such a view to provide services in accordance with the section and subject to resources.' The Minister directed that the HSE formulate and implement appropriate administrative policies, procedures and guidance, and that the approach should be in accordance with Ryan.

A working group of aftercare workers from different parts of the country was established to respond to this, meeting every one to two months. A draft Leaving Care and Aftercare Policy and Procedures document was developed and this was consulted on across HSE Children and Families Services, with relevant NGOs, and with the OMCYA. The policy and procedures were finalised in 2011.

Aftercare Data

At December 31st 2009, there were 847 young people in receipt of aftercare services. By December 31st 2010, this had risen to 1,046, a rise of 23.5%. A performance indicator was introduced in the HSE *National Service Plan 2011* on the number of young adults aged 18-21 in receipt of an aftercare service.

Table 31 compares the number of young people in receipt of an aftercare service to the number of children in care as an indicator of the take-up of aftercare support (this will always be a relatively small percentage, given the narrow age-band for children to receive aftercare support ie 18-21 or up to 23 if in full-time education).

Table 31: Children in receipt of aftercare services compared to number of children in care (Dec 2010)

Region	No. young people receiving aftercare support	No. children in care	%
Dublin Mid-Leinster	320	1,557	21%
Dublin North East	147	1,440	10%
South	267	1,758	15%
West	312	1,210	26%
National	1,046	5,965	18%

In addition to more young people being recorded as receiving aftercare services, the percentage receiving educational/training support increased to 74% in 2010 compared to 69% in 2009 (table 32).

Table 32: Education/training support for young people in receipt of aftercare services x Accommodation type and gender (Dec 2010)

National	Female	Male	Total	Number receiving educational /training support	% receiving educational/ training support
Foster Care	231	256	**487**	393	**80.7%**
Residential Care	53	45	**98**	71	**72.4%**
Supported Lodgings/ assisted independent accommodation	103	109	**212**	159	**75.0%**
Other	109	140	**249**	151	**60.6%**
Total	**496**	**550**	**1,046**	**774**	**74.0%**

Table 33: Education/training support for young people in receipt of aftercare services x Region (Dec 2010)

National Totals	No. in receipt of aftercare services	No. receiving educational /training support	% receiving educational/ training support
Dublin Mid-Leinster	320	170	53%
Dublin North East	147	143	97%
South	267	208	78%
West	312	253	81%
National	**1,046**	**774**	**74%**

8.4 Key Statutory Responsibilities

The *Review of Adequacy 2009* reported improvements during the year in the proportion of children in care with an allocated social worker and the proportion with a written care plan. The recruitment of an extra 200 social workers during 2010 was expected to improve performance in these areas. Performance indicators in the *HSE National Service Plan 2010* aimed for a target of 100% for both of these.

8.4.1 Allocated Social Workers for Children In Care

By December 2010, 93.2% of children in care (n=5,558/5,965) had an allocated social worker, and 406 children did not (table 34). Almost half of the children without an allocated social worker were in Dublin North East. Overall, 16 LHOs had an allocated social worker for all children in care.

Table 34: Proportion of children in care with an allocated social worker x Placement type x Region (Dec 2010)

Region	% Foster care	% Relative care	% Residential	% Other	% All types	No. cases with no allocated SW
Dublin Mid-Leinster	89.3%	92.1%	96.4%	97.6%	91.1%	139
Dublin North East	89.9%	78.3%	94.2%	84.8%	86.1%	200
South	97.1%	96.8%	97.2%	94.6%	96.9%	54
West	99.1%	98.5%	97.9%	100%	98.9%	13
National	**94.0%**	**90.6%**	**96.1%**	**93.5%**	**93.2%**	**406**

8.4.2 Written Care Plans for Children In Care

By December 2010 90.1% of children in care (n=5,376/5,965) had a written care plan, and 588 children did not (table 35). West was very close to the 100% target, with only five children without a written care plan.

Table 35: Proportion of children in care with a written care plan x Placement type x Region (Dec 2010)

Region	% Foster care	% Relative care5	% Residential	% Other	% All types	No. cases with no written care plan
Dublin Mid-Leinster	91.5%	94.8%	93.4%	92.7%	92.7%	114
Dublin North East	85.0%	80.1%	84.3%	84.8%	83.3%	241
South	86.9%	85.6%	91.5%	92.9%	87.0%	228
West	99.1%	98.8%	100%	100%	99.6%	5
National	**90.5%**	**88.9%**	**91.1%**	**91.8%**	**90.1%**	**588**

8.4.3 Performance Indicators for Key Statutory Responsibilities for 2011

The *HSE National Care Plan 2011* again sets targets of 100% for both allocated social workers and written care plans. In addition, a new performance indicator has been devised on *% of children (by care type) for whom a statutory care plan review was due during the reporting period and the review took place.*

8.5 Special Care and High Support

8.5.1 Definition of Special Care

Special care refers to a type of care that is provided to children and young people who are in need of special care or protection by the HSE and would usually be placed in a 'special care unit' (SCU). These units are purpose built secure locked facilities, managed by HSE Children and Families Services (there is one in Dublin, one in Limerick and one in Cork). This means that children/young people placed in a special care unit by order of the High Court cannot leave of their own accord.

A child requiring special care will display behaviour that is considered to be putting him or her at such real and substantive risk to their health, safety, development or welfare that it can only be met through such care. Special care is intended to:

- provide a short-term period of safe and secure care, in an environment where a young person's emotional and behavioural needs can only be met in a special care setting;
- help stabilise an 'extreme' situation which has been persistent and severe;
- provide a controlled and safe environment in which care and appropriate intervention can be given;
- improve the welfare and development of young people in a model of care based on relationships, containment and positive reinforcement;
- provide a model of care which promotes consistency, predictability, dignity, meaningful controls and external structure which will assist young people in developing internal controls of behaviour, self-esteem, personal abilities and strengths and capacity for constructive choice and responsibility.

Special care is intended to be for as short a period as possible, enabling risks and needs to be stabilised so that the child/young person can have their future needs met in a non-secure placement.

Applications for admission to Special Care are considered by the National Special Care Admissions and Discharges Committee on the basis of the *Criteria for the Appropriate Use of Special Care Units* (CAAB/HSE 2008). These criteria were amended in September 2008 in the light of a range of High Court judgements in 2007 and 2008, in particular to clarify that placement in special care was not deemed appropriate where criminal matters were before a district court.

During 2009, the introduction of the Child Care (Amendment) Bill introduced provision that, should they be enacted, would amend this and might lead to an increase in children in the future who meet the criteria. Guidance to the Bill stated (Oireachtas 2009): *"A child convicted of a criminal offence may be placed in a special care unit where s/he has not been sentenced to a custodial sentence which would take effect at the same time as the special care order. Conviction of an offence is not the defining issue; rather it is the type of sentence received. Generally, unless a child has been remanded in custody or received a custodial sentence the HSE can apply for a special care order or an extension of the original order and continue to detain a child in a special care unit. Where a child is remanded in custody or given a custodial sentence the HSE can withdraw its application or apply to have the special care order discharged immediately."* The Bill had not been enacted by the close of 2010.

8.5.2 Definition of High Support

High support units offer a residential service to children and young people who are in need of specialised targeted intervention: they are 'open' in that the young person is not detained. High support units aim to assist young people in developing internal controls of behaviour, to enhance self-esteem, facilitate personal abilities and strengths, and to build a capacity for constructive choice, resilience and responsibility. There are high supports units that are managed locally and two high support units that are managed nationally.

8.5.3 Reports on Special Care

Tracing and Tracking of Children Subject to Special Care Applications

In the second half of 2009, HSE Children and Families Services joined with the Children's Act Advisory Board (CAAB) and the OMCYA for a CAAB-commissioned piece of work to look at outcomes for children who were subject to applications for special care in 2007. This research was undertaken by Mark Brierley of *Social Information Systems Ltd* and HSE Children and Families Services contributed through participation in the steering group for the research and enabling the researcher to interview social work and special care unit staff on the 70 applications covered by the research. All case information provided to the researcher was anonymised. The report *Tracing and Tracking of Children Subject to a Special Care Application* (CAAB/Social Information Systems 2010) found that, of those children admitted to special care in 2007, special care had had a positive effect for 54% (n=15 out of 28), with it providing a place of safety only for another 21% (n=6 – for many of the social workers, this was all that they wanted and expected) while for 18% (n=5) special care was perceived by social workers to have had a negative effect.

The report made 19 recommendations:

- for the HSE at national level and policy makers;
- to support interagency working;
- for practice and processes;
- for monitoring and research.

National Overview Report of Special Care Services

In December 2010, HIQA published a *National Overview Report of Special Care Services Provided by the Health Service Executive* (HIQA 2010c). In October 2010, the Authority had conducted full inspections of Coovagh House and Gleann Alainn and a follow up inspection of Ballydowd Special Care Unit which had had a full inspection in July 2010. HIQA findings included:

- There was no coherent national structure for the strategic development or operation of the services. The HSE had a National Special Care and High Support Management Team which operated under the HSE's Office of Assistant National Director Children and Families Social Services. The strategic and operational management of Coovagh House and Ballydowd came under this structure. Gleann Alainn was managed by the local health area in the HSE South.
- The HSE did not have a comprehensive national strategic plan for the operation and development of the national special care service. Specific themes identified by the Authority where that there were significant failings were in the areas of:
    - governance and management;
    - staffing, training and support;
    - management of behaviour;
    - premises, safety and security.

HIQA made seven recommendations, as shown below:

HIQA Recommendations
1. The HSE should appoint a nominated National Director with delegated specific accountability for children's services. An experienced and suitable manager should be appointed to report to the National Director with specific responsibility and authority for special care as a matter of urgency.
2. The HSE should develop, approve and publish a national strategy for the provision of children's special care services considering short, medium and long-term needs. This should be accompanied by a published strategy-implementation plan, with accompanying timelines. Progress against this plan should be reported to the Board of the HSE, Minister for Children and Youth Affairs and the Authority, and published.
3. The HSE should review the national governance of special care services and implement any appropriate actions to improve the governance arrangements arising from the review.
4. The HSE should appoint one HSE monitoring officer for all special care units.
5. The HSE should implement the recommendations of the Children Acts Advisory Board report, *Tracing and Tracking of Children Subject to a Special Care Application 2010*, within reasonable timeframes.
6. The HSE should ensure that it complies with legislation, regulations and Standards relating to special care services.
7. The HSE should provide a monthly progress report to the Authority, and the Minister for Children and Youth Affairs, on the implementation of the recommendations in the current inspection reports and those of this Overview Report.

8.5.4 HSE Children and Families Services Capacity Review of Special Care and High Support

In 2009, HSE Children and Families Services had taken the decision to close one of the three national special care centres, Ballydowd SCU. This decision was taken against the backdrop of a number of issues, including the deterioration of the fabric of the three units at Ballydowd. Falling demand for special care indicated that reduced national capacity would not be a problem. The process of redeploying staff and children was undertaken in early 2010 but one unit on the site remained open with

a child placed there.

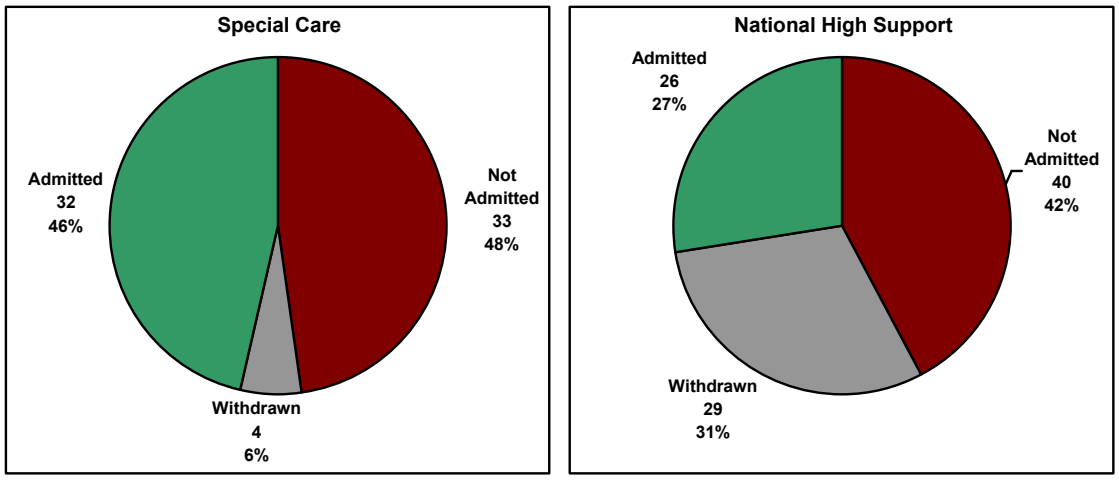
However, during 2010 the number of applications to special care began to rise and the decision to close Ballydowd completely was reconsidered. Instead, a decision was taken to undertake a phased refurbishment of two of the units. There was ongoing discussion with HIQA throughout the year on the development of a revised plan. By the time that HIQA published its national overview report in December:

- operational responsibility for the service had been transferred to the Regional Director of Operations for Dublin North East and there was a plan to appoint a national manager with oversight of both special care and high support services to provide strategic leadership;
- a design team had been engaged to plan the refurbishment of the two six-bed units at Ballydowd SCU.

8.5.5 Special Care and High Support Data

In 2010 there were 164 applications to special care or the national high support units, 95 for high support and 69 for special care (figure 16). Applications to special care were more likely to result in an admission (46%, n=32) than applications to high support (27%, n=26). Almost a third of applications to high support were subsequently withdrawn (31%, n=29). Only 18%[12] (n=7) of applications to Crannog Nua were admitted compared to 35% (n=19) of applications to Ráth na nÒg.

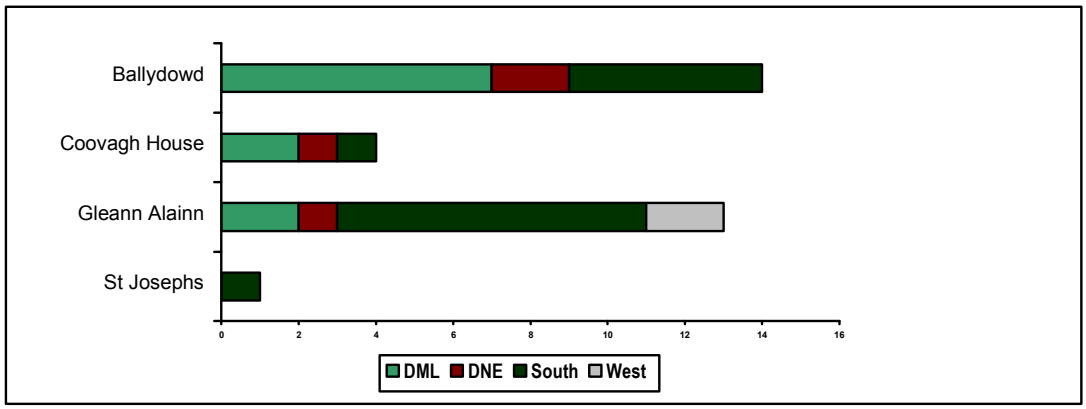
Figure 16: Applications to Special Care and National High Support x Application Outcome



[12] One child was approved for admission, went through the transition placement but was withdrawn before taking the placement

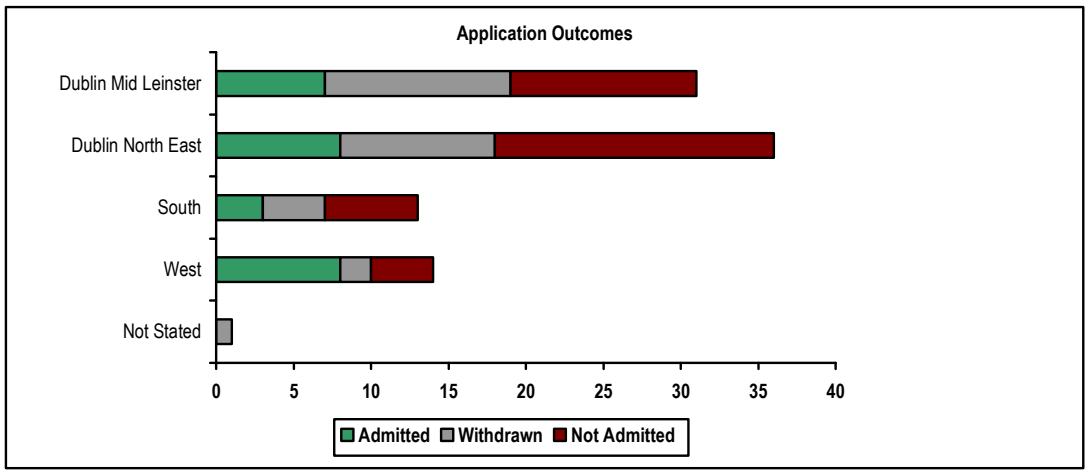
Admissions to each of the three SCUs are shown in Figure 17[13].

Figure 17: Admissions to the SCUs x Region



Outcomes for applications to Crannog Nua and Ráth na nÒg are shown in figure 18. There were many more applications from Dublin North East and Dublin Mid-Leinster than for West and South; the actual numbers of admissions were much more similar across the four regions; there were a high number of withdrawals.

Figure 18: Applications to National High Support x Application Outcome x Region



With regards to gender, 51% (n=81) of all applications for special care and high support combined were for females, and 49% (n=83) were for males. Females were more likely to be the subject of applications for special care (54%, n=37) than males (46%, n=32). Males were more likely to be the subject of applications to high support (54%, n=51) than females (46%, n=44).

[13] St Joseph's, Clonmel was used in addition to the three SCUs because there was no bed available after in SCUs after a High Court decision identified special care as the appropriate placement

8.6 Foster Carers

8.6.1 Approved Foster Carers with Allocated Social Workers

The *HSE National Service Plan 2010* set a target for 100% of approved foster carers to have an allocated social worker. The actual figure was around 88% (table 36, n=2,948/3,367), an improvement on the 2009 figure of 81%. This meant that 491 approved foster carers did not have an allocated social worker. The target set in the *HSE National Service Plan 2011* was again 100%. Overall, only 14 LHOs had a social worker allocated to all approved foster carers.

Table 36: Proportion of approved foster carers with an allocated social worker x Region (Dec 2010)

Region	No. approved foster carers	No. approved foster carers with an allocated social worker	% with an allocated social worker
Dublin Mid-Leinster	718	587	81.8%
Dublin North East	615	519	84.4%
South	1,113	1,000	89.8%
West	921	842	91.4%
National	**3,367**	**2,948**	**87.6%**

8.6.2 National Audit of Foster Care Services

In 2009, the HSE conducted a *National Audit of Foster Care Services*¸ with the final report published in 2010 (HSE 2010e). In June 2010, the HSE published the *Action Plan to Implement the Recommendations in the National Audit of Foster Care Services* (HSE 2010a). This included both a national action plan and four regional action plans.

A summary of the recommendations is shown below:

- **Foster care committees:** most have retained the old health board structure and should be aligned with the emerging new administrative structures; they should have at least one foster/relative care representative (most did); consideration should be given to relevant representation from NGOs and from people with personal experience of the care system.
- **Assessment of foster carers and relatives:** A national protocol is required which gives parity to relatives in relation to the allocation and prioritisation of foster care applications and assessments. Twenty-two LHOs indicated that each foster carer (general) was assessed and approved in accordance with Regulations, with 110 assessments outstanding. Only three LHOs were fully compliant with the Regulations for assessment and approval with regards to relative carers, with 689 of these assessments outstanding.
- **Assessment of the circumstances of the child:** A standardised national framework is required.
- **Contract with foster carers and relative carers:** While it is standard practice for foster carers and relative carers to sign contracts, it is not standard practice that they are issued with a contract: a protocol is required on this, in accordance with Regulations.
- **Information on the child:** A checklist of required information should be drawn up for inclusion in local admission to care procedures.
- **Care plans and reviews:** There were 606 (18%) outstanding care plans for children in foster care and 572 (34%) outstanding care plans for children in relative care. Primarily because of staff vacancies, nine LHOs could not provide information on outstanding reviews for children in foster care, while eight could not do so for children in relative care. The implementation of the

National Care Plan and Review template is required, which sets out the minimum requirements as prescribed by National Standards and Regulations.

- **Maintenance of Register/s:** Consideration should be given to the identification of a software package with the capacity to hold the required information electronically, to be aligned with developments within the National Child Care Information Project.
- **Case records:** A checklist is required, setting out the minimum requirements in relation to the storing of relevant information and documentation, for inclusion in local procedures.
- **Training:** Training for relative carers does not appear to be as high a priority as it is for relative carers. Several LHOs reported a difficulty in getting relative carers to undertake training.
    - consideration should be given to making training compulsory for all foster carers and relative carers;
    - a national training programme addressing the needs of relative carers is required.
- **Supervision and visiting of children:** A national initiative is required to address the issue of children in care who do not have an allocated social worker.
- **Special Reviews:** Regulations provide for any person having a bona fide interest in a child to make a request to review the case. This is an under-used provision and is not well-known. Written information on Special Reviews should be prepared and disseminated through appropriate channels such as preparation courses, training and reviews.
- **Frequency of admissions:** Some 559 children were placed more than once in a 12-month period in foster care, and 231 were placed more than once with relatives. An examination of admission trends is required in LHOs and Areas where multiple-admissions are running above the national average.
- **Removal at request of foster carer or relative carer:** Information on the requirement for written requests to have a child removed, and a sample letter, should be included in information packs and training programmes.
- **Review of foster carers, monitoring and termination:** Standard 17 requires that reviews are held with foster carers to ascertain their continuing capacity to provide high quality care, and the intervals for these reviews. Only one LHO reported having completed all reviews of foster carers.
    - a protocol is required which stipulates the requirement to conduct reviews and provides guidance for doing this;
    - more robust monitoring and quality assurance systems are required at LHO and Area level to manage compliance with Standards, Regulations, performance measures and good practice norms.

During the remainder of 2010 progress was made in revising the Foster Care Committees, with progress on the other recommendations to be made from 2011 onwards.

8.7 Residential Units

Annually, LHOs are required to report on the profile of local residential units within the Child Care Database returns. This has been poorly reported – for example, in 2009 information was provided on only 49 residential units. By contrast, data from HIQA's draft *Social Services Inspectorate Annual Census of Residential Centres for Children in Care* (HIQA 2011a) included returns from 71 'statutory' centres (table 37).

Table 37: Number of children's residential centres by sector and HSE Region on 24 October 2010

Region / Sector	Statutory centres	Non-statutory centres	Total	%
Dublin Mid Leinster	16	34	50	31.1%
Dublin North East	21	32	53	32.9%
South	24	21	45	28.0%
West	10	3	13	8.1%
National	**71**	**90**	**161**	**100.0%**
%	44%	56%	100%	

Around 96% (n=108/112) of the mainstream residential units (statutory and non-statutory) provided a return in HIQA's annual census (table 38). Occupancy of units (statutory and voluntary combined) was 73% (n=345/474). The average designated number of places per unit was 4.4, with the number of places being slightly higher in the South. The average number of occupied places per unit was 3.2, with West being below this figure.

Table 38: Occupancy and average number of places per 'Community based' children's residential centre

	No. centres providing a return	Designated places	Occupied places	% Occupied	Avg designated places per centre	Avg occupied places per centre
Dublin Mid Leinster	40	174	132	76%	4.4	3.3
Dublin North East	35	148	116	78%	4.2	3.3
South	27	127	83	65%	4.7	3.1
West	6	25	14	56%	4.2	2.3
National	**108**	**474**	**345**	**73%**	**4.4**	**3.2**

8.8 Supported Lodgings

The HSE undertook an audit of supported lodgings in April 2010, producing the report *National Audit of Supported Lodgings* in June 2010 (HSE 2010f). The audit was undertaken at the request of HIQA as a means of ensuring that:

- persons providing supported lodgings are vetted, assessed and approved;
- children placed in supported lodgings are there in accordance with their care plan;
- safety and quality assurance systems are in place.

Twenty-five completed responses were received; seven LHOs said that the questionnaire could not be completed because of industrial action. Some 140 service providers were identified, of whom 98%

(n=137) were vetted, 90% (n=120) were assessed and 94% (n=132) were approved. A total of 125 children and young people were identified as being place in supported lodgings, 74% of whom had a care plan. Findings and recommendations are shown below.

Table 39: Findings and recommendations in the *National Audit of Supported Lodgings* (Jun 10)

Finding	Recommendation
There is no legal definition of Supported Lodgings; nor is it the subject of National Standards, regulation from the OMCYA or guidance from HIQA.	The following definition should be introduced nationally: 'Supported lodgings is the provision of accommodation, support and a family setting to young people who cannot live at home, but who are not yet ready to live independently."
Of 127 children in supported lodgings, four were under 12 years, five were aged 12-14, 23 were aged between 14-16.	The provision of Supported Lodgings should be confined to young people aged 16 years or more whose assessed care needs indicate that this is a suitable form of placement.
Some 74% of children and young people in Supported Lodgings were subject to a Care Plan.	Children and young people should be placed in Supported Lodgings in accordance with a Care Plan or an Aftercare Plan where it has been identified as the most appropriate means of meeting a child or young person's needs.
Some young people in Supported Lodgings without a Care Plan had been placed there as a homeless person under Section 5 of the *Child Care Act 1991.*	A national policy should be devised and implemented governing the use of Section 5 as a placement option.
Of the 140 service providers identified, 126 (90%) were reported as having been assessed.	A standardised national assessment framework for Supported Lodgings should be developed and implemented.
Of the 18 LHOs that provided Supported Lodgings, eleven required that providers were approved by local Foster Care Committees.	For children and young people in care approval of Supported Lodgings service provided should be vested in the Foster Care Committee; and a protocol should be drawn up to deal with emergency approval in crisis situations.
While most LHOs indicated that safety and quality was monitored by link workers and allocated social workers, only two stipulated that National Foster Care Standards and Regulations were applied.	All children and young people under 18 years who are placed in Supported Lodgings should be the subject of a Care Plan. Policies and procedures relating to Aftercare should stipulate Supported Lodgings as a placement option, and apply the same standards as any other Aftercare placement.

In the light of these findings, a policy on Supported Lodgings was developed by HSE Children and Families Services in 2011.

8.9 Out of Hours Services

8.9.1 Crisis Intervention Service

The Crisis Intervention Service provided an emergency our of hours service to the Dublin, Kildare and Wicklow areas (the former Eastern Regional Health Authority area). The service comprised:

- A Day Social Work Team.
- An Emergency Social Work Service available from Monday to Sunday between 6pm and 6am and each Saturday, Sunday and public holiday from 9am to 5pm.
- A night reception centre provided by Lefroy House for young people who regularly present to the out of hours service. This service was available from 8pm to 2am. All young people who present were met and assessed by Out of Hours Social Work Staff and were either placed in emergency accommodation or returned to family/relative care. The service also provided one-to-one support with meals and showers for young people.
- Emergency Foster Care Families who were available to provide a place of safety as required for three nights for children under the age of 12 years of age.
- Eight emergency residential beds were available on a night by night basis for young people aged between 12 to 17 years of age, seven at Lefroy and one at Sherrard House.
- Eight beds available for a period of four weeks at Grove Lodge, Portrane.
- Nineteen residential beds available for up to six months at Sherrard House (female 12-17 years), Off the Streets (male and female 16-17 years), Echlin House (male 12-17 years).
- Seven After Care Support Flats available to both males and females aged 17½ years for a period of six to twelve months.

The Crisis Intervention Service provides an emergency response. All details of contact with children are passed to the relevant local social work team by the start of the following day. The local social work team are the case managers and will follow up with further assessments or interventions as necessary. While some of the children and young people who present to the CIS will be homeless, many are not.

The Crisis Intervention Partnership (CISP) was delivered in partnership between HSE Children and Families Services and Focus Ireland and was developed to ensure that there is a comprehensive range of services available to support young people out of home or availing of emergency accommodation. These services included practical day-to-day supports for young people while they are out of home such as meals, showers, and laundry services. The service also provided a key worker to provide one-to-one support and facilitates and supports contacts between the young person and their family with a view to reunification with their family where appropriate. The service worked closely with Focus Ireland Outreach to provide out of hours supports pending placement in emergency accommodation.

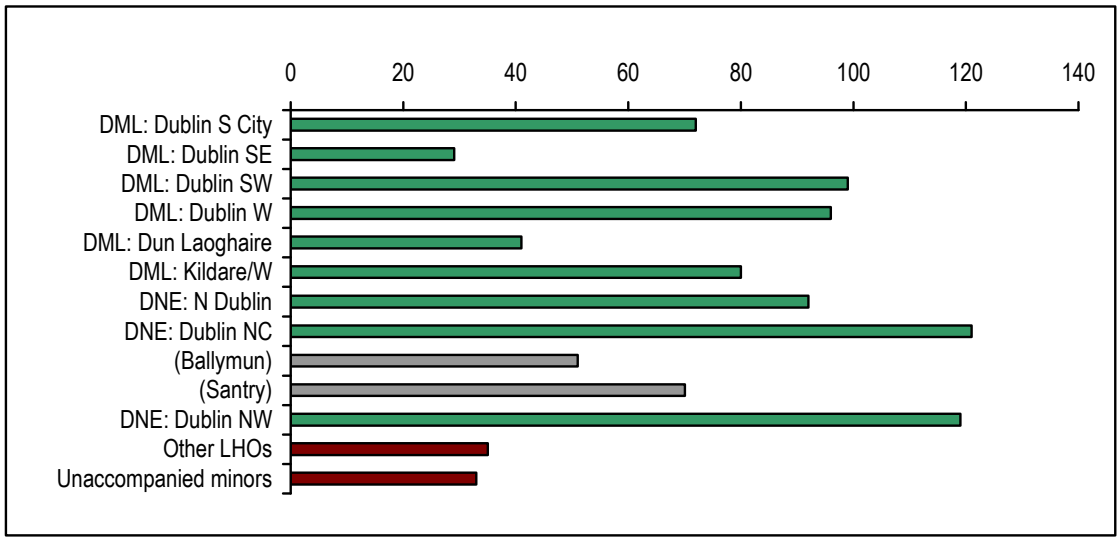
The Focus Ireland Outreach Service provided a wrap-around service for vulnerable young people and newly presenting referrals. The service operates from 5pm to 8pm Monday to Friday, and from 1.30pm to 8.00pm on Saturday and Sunday. The service sought to assist in meeting the needs of young people requiring assistance when the day services finished at 5pm until the availability of services from Lefroy House at 8pm. In addition the Outreach service also engaged in street work, whereby staff sought to identify any young people who may be on the streets in the city centre and direct them towards accessing emergency services.

A tiering system was established to divert the more vulnerable young person from the more experienced service user. The concentration of resources in the city centre had been reduced since late 2008/early 2009 by the establishment of Grove Lodge in Portrane in North Dublin, and the transfer in

November 2008 of Crosscare Eccles Street to Echlin House on the South Circular Road. The absence of residential placements in their local community can be a referring factor for many young people. In addition it can also result in young people remaining in placements for extended periods. As the CIS had a regional brief which covers the ten LHO areas comprising the former ERHA, this might result in young people from rural communities coming in crisis to placements in Dublin.

In 2010 there were 856 referrals to the service, of which 426 were males and 430 were female. Figure 19 shows the number of referrals to the Crisis Intervention Service in 2010 by LHO.

Figure 19: Referrals to the Crisis Intervention Service in 2010 x LHO



8.9.2 Emergency Place of Safety Service

In June 2009 HSE Children and Families Services established the Emergency Place of Safety Service (EPSS), subcontracted to Five Rivers Ireland. Through the EPSS Gardaí could access an appropriate place of safety for children found to be at risk outside normal working hours (5pm-9am Monday to Friday and weekends and bank holidays) under Section 12 of the *Child Care Act, 1991*. The children who were the recipients of the service will include children who present as homeless but figures for service users should not be interpreted as exclusively being homeless children. Under the *Child Care Act, 1991* An Garda Síochána has sole legal responsibility where there is an immediate and serious risk to the health or welfare of a child, and it would not be sufficient for the protection of the child from such immediate and serious risk to await the making of an application for an emergency care order by the HSE under Section 13, to remove the child to safety.

The EPSS provided an emergency out of hours service throughout the country, with the exception of those areas covered by the Crisis Intervention Service. The HSE retains custody, within the meaning of Section 12 of the *Child Care Act, 1991*, with Five Rivers Ireland acting as the HSE's agent in providing the service. EPSS provision is provided by foster carers.

In the early stages, there were some issues relating to perceived lack of awareness of the service and procedures, and this was addressed by meeting with Gardaí in regions, the provision of guidance leaflets, and liaison with HSE social work departments. Difficulties that arose included:

- young people for whom a foster family placement was unsuitable: difficulties have arisen where young people are intoxicated, aggressive or for another reason unsuitable to be placed in a

mainstream family;
- flexibility in relation to the length of placement: on occasion HSE local areas were unable to move the young person within the required 72 hour time frame. Some degree of flexibility has been sought by the HSE;
- option for use of service by hospitals.

The *HSE National Service Plan 2010* set the following as a Deliverable Output: '*Emergency Place of Safety Service augmented within existing resources and monitored on an ongoing basis'* and the *HSE National Service Plan 2011* set the following: '*Pilot sites in South and West fully operational and evaluated. Expansion of services progressed in line with findings of evaluation.'*

The service has steadily increased in both the number of children placed and the number of other enquiries where no placement resulted (tables 40, 41).

Table 40: Number of children placed by the EPSS x by year

Year	Number of children placed	Other enquiries where no placement resulted
2009 (from June)	66	99
2010	171	116
Total	**417**	**302**

Table 41: Children placed by the EPSS x Region[14]

Number Region	2009 (from June)	2010	Total	%
Dublin Mid-Leinster	12	25	37	17%
Dublin North East	7	26	33	15%
South	22	79	101	46%
West	8	37	45	21%
Northern Ireland	0	3	3	1%
Total	**49**	**170**	**219**	**100%**

New performance indicators for 2011 in the *HSE National Service Plan 2011* included:

- number of referrals made to the Emergency Place of Safety Service;
- number of children placed with the Emergency Place of Safety Service;
- total number of nights' accommodation supplied by the Emergency Place of Safety Service.

8.9.3 Homeless Young People

There were two major providers of hostel services to homeless young people in Ireland: the Crisis Intervention Service in Dublin and Liberty House in Cork. Homeless young people might be placed in accommodation by these services under Section 5 of the *Child Care Act, 1991*. Outside of these conurbations, when children present as homeless outside social work department office hours the EPSS might place them within its own accommodation options.

[14] Note: Region was not available for all placements, hence the variance in totals between this table and the previous one.

The *Youth Homeless Strategy 2001* (HSE 2001d) adopted the following definition of youth homelessness:

> *"Those who are sleeping on the streets or in other places not intended for night-time accommodation or not providing safe protection from the elements or those whose usual night-time residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking the other characteristics of a home and/or intended only for a short stay."*

Included within this meaning was *"young people who look for accommodation from the Eastern Health Board Out of Hours Service[15]"* and *"those in insecure accommodation with relatives or friends regarded as inappropriate, that is to say where the young person is placed at risk or where he or she is not in a position to remain"*.

In response to this strategy, Youth Homeless Contact Forms (YHCF) were introduced to record the needs of children who present as homeless and the response to them. However, the YHCFs have not been producing useful data on the extent of youth homelessness:

- the definitions imply that all children referred to the CIS Out of Hours Service are homeless, whereas many will be returned home or to their original placement very rapidly, while others may remain within the service's accommodation options on a medium-term basis to help stabilise their situation and address their needs, with the full implications of being in the care system;
- the YHCFs do not adequately distinguish between the number of children who present and the number of occasions that they present, as a YHCF is completed on each presentation;
- the forms are complex and there have been inconsistencies in completing them.

HSE Children and Families and the OMCYA worked together in 2010 to devise more meaningful data for the future. As a result, performance indicators introduced for 2011 in the *HSE National Service Plan 2011* included:

- number of children placed in youth homeless centres/units for more than four consecutive nights (or more than 10 separate nights over a year);
- number and percentage of children in care placed in a specified youth homeless centre.

Action 35 of the *Ryan Implementation Plan* (OMCYA 2009b) stated: 'The HSE will undertake a national review of current practice in relation to Part II, Section 5 of the Child Care Act, where homeless children can be placed in accommodation and not received into the care of the HSE.' This was included as a Deliverable Output for 2011 in the *HSE National Service Plan 2011*.

[15] That is, the Crisis Intervention Service.

8.10 Separated Children Seeking Asylum

8.10.1 Equity of Care Policy

In 2008, HSE Children and Families Services implemented the *HSE Equity of Care Policy* (HSE 2008a) to ensure that all children and young people receive the same level of care as that afforded to indigenous children.

Since 2000, accommodation for separated children seeking asylum was provided mainly in hostel accommodation or in the one residential unit. Younger children were usually placed in foster care. Action 31 of the Ryan Report Implementation plan recommended that the practice of accommodating SCSA in Hostels was to cease by December 2010, and a phased closure plan was put in place. The practice of placing newly arriving young people in hostels ended in February 2010.

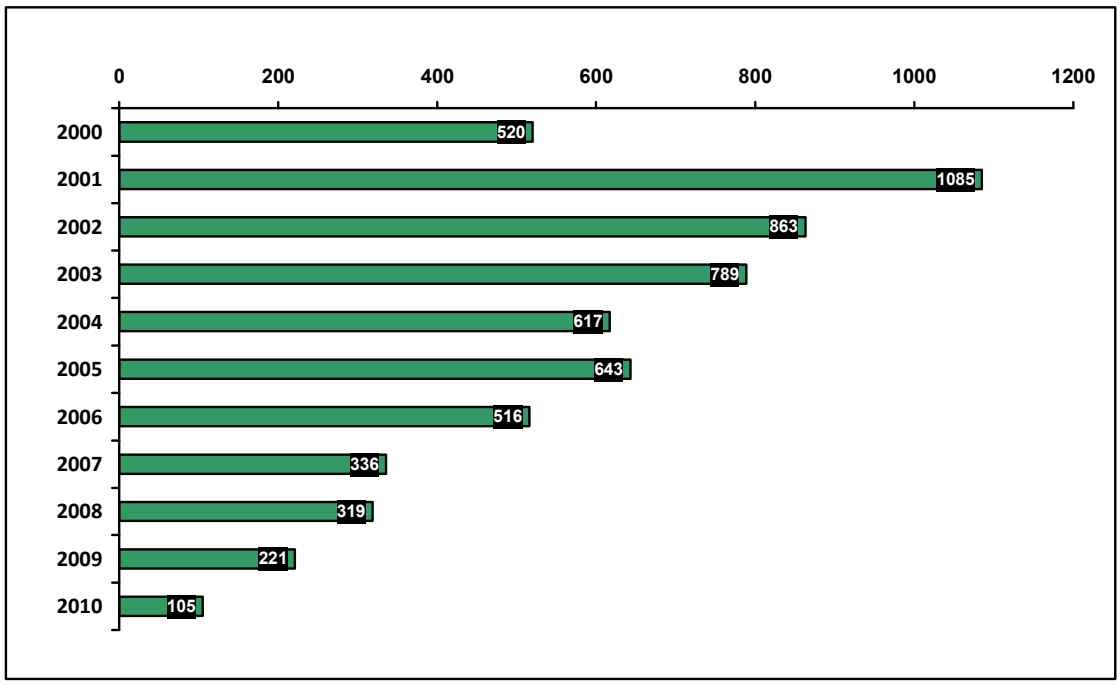
During 2010, all newly arriving children under 12 years of age were placed on arrival in a foster care placement. Newly arrived children over 12 years of age were placed in one of the four registered residential intake units for up to four to six weeks, where a preliminary assessment of the child and their needs was carried out by a social worker in conjunction with qualified residential social care staff. Input from a psychologist was available if required. This assessment informed the most appropriate care option, and identified if the child needed additional supports/links.

HSE Children and Families Services also provided an aftercare service in Dublin to those young people who have been granted status or leave to remain.

8.10.2 Trends in Numbers of Separated Children Seeking Asylum

The number of Separated Children Seeking Asylum (SCSA) has declined since its peak in 2001 (figure 20). The total number of SCSA during the period 2000-2010 was 6,014. This mirrors the overall decline in levels of immigration.

Figure 20: Number of SCSA – 2000-2010



On December 1st 2010, the placement of Separated Children Seeking Asylum was as shown in table 42. All hostel residents were over 18 and in an exam year.

Table 42: Placement of SCSA on Dec 1 2010 x Placement type

Placement type	Number	%
Relative	2	2%
Foster care	35	31%
Residential home	24	21%
Aftercare	18	16%
Supported lodgings	20	18%
Hostels	15	13%
Total	**114**	**100%**

8.11 Adoption Services

Adoption is the process which creates a permanent, legal relationship between the adoptive parents and the child/ren. The child has the same legal rights as if they were born in the adoptive family.

8.11.1 Adoption Act, 2010

The *Adoption Act, 2010* was commenced in November 2010, coinciding with Ireland's ratification of the Hague Convention on the Protection of Children and Co-operation in Respect of Inter-country Adoption. This also repealed all previous adoption regulation and placed on the HSE new roles and responsibilities in relation to the processing of Domestic Adoption applications, in particular the assessing of step-parent adoption applications.

The HSE set up a project group to begin preparing for the enactment of the new Bill expected in 2010. This involved collaborative work with the Adoption Board in preparation for the transfer of responsibilities and staff to HSE Children and Families. The Adoption Board was replaced by the Adoption Authority of Ireland when the Act commenced.

8.11.2 Adoption Data

In recent years, the numbers of Irish children becoming available for adoption has decreased to around 200 every year. In 2010 there were 189 Domestic Adoptions, 35 of which were 'non-family' adoptions, including 18 adoptions by long term foster carers, and 154 of which were 'family' adoptions, almost all of which were 'step-father' adoptions whereby the birth mother jointly adopts the child with her husband (Source: Information provided by the Adoption Authority).

Many prospective parents now look abroad to adopt a child. This process is called Intercountry adoption. There were 342 Intercountry Adoption Assessments completed in 2010, a decline compared to 2009 (table 43). Of these, 272 were for first assessments for newly adoptive parents and 124 were second assessments for families who had already adopted a child.

Table 43: Intercountry Adoption Assessments completed

Year Number of assessments	2009	2010
First assessments (newly adoptive parents)	272	231
Second assessments (families who have already adopted a child)	124	111
Total	**396**	**342**

During the same year 377 assessment applications were withdrawn or deferred, the vast majority before the preparation course (table 44).

Table 44: Assessment applications that were withdrawn or deferred

Year Stage of withdrawal	2009	2010
Number of applications where applicants withdrew their application before the preparation course	193	319
Number of applications where applicants decided not to proceed with the home study/assessment during or following attendance at the preparation course	40	37
Number of applications which were withdrawn by the applicants during or following the home study/assessment stage	16	21
Total that did not proceed	**249**	**377**

9 Education, Training, Research and Policy (ETRP)

9.1 Introduction to Education, Training, Research and Policy

The *Ryan Implementation Plan* (OMCYA 2009b) had a range of actions relating to continuing professional development for staff in Children and Families Services and other agencies, specifically:

50. The HSE will establish a mandatory year of limited caseload, supervision and support for newly qualified social workers and will consider the rotation of social workers across children in care, child protection and child welfare teams.
51. All agencies providing services to children and families will provide ongoing professional development through training programmes for all staff.
52. The HSE will put in place a system to provide social work students with the practice placements required as part of their training, both undergraduate and graduate.
90. The HSE/OMCYA will engage with the Health and Social Care Professionals Council regarding content of qualifying and post-qualifying courses. Similar engagement will take place with other education/accreditation bodies of relevant professionals across the areas of health, education and justice.
91. Continuing professional development (CPD) will be prioritised by all employers in the health, education and justice sectors for their staff working with children and families.
92. Training will be provided for professional staff moving into management positions in the health, education and justice sectors.

As part of the change agenda, a National Specialist was appointed for Education, Research, Training and Policy (ETRP) in November 2009 with a remit to develop a more standardised national approach to child care training and workforce development. Initiatives in 2010 included:

- The establishment in June 2010 of the **HSE Education, Training, Research and Policy National Advisory Group for Children and Family Services** to provide advice on ETRP projects. The Group has a multi-agency membership including HSE staff, academic providers, and other nominees from relevant statutory and non statutory agencies. It is independently chaired. It has three subgroups for: training, staff practice, and research strategies. The group met on a quarterly basis.
- The establishment in April 2010 of a **National Children and Family Services and Regional Representatives Group for ETRP** comprising the National Specialist for ETRP and regional representatives. This group met on a monthly basis from April 2010 to oversee and co-ordinate the work programme.
- A range of **project teams** were used to develop individual training initiatives.

9.2 Strategy and National Framework for Education, Training, Research and Policy

The *Review of Adequacy 2009* noted the need to develop a national blueprint for training in child care for both statutory requirements and professional development. During 2010 substantial work was carried out under the direction of the National Specialist for ETRP. The bulk of this work was focused on education and training with work scoped but not implemented in the research and policy areas. The first draft of a consolidated work plan for a national and regional ETRP was produced.

A draft HSE Children and Families Services National Framework for Education, Training and Research was also produced. The National Framework is required to:

- co-ordinate the alignment and resources of all education, training and research functions within HSE Children and Families Services to facilitate the delivery of the highest quality education, training and research relevant to the needs of children and young people;
- identify gaps and deficits in education, training and research in HSE Children and Families Services and to address these gaps with key educational and research partners;
- design and plan education and training initiatives in HSE Children and Families Services and ensure that these are appropriately supportive of an interdisciplinary policy approach that is responsive to the needs of children and young people;
- develop research strategies within HSE Children and Families Services to improve and support quality, safety and international best practice in HSE Children and Families Services organisation and delivery;
- act as a platform for communication, discussion, collaboration and exchange of information and learning on a multidisciplinary basis between those involved in education, training and research in HSE Children and Families Services, to ensure a collaborative approach to the sharing and maximisation of resources and the development of common education and research agendas;
- drive leadership and management development for HSE Children and Families Services staff, by progressively promoting and providing training for leadership roles through the professional educational continuum from the early stages of training through life-long learning.

9.3 Development of Training Courses

9.3.1 Leadership and Management

A range of training programmes were developed in 2010 related to leadership and management:

- **HSE Leadership Development Programme for First Time Managers:** A leadership development programme was developed by Human Resources in conjunction with Children and Families Services to provide training for first time managers in the HSE. This was the HSE response to Action 92 of the Ryan Implementation Plan. Twenty-one trainers were nominated by Regional Performance and Development Managers to attend. Area Human Resources organised and delivered the programme locally in 2011, with social work team leaders being the priority target group.
- **Induction:** During 2010 a standardised Induction Policy and supporting Guidelines were developed. These provided guidance on the management of caseloads by recommending limited caseloads, supervision and support for the newly qualified social worker. These were signed off by the HSE Management Team and implemented from December 2010 onwards. They will be reviewed following the first full year of implementation.
- **Supervision:** In late 2010 a draft supervision training document was developed. Consultation on the document was planned for 2011. The priority group for supervision training will be all team leaders who had not yet received supervision training with further work to be carried out on standardising supervision training materials in 2011.

9.3.2 Supporting Children First

During 2010 training to support Children First was strengthened:

- **Children First Training Strategy (Basic and Advanced):** A national approach was developed to training and briefings in advance of the launch of new Children First guidelines in 2011. A Standardised Basic Training Module and resources were drafted and a standardised Briefing/Refresher Module was scoped with input from Child Care Trainers from the regions. The final version of the training and briefings modules will be agreed following the publication of revised Children First Guidelines to take on board relevant developments. An implementation plan for standardised delivery was developed in 2011.
- **HSE/An Garda Síochána Children First Joint Training:** The National Specialist (ETRP) and the Director of Training for An Garda Síochána, agreed in 2010 that the Children First joint training programme would be re-established for both agencies for staff who work together in delivering child protection.
- **Establishment of HSE Process to Support Joint HSE/Gardaí Specialist Interview Training for Investigation of Child Abuse:** A project team was established in October 2010 to review work in joint specialist interview training and its utilisation by social work staff in preparation for the establishment of a HSE process to manage this work effectively. An evaluation of this training and its utilisation took place by surveying those who have received training in Q1 of 2011.

9.3.3 Other Training

Brief Encounters® Training for health service staff develops knowledge, skills and confidence to enable them to make a timely and effective first level intervention as a means to empower parents in solving their own problems and as a means to prevent a problem of parental/family relationships difficulties escalating to a more serious level. A project team was established to pilot this in June 2010. A three day Training Programme for PCT members on the *Brief Encounters*® model of brief intervention was delivered in four LHO areas for a pilot phase. A recommendation on national roll-out will be made post evaluation in 2011.

9.4 Social Work Practice Placements

The *Framework for Social Work Practice Placements* (HSE 2010b) document outlining a national policy statement was completed by the National Social Work Placements Forum. The National Specialist (ETRP) participated in this Forum. Draft HSE Social Work Practice Placement Standards were developed.

Social Work Practice Placements systems will be developed in line with the *Framework for Social Work Practice Placements* in 2011 subject to the recruitment of two national Social Work Practice and Education Co-ordinators.

9.5 Research

9.5.1 Management of Postgraduate Courses and Research Contracts Funded by Children and Families Services and the Establishment of Service Level Agreements with Academic Providers

A Grant Aid Agreement has been agreed between the HSE and Trinity College Dublin with assistance from Education Contracts Management Section of HR for the Postgraduate Diploma in Child Welfare and Protection. A co-ordination process was commenced with the Child and Family Research Centre in NUI Galway in relation to the management of the contract for research work.

9.5.2 Retention of Social Workers

The HSE commissioned University College Dublin (UCD) study on *The Retention of Social Workers in the Health Services: An Evidence-Based Assessment* final draft was submitted to Children and Families Services in December 2010. Feedback on the recommendations was provided by the National Specialist (ETRP). The recommendations highlighted the need for the HSE to support newly qualified social workers through a range of supports including induction, supervision, and caseload management. Education, training and research needs for the social work workforce were identified as critical areas requiring additional support and development to address retention issues. The National Specialist (ETRP) will work with UCD to ensure that all findings are disseminated appropriately to key stakeholders.

9.5.3 North South Child Protection Hub (NSPCH)

The National Specialist (ETRP) is a member of the North South Ministerial Council Child Protection Cross Border Subgroup on Research and Knowledge Transfer that developed and commissioned the North South Child Protection Hub (NSPCH), launched in November 2010. A national contract was agreed between HSE Children and Families Services and Child Link to establish access for all HSE staff to the NSCPH (available through intranet and HSELanD). A dissemination plan was developed to ensure that all relevant HSE staff and HSE-funded agencies could have access to this resource.

10 Summary of Data

The estimated 0-17 population rose by 8.0% between 2006 and 2010 from 1,039,500 to 1,123,000 (p12, table 3).

Reports to HSE Children and Families Services rose between 2007 and 2010 by 26.4% from 23,168 to 29,277 per year (p36, figure 6), with the number of welfare reports rising by 29.4% (from 12,715 to 16,452) and the number of child protection reports rising by 22.7% (10,453 to 12,825). Between 2009 and 2010 the number of reports increased by 9.1%.

There were 114.2 child protection reports per 10,000 population aged 0-17 in 2010 (p37, table 15).

There were 461 referrals for Family Welfare Conferences in 2010, a rise of 3.8% on 2009 (p22, figure 1). Some 282 Family Welfare Conferences were convened, a rise of 4.8% on 2009 (p22, figure 2).

The number of Springboard referrals fell in 2010 by 2.8% from 1,120 to 1,089 (p23, figure 3).

Admissions to care per year between 2006 and 2010 rose by 24.2% from 1,845 to 2,291 but fell by 3.4% between 2009 and 2010 from 2,372 to 2,291 (p47, figure 11). Around 67% of children were admitted to care on a voluntary basis (p48, table 25).

The number of children in care rose by 13.7% between 2006 and 2010 (from 5,247 to 5,965), with a rise of 5.1% in 2010 from 5,674 in 2009.

The percentage of children in mainstream foster care (60.6%) and relative foster care (29.2%) were in line with national targets but the percentage in residential care was slightly above (7.4%) (p49, figure 12).

The percentage of children aged 12 or under in residential care fell by 29.4% from 12.6% in 2009 to 8.9% in 2010 (p51, table 27).

Between 2006 and 2010, the number of children who had been in residential care for more than five years halved from 60 to 30 (p53, figure 15)

In 2010 22 children were placed abroad, a rise of 69.2% on the 13 placed abroad in 2009 (p54, table 29).

Around 34% of children admitted to care during 2010 were also discharged within the year (p55).

Around 23.5% more young people were in receipt of aftercare services in 2010 than in 2009 (1,046 compared to 847) (p56, table 31).

Some 93.2% of children in care had an allocated social worker compared to 83% in 2009 (p57, table 34). Around 90.1% had a written care plan compared to 84.7% in 2009 (p58, table 35). Some 87.6% of approved foster carers had an allocated social worker compared to 78.6% in 2009 (p63, table 36).

There were 95 applications to Special Care, of whom 32 were admitted, and 69 applications to national High Support, of which 27 were admitted (p61, figure 16).

Residential centres had a 73% occupancy level (p65, table 38).

The number of Separated Children Seeking Asylum continued a downward trend, falling by 52.5% from 221 in 2009 to 105 in 2010 (p71, figure 20).

The number of Intercountry Adoptions fell by 13.6% from 396 in 2009 to 342 in 2010 (p71, table 43).

11 Conclusions

During 2010 social work services received over 29,000 child welfare and protection reports and almost 6,000 children were in care. It is important to acknowledge that the vast majority of the services delivered to the children and families concerned were adequate and many were of a high standard. In addition to financial constraints, organisational responsiveness and consistency is a major challenge. The establishment of a separate National Directorate for Children and Families Services, which commenced in January 2011, will remain a key driver for reform in the coming years.

While reports of child welfare and child protection are increasing, the majority of reports still concern welfare issues that are best responded to by family support services. While more children are in care, the care population is lower than other comparable jurisdictions and over 90% of all children in care live in family settings. The numbers of children aged less than 12 years placed in residential care was down on the previous year.

Finally improvements have been made in the area of continuous learning for staff. Training has been introduced for first time managers and training to support Children First has been strengthened.

The emphasis in 2011 will include ongoing organisational reform, standardisation of business processes, stronger management at national, regional and local levels and improved performance management.

12 Bibliography

Note: Acts and Regulations are generally available from www.irishstatutebook.ie. Acts can be found under *Acts of the Oireachtas* and Regulations under *Statutory Instruments.*

Adoption Act, 2010.

AIHW (2010). *Child Protection Australia 2008-09.*

Buckley, Helen (2009, unpublished). *Health Service Executive Social Work and Family Support Survey 2008 Reviewed by Helen Buckley, School of Social Work and Social Policy, Trinity College Dublin.*

Central Statistics Office (CSO 2007). *Census 2006 Volume 1 – Population Classified by Area*.

Central Statistics Office (CSO 2010a). *Population and Migration Estimates April 2010.*

Central Statistics Office (CSO 2010b). *Survey on Income and Living Conditions (SILC) 2009.*

Central Statistics Office (CSO 2011). *Vital Statistics: Fourth Quarter and Yearly Summary 2010.*

Child Abduction and Enforcement of Custody Orders Act, 1991.

Child Care (Amendment) Act, 2007.

Child Care (Amendment) Bill 2009.

Child Care (Placement of Children in Foster Care) Regulations, 1995.

Child Care (Placement of Children in Residential Centres) Regulations, 1995.

Child Care (Placement of Children with Relatives) Regulations, 1995.

Child Care (Pre School Services) Regulations, 2006.

Child Care (Special Care) Regulations, 2004.

Child Care (Standards in Children's Residential Centres) Regulations, 1996.

Child Care Act, 1991.

Child Trafficking and Pornography Act, 1998.

Children (Family Welfare Conference) Regulations, 2004.

Children Act, 2001.

Children Acts Advisory Board and Health Service Executive (CAAB/HSE 2008). *Criteria for the Appropriate Use of Special Care Units.*

Children Acts Advisory Board and Social Information Systems (2010). *Tracing and Tracking of Children Subject to a Special Care Application*. Dublin: Children Acts Advisory Board.

Commission of the Inquiry into Child Abuse (2009). *Report of the Commission to Inquire into Child Abuse.* Available at: www.childabusecommission.ie

Commission on the Family (1998). *Final Report to the Minister for Social, Community and Family Affairs: Strengthening Families for Life.* Dublin: Stationery Office.

Data Protection Act, 1988 & Data Protection (Amendment) Act, 2003.

Denyer, S., Thornton, L and Pelly, H. (1999). *Best Health for Children: Developing a partnership with Families*. Manorhamilton: National Conjoint Child Health Committee, Health Board Chief Executive Officers.

Department for Education, England (2010). Children looked after in England (including adoption and care leavers) year ending 31 March 2010

Department of Health and Children (DoHC 1998). *Pilot Projects for Children at Risk: Guidelines for Preparation of Proposals*. Dublin: Department of Health and Children

Department of Health and Children (DoHC 1999a). *Children First, National Guidelines for the Protection and Welfare of Children.* Dublin: Stationery Office.

Department of Health and Children (DoHC 1999b). *National Standards for Special Care Units.* Dublin: Stationery Office.

Department of Health and Children (DoHC 1999c). *Towards a Standardised Framework for Inter-Country Adoption Assessment Procedures.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2000a). *National Children's Strategy.*

Department of Health and Children (DoHC 2000b). *National Standards for Children's Residential Centres.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2001a). *Foster Care - A Child Centred Partnership.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2001b). *Quality and Fairness, A Health System for You.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2001c). *Youth Homeless Strategy.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2002). *Our Duty to Care: The principles of good practice for the protection of children and young people.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2003). *National Standards for Foster Care.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2007). *Child Care (Standards in Children's Residential Centres) Regulations 1996 and Guide to Good Practice in Children's Residential Centres.* Dublin: Stationery Office.

Department of Health and Children (DoHC 2008). *The Monageer Inquiry.* Dublin: Stationery Office.

Department of the Taoiseach (2006). *Towards 2016 – Ten Year Framework Social Partnership*

Agreement 2006-15.

DHSSPP, Northern Ireland. (DHSSP 2010). *Children Order Statistical Tables for Northern Ireland 2009-10*

Disability Act, 2006.

Domestic Violence Act, 1996.

Family Law Act, 1995.

Fox, M., and McTeigue, D. (1999). *Standards and Criteria for the Inspection of Children's Residential Centres.*

Freedom of Information Act, 1997 & Freedom of Information (Amendment Act) 2003.

Hardiker, P., Exton, K., and Barker, M. The Social Policy Contexts of Prevention in Child Care. In (1991) *British Journal of Social Work 21 (4).* Pp 341-359.

Health Act, 2004.

Health Act, 2007.

HIQA (2010a). *Draft National Quality Standards for Residential and Foster Care Services for Children and Young People.*

HIQA (2010b). *Guidance for the HSE for the Review of Serious Incidents including Deaths of Children In Care*.

HIQA (2010c). *National Overview Report of Special Care Services Provided by the Health Service Executive*.

HIQA (2011a). *Health Information and Quality Authority Annual Report 2011.*

HIQA (2011b). *Summary of Findings from Census of Residential Centres for Children in Care 2010.* (unpublished).

HSE (HSE 2007). *Treatment Services for Persons who have Exhibited Sexually Harmful Behaviour.*

HSE (HSE 2008a). *HSE Equity of Care Policy*.

HSE (HSE 2009a). *Education, Training and Research: Principles and Recommendations.*

HSE (HSE 2009b). *HSE Social Work and Family Support Survey 2008.*

HSE (HSE 2009c). *Report of the Ferns 4 (Children) Working Group: Assessment, therapy and counselling needs of children who have been sexually abused, and their families.*

HSE (HSE 2010a). *Action Plan to Implement the Recommendations in the National Audit of Foster Care Services.*

HSE (HSE 2010b). *Framework for Social Work Practice Placements.*

HSE (HSE 2010c). *HSE National Service Plan 2010.*

HSE (HSE 2010d). *Induction of Social Workers: A Policy and Guidelines for Children and Families Social Services.*

HSE (HSE 2010e). *National Audit of Foster Care Services.*

HSE (HSE 2010f). *National Audit of Supported Lodgings.*

HSE (HSE 2010g). *Performance Report on NSP 2010 – December 2010.*

HSE (HSE 2010h). *Report of the Task Force for Children & Family Services: Principles and Practice.*

HSE (HSE 2011a). *HSE Annual Report and Financial Statements 2010.*

HSE (HSE 2011b). *HSE National Service Plan 2011.*

HSE/PA Consulting (2009). *Improving Confidence in Children and Families Services. Putting Children First and Meaning It – Strategic Review of the Delivery and Management of Children and Families Services*.

Mental Health Act, 2001.

Murphy, Francis D., Buckley, Helen, and Joyce, Larain. (2005). *The Ferns Report*, *presented by the Ferns Inquiry to the Minister for Health and Children.*

National Core Child Health Programme Review Group (2005). *Best Health for Children Revisited: Report from the National Core Child Health Programme Review Group to the Health Service Executive.*

National Review Panel (2011). *National Review Panel Annual Report 2010.*

Non-Fatal Offences Against the Person Act, 1997.

Office for Social Inclusion (2002). *Building an Inclusive Society.*

Office for Social Inclusion (2003). *National Action Plan Against Poverty and Social Exclusion 2003-05.*

Office of the Minister for Children and Youth Affairs (OMCYA 2007). *The Agenda for Children's Services: A Policy Handbook.* Dublin: Stationery Office.

Office of the Minister for Children and Youth Affairs (OMCYA 2008). *National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children.* Dublin: OMCYA.

Office of the Minister for Children and Youth Affairs (OMCYA 2009a). *National Policy in Relation to the Placement of Children aged 12 Years and Under in the Care or Custody of the Health Service Executive.*

Office of the Minister for Children and Youth Affairs (OMCYA 2009b). *Report of the Commission to Inquire into Child Abuse, 2009: Implementation Plan.* Dublin: OMCYA.

Office of the Minister for Children and Youth Affairs (OMCYA 2010a). *Report of the Commission to Inquire into Child Abuse 2009 Implementation Plan – First Progress Report.*

Office of the Minister for Children and Youth Affairs (OMCYA 2010b). *State of the Nation's Children.* Dublin: OMCYA.

Ofsted (2010). *Learning Lessons from Serious Case Reviews 2009-10.*

Oireachtas Library and Research Service (Oireachtas 2009). *Bills Digest: Child Care (Amendment) Bill, 2009.* Dublin: Oireachtas Library and Research Service.

Ombudsman for Children Act, 2002.

Ombudsman for Children's Office (OCO 2010). *A report based in an investigation into the implementation of Children First: National Guidelines for the Protection and Welfare of Children.* Dublin: Ombudsman for Children's Office.

Protection of Children (Hague Convention) Act, 2000.

Protections for Persons Reporting Child Abuse Act, 1998.

Refugee Act, 1996.

Roscommon Child Care Inquiry Team (2010). *Roscommon Child Care Case: Report of the Inquiry Team to the Health Service Executive.*

Ryan Report Monitoring Group (2011). *Ryan Report Implementation Plan: Second Progress Report*.

Scottish Government (2011). *Children Looked After Statistics 2009-10.*

Separated Children in Europe Programme (2009, 4th edition). *Statement of Good Practice: Separated Children in Europe Programme.* Copenhagen: Save the Children.

Statistics for Wales (2010). *Adoptions, Outcomes and Placements for Children Looked After by Local Authorities: year ending 31 March 2010.*

UN Convention on the Rights of the Child, 1989.