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Family Services Supporting Children and their Families

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This paper has been prepared by staff in the Department of Public Expenditure & Reform. The views presented in this paper are those of the author alone and do not represent the official views of the Department of Public Expenditure and Reform or the Minister for Public Expenditure and Reform.

Under *A Programme for a Partnership Government*, the Department of Public Expenditure & Reform has established a Prevention and Early Intervention Unit (PEIU). The focus of the PEIU's work is on prevention and early interventions that can improve the life outcomes of children as well as the quality of life of older people dealing within long term conditions such as chronic illness; which the PEIU is locating within the context of population health.

These types of interventions have a strong common-sense appeal; most people are familiar with the idiom that "prevention is better than cure". However, effective prevention and early interventions rely on both knowing what to do (scientific understanding of cause and effect) and being in a position to act (the capacity of the government to intervene).

The PEIU is undertaking a series of Focussed Policy Assessments on key prevention and early interventions supported by public resources. The approach is to describe each intervention by following a common structure:

- *Rationale* for the intervention;
- *Public resources* provided to support the delivery of the intervention;
- *Outputs and services* provided; and
- *Achievements* of the intervention relative to its stated goal.

As a whole, this series of descriptive reports will provide the evidential base for a thematic consideration of prevention and early interventions in Ireland.

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Introduction[1]

The family unit is a fundamental building block for society.[2] Family living is the single greatest influence on an individual's life. Families have deep and enduring effects on the well-being of individuals and society. In family relationships, continuity and stability help families meet basic emotional needs for security, belongingness, support and intimacy; these are especially important for children. Irrespective of the family structure it is in the interests of both children and their parents that children should have the opportunity of developing close relationships with both parents.[3]

Parenting is a complex and important task. Parents are the primary carers of children and young people. They can have a significant influence on their children, particularly in the early years of a child's life, and can provide the foundation for good child outcomes through their relationships and interactions with their children. The quality of interaction between a child and their parent is an important predictor of a child's normal healthy development. Children have better outcomes when parenting is sensitive, responsive, attentive and cognitively stimulating.[4]

Ireland's national policy framework for children and young people, *Better Outcomes, Brighter Futures* (2014: 26) recognises that:

> Effective parenting can provide a loving, secure home; encourage learning and healthy living; promote the child's development of social networks; and support young people in taking steps towards greater independence and engagement in the world around them.

For the most part, parents find raising children a positive and fulfilling experience and children identify a close bond with their parents and are happy in their families.[5]

However, parenting can be challenging and sometimes parents need support and advice. One of the transformational goals set out in *Better Outcomes, Brighter Futures* (2014: 26-28) is to "support parents" such that they feel more confident, informed and able to parent. In its *High-Level Statement on Supporting Parents and Families*, the Department of Children & Youth Affairs (2015: 17) has stated that parenting and family support is:

> …recognised as both a style of work and a set of activities that reinforce positive informal social networks through integrated programmes. These programmes combine statutory, voluntary, community and private services and are generally provided to families within their own homes and communities. The primary focus of these services is on early intervention aiming to promote and protect the health,

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[1] The author is grateful to colleagues in the Department of Children & Youth Affairs and Tusla for providing valuable insights and comments. The author would also like to thank staff in the National Self-Harm Registry Ireland who provided additional data.

[2] There is a diversity of family life in Ireland. While most children in Ireland live in families based on marriage there is a wide range of *de facto* families. Other types of families include children whose parents are cohabiting or whose parents are living without a partner. As such then, family may be seen in terms of the set of close personal relationships which link people together, especially but not exclusively the relationship between parents and their children. These relationships are created socially and biologically and may or may not have a formal legal status. The members of a family may or may not be living in the same household.

[3] Family Support Agency, 2013: 10-11; Commission on the Family, 1996.

[4] *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, NIH, DHHS, 2006: 23.

[5] Merriman, Greene, Doyle and McDaid, 2013; Harris, Doyle and Greene, 2011.

> wellbeing and rights of all children, young people and their families. At the same time particular attention is given to those who are vulnerable or at risk.

Under the whole-of-government strategy for babies, young children and their families, *First 5* (2018: 42), one of the objectives is that:

> Parents will benefit from high-quality, evidence-based information and services on various aspects of parenting to support child development and positive family relationships along a continuum of need.

Within the context of this objective, the Department of Children & Youth Affairs has established a Parenting Support Policy Unit. The purpose of this Unit is to provide cross government co-ordination of policy direction and activity relating to parenting support for parents of children aged between 0 and 18 years. In carrying out its work, the Department of Children & Youth Affairs states that the Parenting Support Policy Unit will work closely with Tusla, the HSE and other stakeholders to develop a national model of parenting services. Furthermore, the Department of Children & Youth Affairs has launched its *What Works* initiative. This initiative takes a coordinated approach to enhancing capacity, knowledge and quality in prevention and early intervention for children, young people and their families. The initiative is aimed at ensuring that key groups working with children, young people and their families know what works, how it works and will provide an evidence supported approach to applying this work. This initiative also offers opportunities for connections and learning across policy areas relating to the *Better Outcomes, Brighter Futures* National Outcomes for children, young people and their families.

While support and assistance can help many families that encounter challenges to make the necessary changes, on other occasions, parents are not able to provide proper care and protection for their children and more intensive assistance is required to keep children safe from harm. A national outcome under *Better Outcomes, Brighter Futures* is that children and young people are "safe and protected from harm", that is, they should have a secure, stable and caring home environment; be safe from abuse, neglect and exploitation; protected from bullying and discrimination; and be safe from crime and anti-social behaviour.[6]

In Ireland, child welfare and protection policy is based on a legal framework provided primarily by the Child Care Act 1991 (as amended) and the Children First Act 2015 with the policy and practice that apply in this area set out in *Children First – National Guidance for the Protection and Welfare of Children*. There are a number of key principles of child protection and welfare that inform both Government policy and best practice for those dealing with children, young people and their families, including:

- The safety and welfare of children is everyone's responsibility;
- The best interests of the child should be paramount;
- The overall aim in all dealings with children and their families is to intervene proportionately to support families to keep children safe from harm;
- Interventions by the State should build on existing strengths and protective factors in the family;

[6] Department of Children & Youth Affairs, 2014: 74-83.

- Early intervention is key to getting better outcomes. Where it is necessary for the State to intervene to keep children safe, the minimum intervention necessary should be used; and

- Child protection is a multiagency, multidisciplinary activity. Agencies and professionals must work together in the interests of children.[7]

The focus of this paper is on the work of Ireland's National Child and Family Agency, Tusla, in supporting children and their families.[8] While support for children and their families is a whole of government effort (many aspects of public policy impact on parenting, such as healthcare, education, housing provision, employment law and social protection) involving both public service agencies and community and voluntary organisations, under the Child and Family Act 2013, Tusla has statutory responsibility for supporting and promoting the development, welfare and protection of children as well as the effective functioning of families. Tusla also has responsibility for offering care and protection for children where parents have not been able to (or are unlikely to) provide the care that a child needs.[9]

Another of the transformational goals set out in *Better Outcomes, Brighter Futures* (2014: 29-30) is "earlier intervention and prevention" in a way that addresses "the early indicators of developing problems and to support a trajectory to more positive outcomes, with a focus on breaking intergenerational disadvantage". In terms of achieving this goal, Tusla is committed to:

> Provide and commission both universal and targeted evidence-informed parenting supports and ensure early identification of 'at risk' children and families to strengthen families and reduce the incidences of children coming into, and remaining in, care.[10]

The *Parenting Support Strategy* (2013) has developed and expanded parenting supports to provide universal access to good-quality parenting advice and programmes as well as targeted supports to those parents with greatest needs. Tusla's prevention and early interventions in family support are intended to offer advice and support that address the needs of families and, where necessary, to work in partnership with families and professionals to identify and respond quickly to the needs of children. Tusla states that:

> Integrated, high-quality services to children and families must be provided at the earliest opportunity across all levels of need. These services are delivered on the basis of low, medium or high prevention.[11]

This approach is evident in how the Department of Children & Youth Affairs (2017: 60-61) has described the "pathways" along which a child welfare or protection concern is dealt with by Tusla. This paper focuses on the first two pathways as they correspond to low and medium prevention. (The other pathways and high prevention are summarised in Appendix A.)

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[7] Department of Children & Youth Affairs, 2017: 2-3.
[8] While this report is primarily focussed on the work of Tusla in supporting children and their families, it should be noted that the HSE also funds or co-funds with Tusla a number of family support services.
[9] As the statutory body with responsibility for child protection and welfare in Ireland, Tusla operates within extensive domestic and international legislation including: The Child Care Act 1991; The Child and Family Agency Act 2013; The Children's First Act 2015; The Education (Welfare) Act 2000; Adoption Act 2010; Adoption (Amendment) Act 2017; The Adoption (Information and Tracing) Bill 2016; as well as Aftercare legislation, domestic violence legislation and UN Convention on the Rights of the Child.
[10] Department of Children & Youth Affairs, 2014: 127.
[11] Tusla, Undated 1 and 2.

As with the other papers in this series, the basic structure of this paper is one that examines the rationale for public policy intervention, the public resources provided, the services delivered and the results achieved. This paper is one of a series of descriptive reports that taken together will inform a thematic consideration of prevention and early interventions in Ireland.[12]

The rationale for policy in this area centres on the family context within which children live. These contexts and the challenges children face are shaped by a wide and complex range of factors. One way of understanding the factors that shape the context of family life for some children in Ireland is in terms of adverse childhood experiences (or childhood trauma). Research in this area has focused on a set of experiences that includes emotional abuse, physical abuse, sexual abuse, neglect, mental illness, parental illness and disability, parental divorce or separation and poverty. This work not only provides a way of understanding the problematic context within which some children are living it also raises awareness of the potential consequences that these experiences may have for them in later life and creates a common language between early years practitioners working in different sectors.[13]

In order to set out an overall context of adverse childhood experiences in Ireland, this paper draws on a broad range of metrics that seek to describe the context in which some children are living, a context that is shaped by experiences of adversity. It should be noted that these are not measures of prevalence (how common something is in a given population at a given point in time). At best they are measures of incidence (the number of new cases emerging over a given time period) but in many cases they are proxies for what is happening in Irish families and society.

The paper then focuses more specifically on Tusla - the Child and Family Agency and the services that it provides in support of children and their families. The first part of this consideration focuses on the public resources that have been provided. Expenditure on both Prevention, Partnership and Family Support services and grants to Family Resource Centres have increased more or less in line with overall expenditure by Tusla; account for an average of 6% of overall expenditure by Tusla. (See Table 1.) This expenditure is within a broader context of more than half of Tusla's expenditure being allocated to services that seek to address the consequences of problems within families (e.g. children in care, child welfare and protection).

Tusla supports the provision of a range of services that offer advice and support that address the needs of children and their families. It works in partnership with families, other agencies and professionals to identify the needs of children at the earliest opportunity and to respond quickly. Through its *Prevention, Partnership and Family Support* programme, Tusla is seeking to embed prevention and early intervention into its culture and operations by making all services more preventative, integrated, evidence informed and participatory. Key elements of this programme include Meitheal, Child & Family Support Networks for multidisciplinary and interagency support for children and families, the publication of Tusla's *Child and Youth Participation Strategy* and the incorporation of the *Area Based Childhood Programme* within the organisation. Tusla also supports the provision of a range of services through its funding of Family Resource Centres and the community and voluntary sector.

[12] In drafting this report, the author only considered publically available information and did not have access to any considerations that might be underway as to how the programmes considered could be developed. As noted this report is part of a series of reports that taken together will inform a thematic consideration of prevention and early interventions in Ireland. As such, within this overall approach the individual reports are not evaluations of the programmes considered and do not seek to arrive at any conclusions or make any recommendations.

[13] Science and Technology Committee, 2018: 13.

The complexity of policy in this area presents a particular challenge for any effort to describe goals and achievements. The policy interventions are not only focussed on children but are also concerned with their parents or carers and the family group within which they live and interact. The needs of children and their parents are shaped by household characteristics and by the area within which they live. Promoting the well-being of children and their families is a cross-government responsibility that requires collaboration between the various departments, agencies, community and voluntary organisations as well as with the individual families themselves (e.g. health, education, early learning, housing, social supports and so on).[14]

There is a recognition that the purpose of services is to meet the needs of children and their families and that services are valuable only if their outcome improves the well-being for children and families.[15] Furthermore there is a recognition that in order to know if an intervention is working it is necessary to monitor and evaluate its performance.[16]

As noted above, a variety of policy and strategic documents set out overall goals of policy in this area. How effectively policy in this area can achieve its intended outcomes is shaped by the layers of personal, household and societal influences that envelope parents and children. The complexity of the policy area and the diversity of challenges that children and their families face means that a specific focus is required to articulate policy goals in ways that are amenable to measuring the impact of services on the lives of children and their families.

Rationale

Family living is the single greatest influence on an individual's life and has deep and enduring effects on the well-being of individuals and society. Parents are the primary carers of children and young people and can have a significant influence on their children; providing the foundation for good child outcomes through their relationships and interactions with their children.

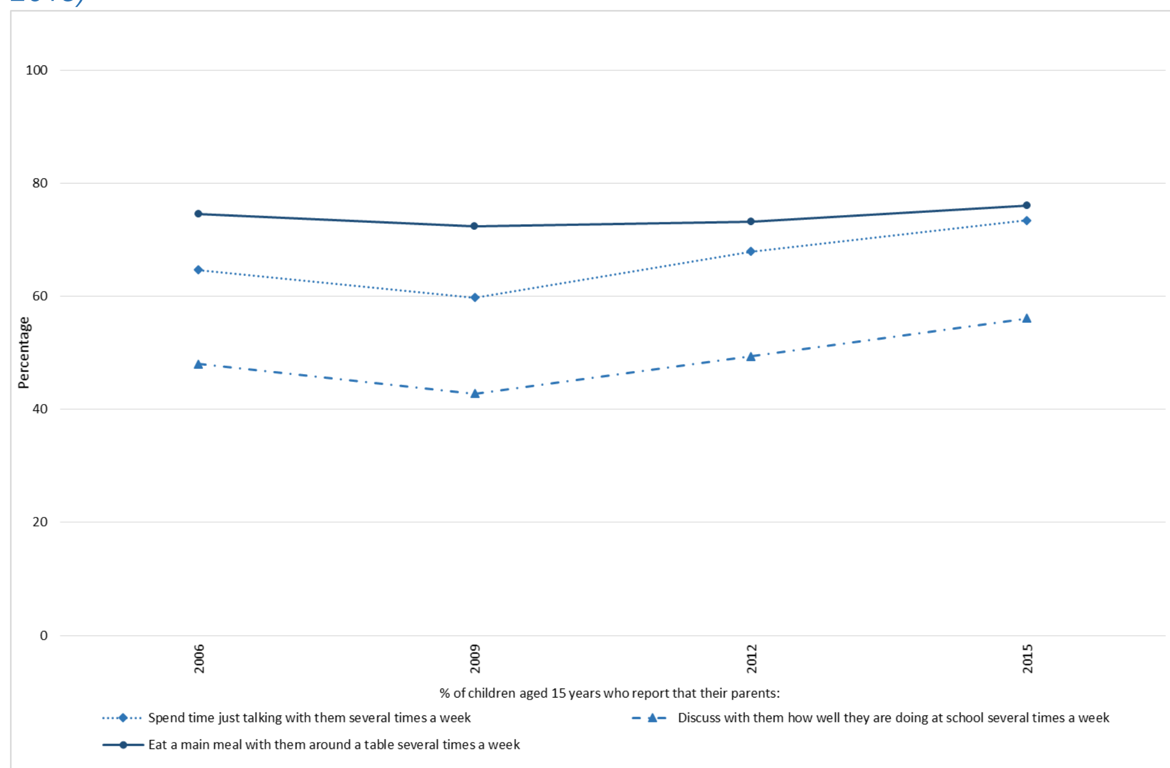
In family relationships, continuity and stability help families meet basic emotional needs for security, belongingness, support and intimacy. The quality of interaction between a child and their parent is an important predictor of a child's normal healthy development. Evidence from *Growing Up in Ireland* has shown the importance for child well-being of parent-child relationships and maternal well-being.[17]

Within many Irish families there is evidence to suggest that young people have open and supportive relationships with their parents. In terms of general engagement, about three-quarters of 15 year olds report that they talk with their parents and have a main meal with them several times a week. (See Figure 1.) It is worth noting that there has been a notable increase of parents "just talking" with their teenagers (by almost 9 percentage points).

The strength of parent-child relationships within families is also evident in the young people's (children aged 10-17 years) willingness to turn to either their mothers or fathers if something is bothering them. (See Figure 2.) While young people are more likely to turn to their mothers than their fathers when something is bothering them, there is an increasing willingness amongst young people to turn to their fathers (increased by 14 percentage points).

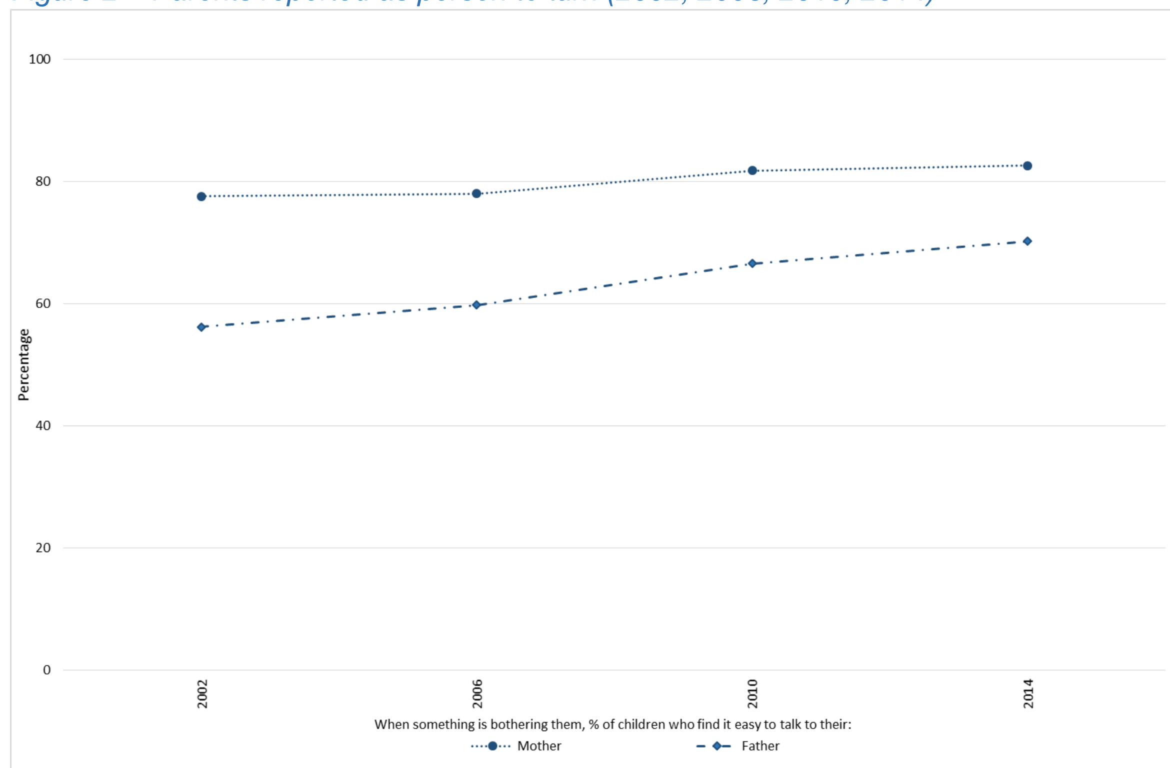
[14] Family Support Agency, 2013; Center on the Developing Child, 2017.
[15] Family Support Agency, 2013: 24.
[16] Family Support Agency, 2013: 42-44.
[17] Nixon, 2012; Pratchke, Haase and McKeown, 2011

Figure 1 – Parental Engagement as reported by their 15 year old children (2006, 2009, 2012, 2015)



Source: Various PISA Surveys (reprinted in *State of the Nation's Children 2016*: 47, 49 and 51)

Figure 2 – Parents reported as person to turn (2002, 2006, 2010, 2014)



Source: Various HBSC Surveys (reprinted in *State of the Nation's Children 2016*: 39 and 43)

While the overall context is generally positive, especially in terms of the improving levels of engagement, there remains a sizeable proportion of young people for whom there are weak levels of parental engagement, especially with regard to their progress at school. Furthermore, large proportions of young people do not feel that they have parental resources that they can turn to in times of difficulty or challenge.

Parenting is an important but complex role. Sometimes parents need support and advice. The ways in which public policy can offer support to children and their families depends on the degree of the challenge that a family faces. In some cases a child or young person might have needs that require some additional support without which they would be at risk of not reaching their full potential (e.g. health, social, educational issues). In such cases, interventions might focus on strengthening developmental opportunities for the child and family rather than on specific problems.

Sometimes parents face problems that hinder their ability to parent effectively (e.g. poverty, relationship problems with partner or children, addiction). In these cases, support for children and their families may aim to support the parents in their parenting role by addressing the factors that are undermining both their own and their children's well-being and improving the family's capacity to provide a nurturing environment.

However, in other cases a child or young person may be at risk of harm and require specialist assessment from a collaboration of experienced professionals. In such cases, the family support falls within the remit of the child protection system and the aim is to protect the child from an immediate risk of harm or reoccurrence of an incident and may involve removing them from their parents / carers.

Over the last few decades, increased attention has been given to the impact of adverse childhood experiences on child development and a broad range of outcomes in adulthood.[18] Research on people's experience of adversity in childhood provides a way of understanding the problematic context within which some children are living.[19] Furthermore, research in this area has focused attention on the consequences that these experiences may have on the longer-term development and future prospects of the child; the 'causes of the causes' (Marmot, 2018).

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[18] The term *battered child syndrome* was coined in the early 1960s to characterize the clinical manifestations of serious physical abuse in young children. The publication of Kempe et al.'s (1962) seminal study contributed to more widespread attention being given to issues around children's well-being and protection by both the medical profession and the general public. In the late 1990s, the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic undertook the Adverse Childhood Experiences (ACE) Study. The purpose of this study was to describe the long-term impact of abuse and household dysfunction during childhood on adult disease risk factors and incidence, quality of life, health care utilisation and mortality. (Felitti, Anda and Nordenberg, 1998.) There is evidence that adverse experiences in childhood are associated with a broad range of emotional, behavioural and physical health problems. The ACE Study has demonstrated that what happens in childhood commonly lasts throughout life: "time does not heal; time conceals". (Felitti, 2009)

[19] In general terms, adversity can be defined as a lack of positive circumstances or opportunities, which may be brought about partially by physical, mental or social losses, or by experiencing deprivation or distress. The types of experiences that encompass 'adverse childhood experiences' include emotional abuse; physical abuse; sexual abuse; neglect; mental illness; parental illness and disability; parental divorce or separation; and poverty. (See: Science and Technology Committee, 2018; Felitti et al., 1998; Runyan et al, 2002; Spratt, 2011; Hildon, Smith, Netuveli and Blane, 2008; Sun and Li, 2009; Frisco, Muller and Frank, 2007; Amato, 2001.; Rhoades, 2008; Kushner, 2009; Booth and Amato, 2001.)

Spratt et al (2019) have posited that while the evidence relating to the impact of adversity in childhood on outcomes in adulthood is important:

> …it is the simplicity of the ACE concepts that have proved persuasive. The idea that when bad things happen to us this increases the probability of detrimental effects, which are beyond the immediate, reflects common experience. The notion that the more bad things that happen, so we experience reduction in our ability to resist their effects and so increases probability of undesired outcomes, feels intuitively right.[20]

In terms of the degree to which adversity impacts on a child, the research suggests that this can vary from child-to-child[21] and depends on a combination of factors including the:

- Child's age and development status (including the child's innate resilience[22]) when the abuse or neglect occurred;
- Type of abuse or neglect and its occurrence with other forms of maltreatment and household dysfunction;
- Frequency, duration and severity of the abuse or neglect; and
- Relationship between the child and the perpetrator.[23]

In particular, the evidence indicates that there is a strong relationship between the number of adverse experiences in childhood and short, medium and long-term outcomes.[24] The ACE study noted:

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[20] Spratt, Devaney and Frederick, 2019.

[21] While there are correlations between experiencing adversity in childhood and negative outcomes in later life, especially in terms of health harming behaviours (e.g. smoking, excessive alcohol consumption), the majority of individuals who have suffered four or more ACEs do not engage in each of these behaviours and people who have not experienced any ACES do engage in these behaviours.

[22] Morgan et al. (2016) have noted that having to deal with adversity is not always detrimental to the person. The experience of having to cope with low levels of adversity can enable people to deal with later difficulties, "resilience". Resilience is not an inherent trait but is perhaps best understood as an interaction between psychological processes and ecological influences - it is both nature and nurture. (Masten, 2001; Harrop, Addis, Elliott and Williams, 2006) Resilience results from a mixture of both protective and risk factors and ranges on a continuum from "basic survival" to "flourishing resilience". (Palmer, 1997) Protective factors work to buffer an individual from the likelihood of negative effects of a particular problem and include positive attachment, self-esteem, intelligence, emotion regulation, humour and independence. (Shonkoff and Garner, 2012; Child Welfare Information Gateway, 2013) The relationship between the child and their primary caregiver can provide the foundation for resilience. In early childhood, stable and responsive relationships can help protect children from the potential harm associated with adverse childhood experiences. Responsive relationships early in life are the most important factor in building sturdy brain architecture (i.e., the adult responding with eye contact, words or hugs to an infant or young child's babbles or gestures). (Parrott, Jacobs and Roberts, 2008; Center on the Developing Child, 2017; Ainsworth, Blehar, Waters and Wall, 1978.) Children who "do well" despite having encountered adverse experiences have usually had at least one stable committed relationship with a supportive parent, caregiver or other adult. This relationship with a significant adult is seen in terms of helping buffer the child from development disruption and building skills such as the ability to monitor and regulate behaviour and adapt to changing circumstances. (National Scientific Council on the Developing Child, 2015; Center on the Developing Child, 2017)

[23] Centers for Disease Control and Prevention, 2008; Chalk, Gibbons and Scarupa, 2002; Caspi, McClay, Moffitt et al., 2002; Child Welfare Information Gateway, 2013; Morgan et al., 2016.

[24] Spratt, 2011. In the UK, research has found that people who experienced four or more adverse childhood experiences when compared with those have no such experience are more likely to have: poor educational and employment outcomes; poor health (including chronic or serious health

> …the impact of these adverse childhood experiences on adult health status is strong and cumulative.[25]

There is a substantial risk that experience of one adverse event will be associated with multiple adverse childhood experiences.[26] For instance, it is not difficult to imagine how a parent's abuse of alcohol may result in family conflict, which in turn may result in separation or divorce, and contribute to a reduction in family income and an unstable home environment for one or both parents.[27]

While the number of adverse experiences is a relevant factor, the number of adversities experienced by a child **should not be** aggregated to determine a 'score'. Individual adverse childhood experiences should not be reduced to a 'type'. Any form of abuse encompasses a wide range of incidents and experiences as well as different relationships between the child and the perpetrator, durations, impacts on the individual and contexts in which the abuse took place.[28]

Evidence of Adversity in Childhood in Ireland

In Ireland, the results of the *Irish Longitudinal Study on Ageing* (TILDA) have provided support of the 'lasting legacy' of childhood adversity for disease risk in later life. The results have shown that the experience of adversity in childhood (physical abuse, sexual abuse and parental alcohol/drug abuse) is associated with significant increased risk in later life of cardiovascular disease, lung disease, asthma and psychiatric disorders. Furthermore, there was a stronger association between childhood adversity and diseases related to stress response (i.e., cardiovascular disease and psychiatric disorders) than there was for other diseases (i.e. cancer and diabetes).[29]

Studies of illicit drug use have found high percentages of childhood trauma (emotional, sexual and physical abuse) in drug dependent clients.[30] An Irish study of those with an Opioid Use Disorder (OUD) found that childhood adversity was a common occurrence across interviewees. Amongst those who participated in the study, there were reports of both physical and verbal abuse (in particular, paternal physical abuse), alcoholism (often coupled with reports of domestic violence), parental separation, a family member in prison, mental illness and bullying outside the home. Most of those who participated in the study reported exposure to a culture of illicit drug use from a very young age. The study notes that amongst this cohort misfortune and difficulties continued to permeate their lives from childhood onwards and their inability to cope with the associated stress resulted in the commencement and continued use of heroin.[31]

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conditions, earlier development of illness and recent inpatient hospital care as well as being more likely to smoke, drink heavily and be morbidly obese); become a parent under the age of 18 years; low mental well-being and life satisfaction; and engaged in criminal behaviour (such as recent violent involvement and been sentenced to prison). (Bellis et al., 2014; UCL Institute of Health Equity, 2015.)

[25] Felitti et al., 1998: 251.
[26] Bromfield, Gillingham and Higgins, 2007; McGavock, and Spratt, 2017; Dong, Anda, Felitti, et al., 2004.
[27] Gadalla, 2008; Mahon and Moore, 2011.
[28] Science and Technology Committee, 2018:12
[29] McCrory, Dooley, Layte and Kenny, 2015.
[30] Dube, Felitti and Dong, 2003.
[31] Moran et al., 2018.

This section draws on a broad range of metrics to set out an overall context of adverse childhood experiences in Ireland. However, it should be noted that these are not measures of prevalence (how common something is in a given population at a given point in time).

It can be difficult to establish the prevalence of adverse childhood experiences in society.[32] Given the nature of the policy problem associated with adverse childhood experiences, studies of prevalence tend to rely on recall or an examination of children's histories.[33] At best, the data presented here are measures of incidence (the number of new cases emerging over a given time period) but in many cases they are proxies for what is happening in Irish society.

Essentially, the data presented here is seeking to describe the context in which some child are living, a context that is shaped by experiences of adversity. This section begins by looking at a measure of prevalence as operationalised in *Growing Up in Ireland* (i.e., mothers / primary caregivers were asked about whether or not the study child had experienced one or more specified "stressful life events"). The paper then focuses on an initial set of metrics that are associated with children and young people having direct experience of adversity. In particular, this focuses on the number of children about whom a child welfare and protection referral was made to Tusla or the child was taken into care. This section also sets out data relating to how some of these concerns can have a very direct impacts on the lives of children and young people (i.e., leading to injury or mortality). The next set of metrics provide some understanding of the challenging context in which children live (i.e., breakdown of parental relationships, substance abuse, domestic violence, poverty, homelessness, unauthorised halting sites). The final set of metrics reflect ways in which experience of adversity in childhood may become evident through the behaviour of young people (i.e. health risk behaviours, sexual behaviours, self-harm and suicide).[34]

[32] It is likely that only a small percentage of adverse experiences are reported as many of the behaviours contributing to these adverse experiences are secreted behind front-doors. Children who experience "hidden harm" have not been formally referred to child welfare services and are at risk of suffering harm in a number of ways as a result of compromised parenting (e.g. parental problem alcohol and other drug use) which can impede the child's social, physical and emotional development. In 2019, Tusla and the HSE published *Hidden Harm Strategic Statement - Seeing Through Hidden Harm to Brighter Futures*. There is a risk that the potential to intervene early to assist the child or young person is not availed of because of the focus on treating the parent. The *Hidden Harm Strategic Statement* is a recognition by Tusla and the HSE of the need to conjointly respond and 'assist together' these children and their families so that parents with alcohol and other drug problems are helped and children, and families are supported. The *Hidden Harm Strategic Statement* sets out the commitment and role of Tusla and the HSE to address the sensitive and emotive issue of parental problem alcohol and other drug use in order to improve outcomes for children and families and how it is intended to bridge the gap between adult and children's services in favour of a more family-focused approach that considers the needs of dependent children and other family members. (See: Russell, 2006; Advisory Council on the Misuse of Drugs, 2003; McGee et al. 2002; Watson and Parsons, 2005; *Task Force on Violence Against Women*, 1997; Hennessey, 2004.)

[33] Felitti, 2009; Centers for Disease Control and Prevention, 2008: 1; Zellman, and Faller, 1996; MacMillan, Jamieson and Walsh, 2003; Everson et al., 2008.

[34] The ACE study placed a particular emphasis on how adverse childhood experiences can lead to behaviours that have negative consequences for a person's health in later life. It posits that these behaviours may initially have been adopted as part of a coping mechanism for dealing with adverse experiences. See: Child Welfare Information Gateway, 2013: 4-6; Gold, Wolan Sullivan and Lewis, 2011; Felitti and Anda, 2010; Centers for Disease Control and Prevention, 2008: 2. Putnam, 2003; Chapman, Whitfield, Felitti et al., 2004; Dube, Anda, Felitti et al., 2002.; Anda, Chapman, Felitti et al., 2002.

Prevalence

Growing Up in Ireland

When *Growing Up in Ireland* focussed on the lives of 9-year olds, the mother of the Study Child was asked to report which events, if any, from a fixed list of “stressful life events”[35], her child had experienced.[36] The study has reported that just over 78% of 9 year olds had experienced some form of stressful life event:

- 34% of 9-year olds had experienced just one event,
- 36% had experienced two or three events and
- 9% had experienced four or more events.[37]

When *Growing Up in Ireland* focussed on the lives of children aged 13 years, the primary caregiver was asked to record if the Study Child had experienced any of a fixed list of stressful life events since the time of the interview when he or she was 9 years of age.[38] The study recorded that 64% of 13 year olds as having experienced at least one stressful event over the previous four years:

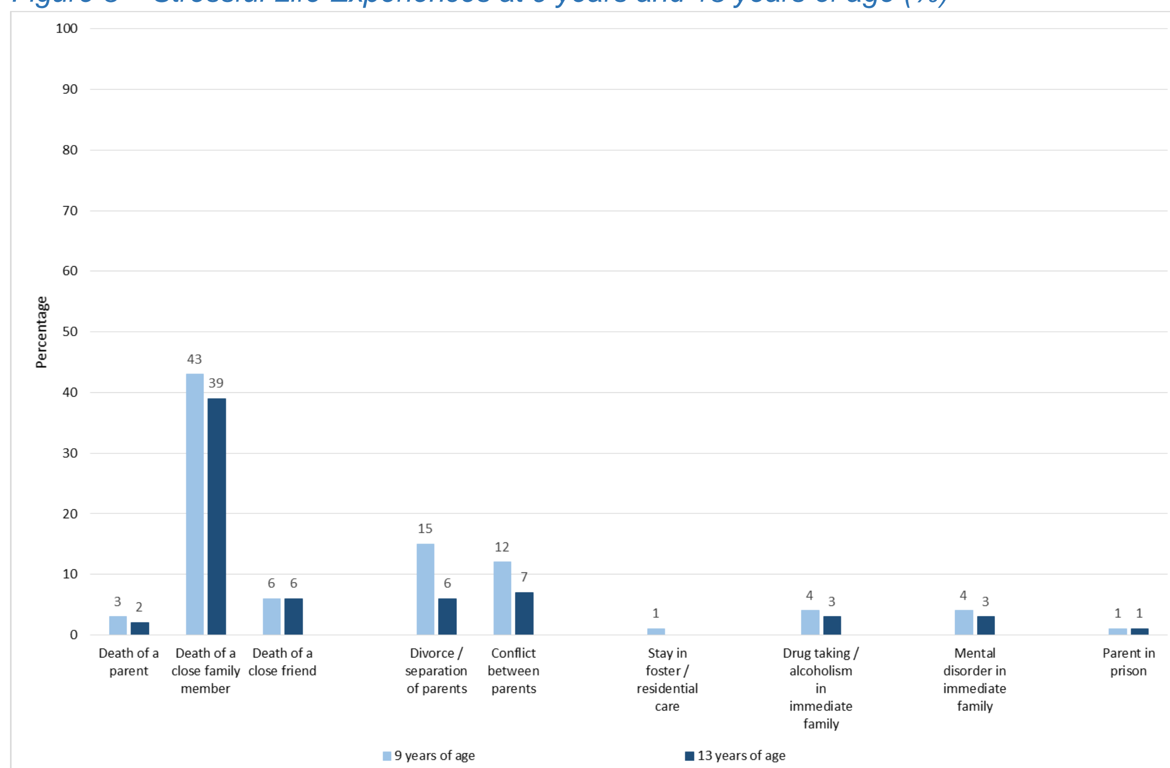
- 15% of Study Children had experienced two of the stressful events with
- 8% experiencing three or more such events.[39]

Figure 3 focuses on those “stressful life experiences” that are similar to adverse childhood experiences. The death of a close family member had been experienced by about 4-in-10 children aged nine years and younger and by children in the aged 9 – 13 years. It is also evident that the percentages of children experiencing substance abuse, mental health disorders and a parent in prison are more or less the same in the child’s first nine years as they are over the next four years. The one notable difference is with regard to difficulties within their parents’ relationship. It would seem that relationship difficulties are almost twice as likely to become manifest in the first nine years of a child’s life than in the next four years.

The *Growing Up in Ireland* (2009: 83 and 2018: 149) study has found that children who experienced one or more stressful life events were more likely to experience heightened socio-emotional and behaviour difficulties compared to those who had experienced none. Furthermore, children who had experienced three (four) or more stressful life events had substantially heightened difficulties.

[35] The *Growing Up in Ireland* study refers to “stressful life events” rather than “adverse childhood experiences”.
[36] Williams et al., 2009.
[37] Williams et al., 2009: 81-82.
[38] Williams et al., 2018.
[39] Williams et al., 2018: 149.

Figure 3 – Stressful Life Experiences at 9 years and 13 years of age (%)



Source: (a) 9 years of age – Williams et al., 2009: 82; (b) 13 years of age – Williams et al., 2018: 149.

Indicators Associated with Direct Experience of Adversity

Child Welfare Referrals

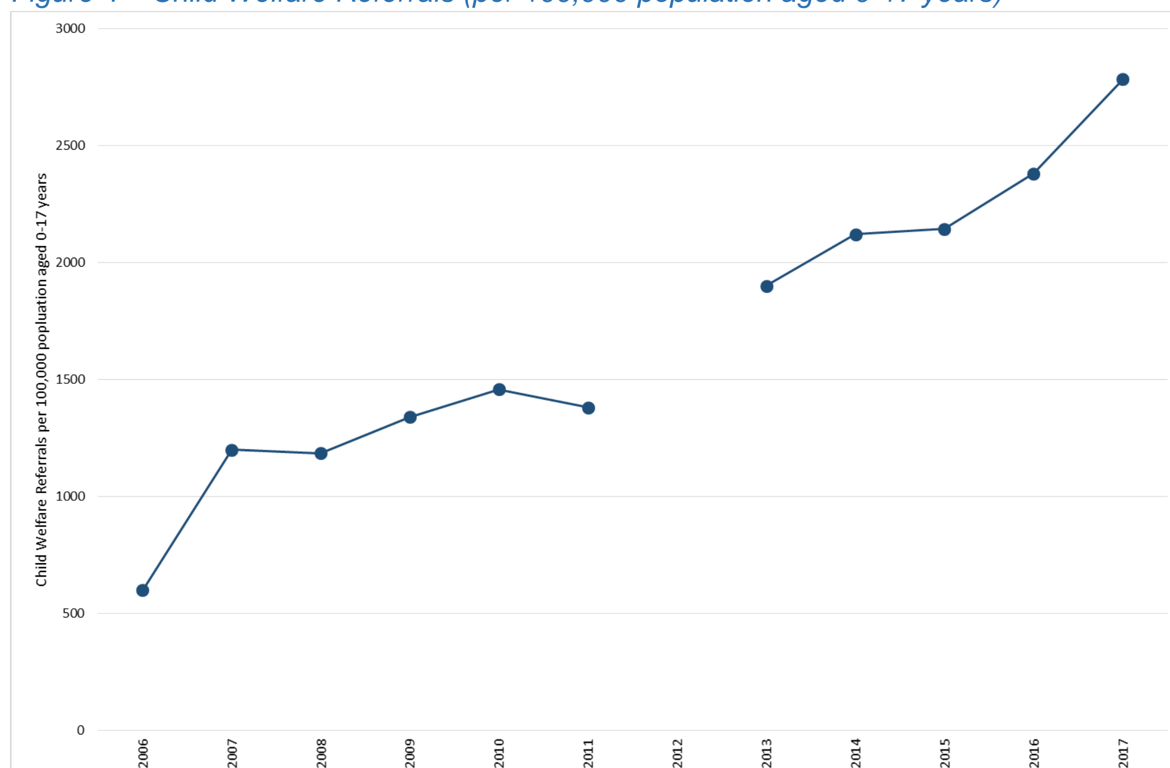
A referral to Tusla is a notification of concern about a child and can be made by anyone who has concerns about the welfare or safety of a child.

A child welfare referral may be because of concerns relating to a problem experienced directly by a child, or by a family of a child, that is seen to impact negatively on the child's health, development and welfare.

The number of child welfare referrals has increased from just over 22,190 children in 2013 to almost 33,220 children in 2017 (+50%).

Figure 4 sets out the number of child welfare referrals taking account of changes in the population size. When changes in the population are taken into account, the number of referrals per 100,000 children aged 0-17 years has increased from just over 1,900 children in 2013 to 2,785 children in 2017 (+46%).

Figure 4 – Child Welfare Referrals (per 100,000 population aged 0-17 years)



Source: Author's calculations based on data from (a) 2006-2015 – Department of Children & Youth Affairs. Various. *State of Nation's Children*; (b) 2016 – Tusla. 2018. *Annual Review of Adequacy of Child Care and Family Support Services Available 2016*; (c) 2017 - Tusla. 2018. *Quarterly Performance and Activity Data Q2 2018* and standardised using Central Statistics Office population estimates for each year by age cohorts.
Note: Data prior to 2012 cannot be used for comparative purposes. From 2012 onwards all areas were operating under the standardised business process for the National Child Care Information System (NCCIS). Prior to 2012, some areas returned a child as a referral and some returned a family (multiple children counted as one).

Child Protection Referrals[40]

There are reasonable grounds for believing that a child may have been, is being or is at risk of being physically, sexually or emotionally abused or neglected.[41]

In 2017, emotional abuse accounted for 7,615 child protection referrals with physical abuse accounting for 4,942 referrals, neglect accounting for 4,810 referrals and sexual abuse 3,170 referrals.

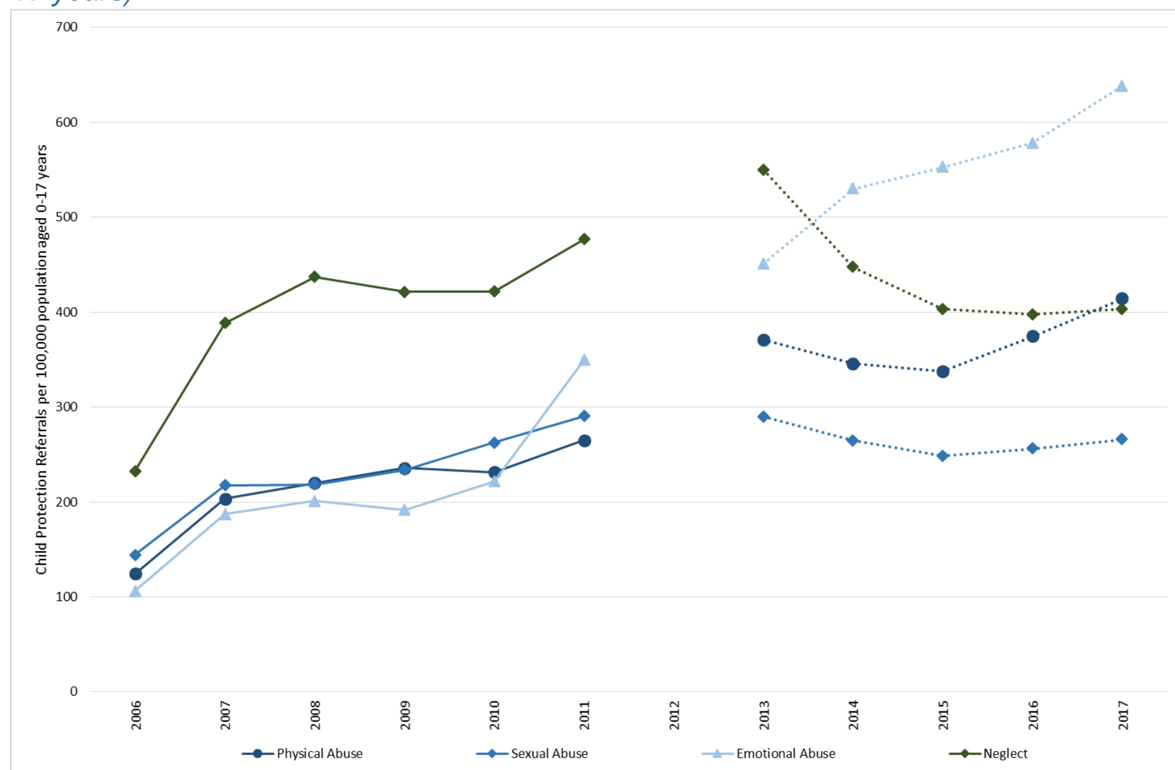
Between 2013 and 2017, emotional abuse accounted for 34% of child protection referrals with neglect accounting for 27% of referrals, physical abuse accounting for 23% and sexual abuse 16%.

[40] These kinds of referrals can be made by any person under the Children First Act 2015 and certain categories of professionals are now "mandated reporters".
[41] The number of child protection referrals has increased from 19,407 in 2013 to 20,537 in 2017 (+6%). When account is taken of change in the size of the number of children aged 0-17 years, the number of child protection referrals has increased from 1,662 referrals per 100,00 children aged 0-17 years in 2013 to 1,722 referrals per 100,000 children aged 0-17 years in 2017 (+4%).

Figure 5 sets out the number of child protection referrals taking account of changes in the population size. When changes in the population are taken into account, between 2013 and 2017, the number of referrals per 100,000 children aged 0-17 years for:

- Emotional abuse increased from 451 children to 638 children (+41%);
- Physical abuse increased from 371 children to 414 children (+12%); while
- Sexual abuse decreased from 290 children to 266 children (-8%); and
- Neglect decreased from 550 children to 403 children (-27%).

Figure 5 – Child Protection Referrals by Category of Abuse (per 100,000 population aged 0-17 years)



Source: (a) 2006-2015 – Department of Children & Youth Affairs. Various. *State of Nation's Children*; (b) 2016 – Tusla. 2018. *Annual Review of Adequacy of Child Care and Family Support Services Available 2016*; (c) 2017 - Tusla. 2018. *Quarterly Performance and Activity Data Q2 2018* and standardised using Central Statistics Office population estimates for each year by age cohorts. *Note*: Data prior to 2012 cannot be used for comparative purposes. From 2012 onwards all areas were operating under the standardised business process for the National Child Care Information System (NCCIS). Prior to 2012, some areas returned a child as a referral and some returned a family (multiple children counted as one).

Children in Care

Alternative Care refers to State provision of care for children who cannot remain in the care of their parents.

At end-2017, there were 6,190 children in care in Ireland; having peaked at almost 6,470 in 2013. Compared to the position over a decade ago, there are more children in care:

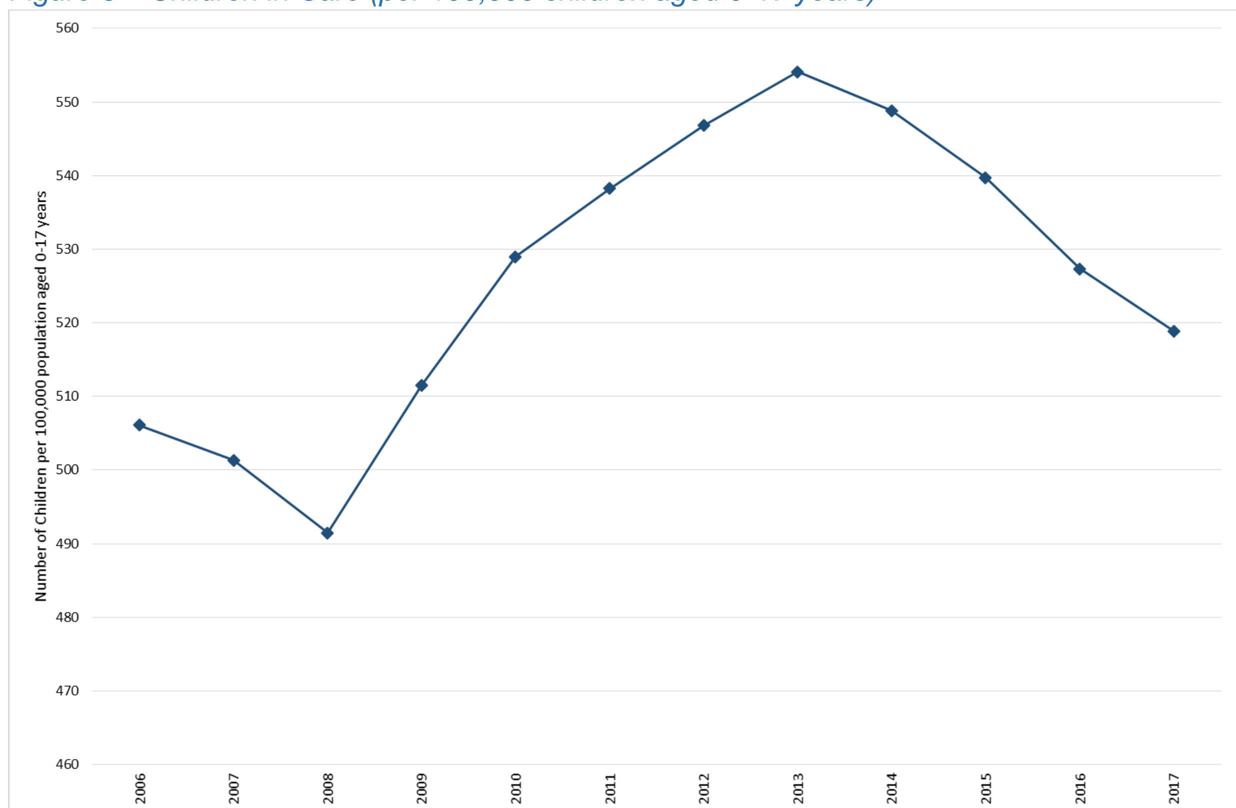
- an average of just over 5,300 children in 2006-08 and

- an average of 6,280 children in 2015-17 (+18%).

Figure 6 sets out the number of children in care taking account of changes in the population size. When changes in the population are taken into account, the trend increased from:

- an average of 500 children per 100,000 children aged 0-17 years in 2006-08 to
- an average of 550 children per 100,000 children aged 0-17 years in 2012-14 (+10%), but decreased to
- an average of 529 children per 100,000 children aged 0-17 years in 2015-17 (-4% relative to 2012-14 but +6% compared with 2006-08).

Figure 6 – Children in Care (per 100,000 children aged 0-17 years)



Source: Author's calculation based on data taken from (a) 2006-2016 – Tusla. 2018. *Annual Review of Adequacy of Child Care and Family Support Services Available 2016*; (b) 2017 - Tusla. 2018. *Quarterly Performance and Activity Data Q2 2018* and standardised using Central Statistics Office population estimates for each year by age cohorts.

External Injuries

Hospital discharges can record up to 20 diagnoses. The focus here is on discharges where the cause of an external injury was either an assault or is not clearly stated.

In 2015, 175 discharges of children aged 17 years or younger from hospital were for external injuries associated with assault.

The number of injuries to children from assault has decreased from an average of 312 discharges in 2005-07 to 186 discharges in 2013-15 (-40%).

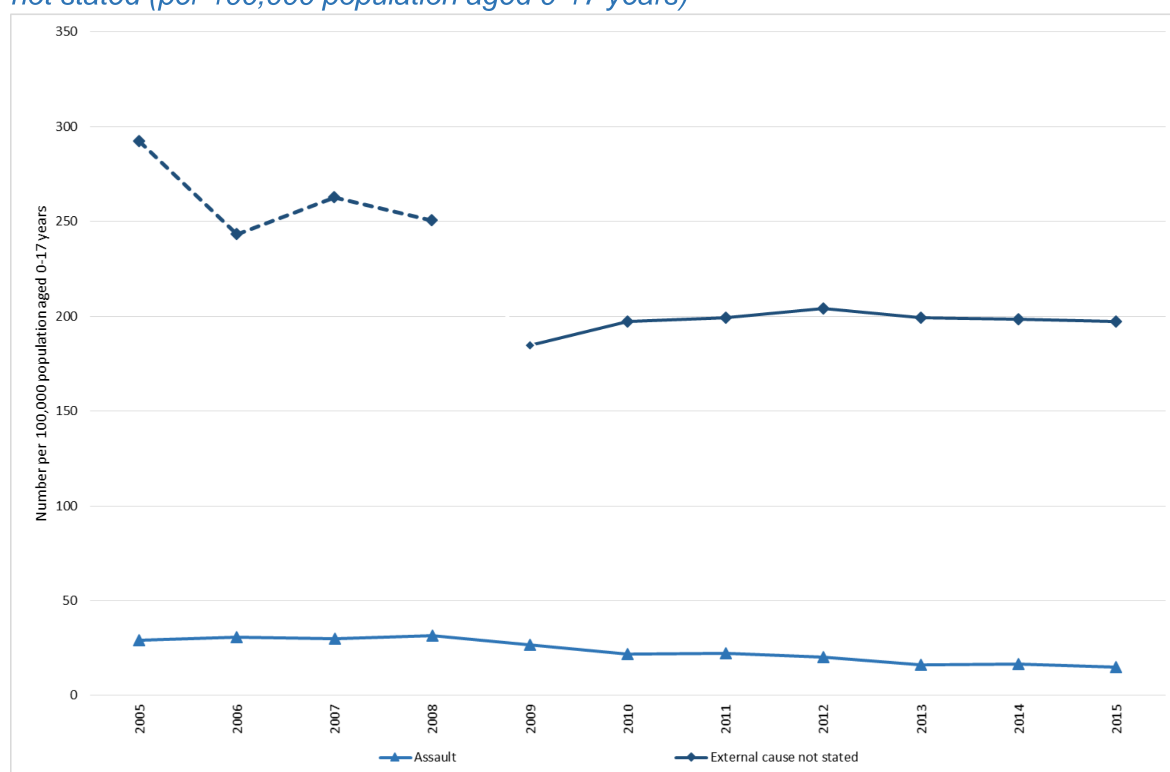
Figure 7 takes account of changes in the size of the population. The average number of discharges associated with assault per 100,000 children aged 0-17 years has decreased from 30 discharges in 2005-07 to 16 discharges in 2013-15 (-47%).

As adverse childhood experiences of this nature are likely to be "hidden", it is also illustrative to note the number of discharges from hospital where the diagnosis does not state the external cause. In 2015, 2,334 discharges of children from hospital did not state the external cause of the injury.

The number of injuries to children from unstated external causes has increased from an average of 2,184 discharges in 2009-11 to 2,331 discharges in 2013-15 (+7%).

The average number of discharges associated with unstated external causes per 100,000 children aged 0-17 years has remained relatively unchanged: from 194 discharges in 2009-11 to 198 discharges in 2013-15 (+2%).

Figure 7 – Hospital Discharges – Cases in which principal diagnosis was either Assault or not stated (per 100,000 population aged 0-17 years)



Source: Author's calculations based on data from Hospital In-Patient Enquiry presented in Department of Children & Youth Affairs. Various. *State of the Nation's Children* standardised using Central Statistics Office population estimates for each year by age cohorts.
Note (1): 'External cause not stated' includes cases where the first-listed external cause was either 'accident, not otherwise specified', 'event of undetermined intent', 'other external causes of injury' or 'external cause not reported'.
Note (2): There is a break in the data series between 2008 and 2009 due to a reclassification of some cases from 'other external causes of injury' to 'accidents caused by objects'.

Child Mortalities

The most serious consequence of child abuse or maltreatment is that which results in the death of a child or young person.

The World Health Organization has published data that indicates that in Ireland 58 children have died as a result of assault between 1979 and 2014. Of these children, at the time of their deaths, eight were younger than one year, 21 were aged between 1 and 4 years and 29 were aged between 5 and 14 years.[42]

The *Report of the Independent Child Death Review Group* examined the deaths of 196 children that occurred during the period 1 January 2000 to 30 April 2010. At the time of their deaths, these children were either:

- In care within the meaning of the Child Care Act 1991 – there were 36 deaths in total, of which 17 were from non-natural causes;
- In receipt of aftercare within the meaning of Section 45 of the Child Care Act 1991 – there were 32 deaths in total, of which 27 were from non-natural causes; or
- Known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January 2010 – there were 128 deaths in total, of which 68 were from non-natural causes.[43]

Of the 68 children who were known to the HSE who died of non-natural causes, 25% were aged 3 years or younger, 22% were aged 4-12 years and just over half (53%) were aged 13-19 years.[44]

Of the 68 cases, the non-natural causes of death most associated with adverse childhood experiences were[45]:

- suicide - 16 cases (24%);
- unlawful killing - 13 cases (19%);
- drug related - 11 cases (16%);
- due to head injuries (cause unknown) - 2 cases (3%); and
- unknown cause - 2 cases (3%).[46]

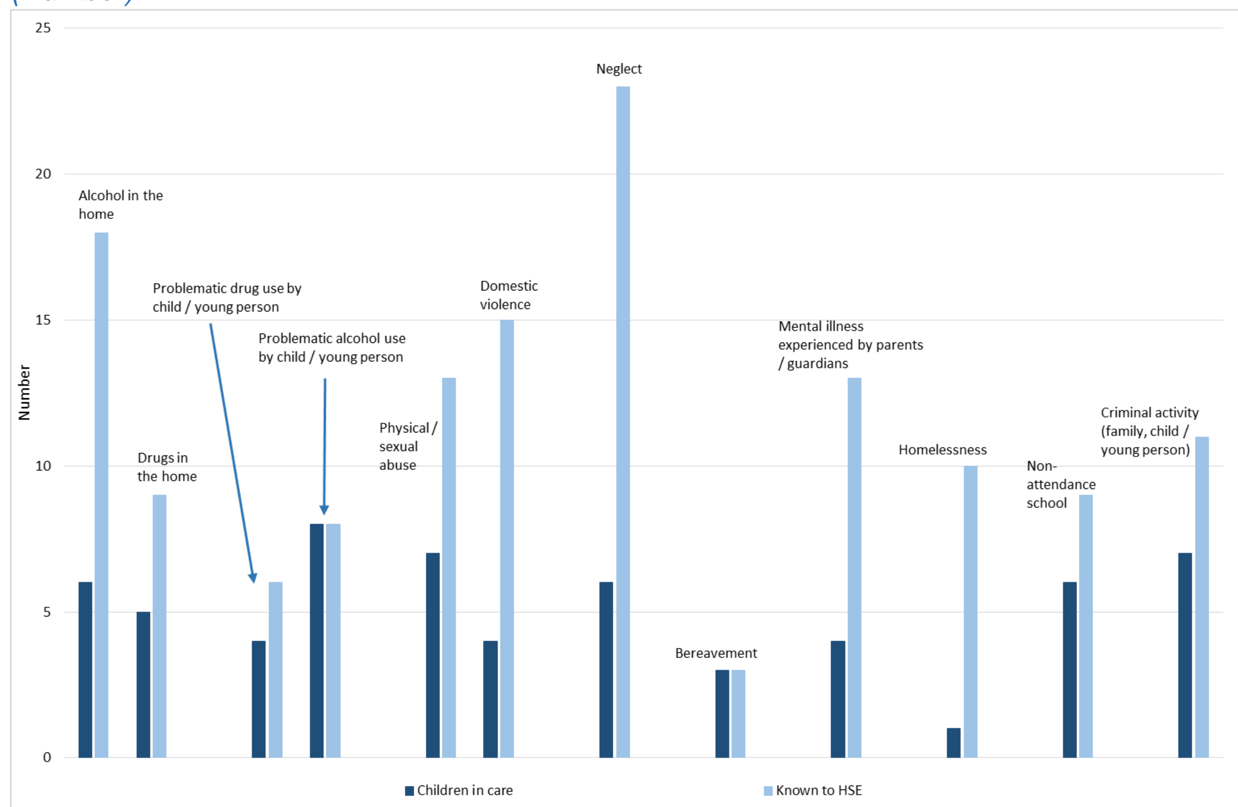
Shannon and Gibbons (2012: xxvii-xxviii and 287-288) have found that the problems facing the children and young people who died began early in their lives. The young people admitted to care tended to come to the attention of the HSE after a serious incident or series of incidents that gave rise to concerns as to their welfare.

Figure 8 sets out the prior experiences of adversity in these children who died from non-natural causes. The lives of the children who died from non-natural causes were associated with

[42] http://apps.who.int/healthinfo/statistics/mortality/whodpms/ *Accessed*: 4 March 2019.
[43] Shannon and Gibbons, 2012: vi.
[44] Shannon and Gibbons, 2012: xx.
[45] The other non-natural causes of death were accidental asphyxia (3 cases) and drowning (3 cases), road traffic accidents (11 cases), accidental falls (2 cases) and house fires (2 cases).
[46] Shannon and Gibbons, 2012: xxi.

experiences of neglect, alcohol in the home, physical or sexual abuse and domestic violence. In particular, Shannon and Gibbons have noted that issues around alcohol can contribute to children being exposed from their earliest years to poor parenting, neglect, abuse and psychological trauma. While acknowledging that the complexity of many of the cases they examined go beyond the single issue of alcohol, Shannon and Gibbons argue that the ability to address other underlying issues is made very much more difficult where serious misuse of alcohol is the established pattern.

Figure 8 – Experience of Adversity Amongst Cases of Non-Natural Deaths in Children (Number)



Source: Shannon and Gibbons, 2012: xxvi.

Shannon and Gibbons (2012: xxvii) have also noted that while some element of risk taking is a feature of young people emerging into adulthood, in the cases they reviewed the judgement and tolerance of risk was "extremely problematic".

Household Factors Associated with Experiences of Adversity

Breakdown of Parental Relationships

The breakdown of parental relationships either through divorce or separation can have a negative impact on child behaviour. That said, the risk posed is dependent on the nature of the parental relationship. Children who are living in a high-conflict parental relationship tend to fare better if their parents separate rather than stay together.[47]

[47] Sun and Li, 2009.; Frisco, Muller and Frank, 2007; Amato, 2001.; Rhoades, 2008; Kushner, 2009; Booth and Amato, 2001.

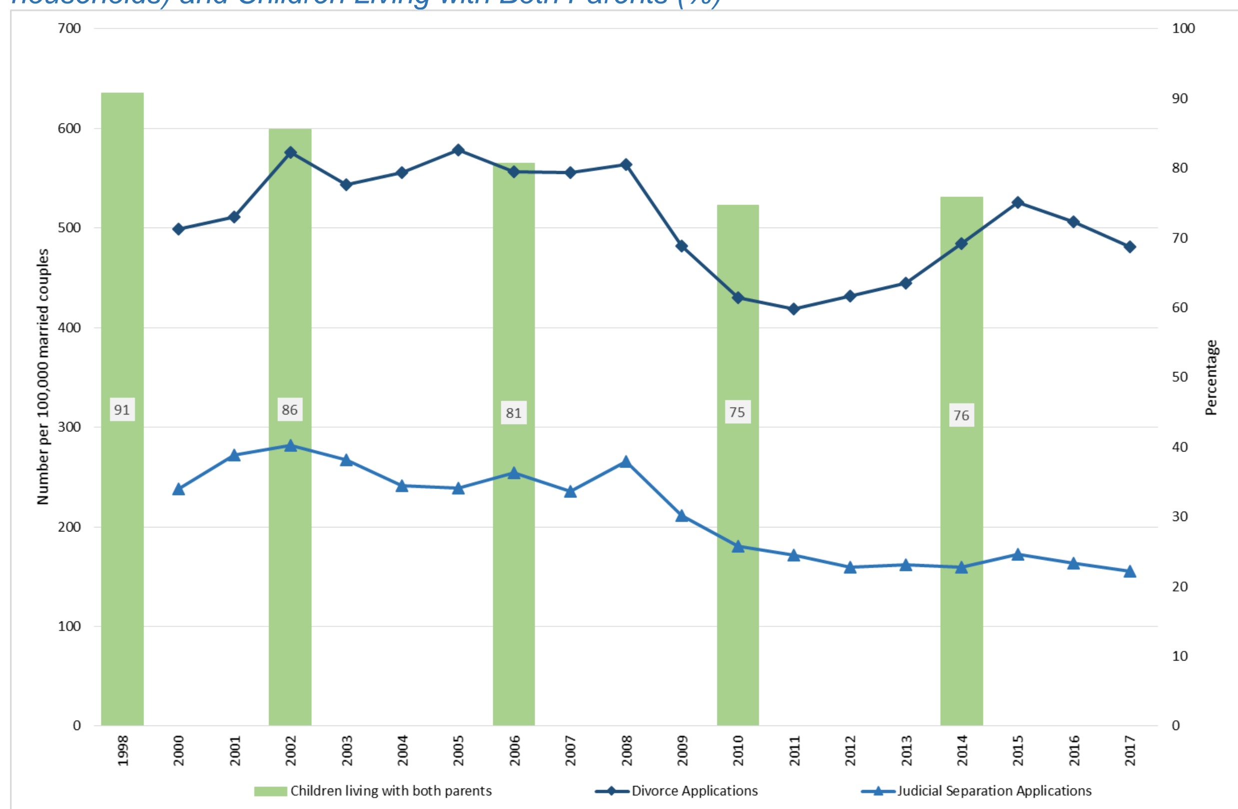
The number of court applications seeking a divorce[48] or a judicial separation[49] provide some evidence of the extent of marital discord and breakdown that is shaping the context within which some children live. (The available data does not distinguish between households with children and households without children.)

In 2017, there were 3,995 applications seeking a divorce and almost 1,295 seeking a judicial separation:

- Over the last two decades, the number of applications seeking a divorce has increased from an average of just over 3,580 applications in 2000-02 to almost 4,165 applications in 2015-17 (+16%).

- The number of applications seeking a judicial separation has decreased from an average of almost 1,790 applications in 2000-02 to 1,355 applications in 2015-17 (-24%).

Figure 9 – Divorce and Judicial Separation Application Rates (per 100,000 married households) and Children Living with Both Parents (%)



Source: (a) Numbers of Divorce and Judicial Separation Applications - Courts Service. Various. *Annual Report*; (b) Rates calculated based on extrapolation of number of married couples for each year – Central Statistics Office. Various. *Census*; (c) Children living with both parents – Keane et al., 2017: 31-32

[48] A decree of divorce dissolves a marriage and allows each party to remarry.
[49] A decree granted by the court relieving spouses to a marriage of the obligation to cohabit.

In order to take into account changes in the number of married couples, Figure 9 examines the number of applications seeking a divorce or judicial separation taking account of the number of married couples.[50]

Over the last two decades, the number of applications seeking:

- A divorce has decreased from an average of 529 applications per 100,000 married couples in in 2000-02 to 504 applications per 100,000 married couples in 2015-17 (-5%); and

- A judicial separation has decreased from an average of 264 applications per 100,000 married couples in in 2000-02 to 164 applications per 100,000 married couples in 2015-17 (-38%).

Change in a variety of societal factors, beyond simply that of marital stability, have contributed to the decreasing trend in the percentage of children who are living with both parents. While the majority of children in Ireland live in families based on marriage / cohabiting parents, a sizeable proportion live with one of their parents who may or may not be living with a partner.

Substance abuse

There is evidence that parental substance abuse can have serious adverse effects on children's lives. However, collecting data about these households is hindered by stigma, secrecy and the fear of repercussions surrounding alcohol and other drug use.[51]

In Ireland, a number of reports illustrate how parental substance abuse impacts on the context in which some children live:

- Alcohol was identified as a risk factor in three-quarters of Irish teenagers for whom social workers applied for admission to special care;[52]

- Alcohol was identified as a "potential trigger" in one third of cases of abusive behaviour (emotional, physical and sexual) of a partner;[53] and

- Over a fifth of those in treatment for problem alcohol use were living alone with their children or with partners and their children.[54]

Domestic Violence

In Ireland, Hogan et al (2007) carried out in-depth interviews with professionals, mothers and children to examine how domestic violence impacts on children's lives.[55] The children interviewed had suffered physical abuse, witnessed violence, overheard violence or seen the injuries that resulted from violence. The impact on children of living with domestic violence is evident in one mother's account of how her 8-year old son pleaded with her to remove herself from immediate danger:

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[50] Over the last couple of decades the number of married couples has increased from an average of just over 677,055 at the turn of the millennium to an average of 825,550 in more recent years (+22%).
[51] Tusla and HSE, 2019: 22.
[52] Brierley, 2010.
[53] Watson and Parsons, 2005.
[54] Mongan, Hope and Nelson, 2009.
[55] Hogan and O'Reilly, 2007.

> …so I went upstairs with him to bed and I put him in the bed and I lay down beside him, touching his head until he went off to sleep, I said it's alright, mammy won't go back down anymore, daddy will fall asleep down there, I said, and we will leave him down there until morning. You and me will stay here. [He said], 'Promise now, mammy, promise now when I go asleep you won't go back down there'. (Hogan et al, 2007: 26)

As well as the immediate consequences of physical violence, and the more long-term developmental consequences, domestic abuse may also lay the foundations of further instances of violence within the household as there may be an effort to exact retribution. One young woman recounts how her mother, having survived 21 years of domestic violence, only sought a barring order against her husband in order to protect her son:

> …and when my mum got up, my brother had him [father] pinned up against the wall, his hand on his neck so…she, she explained this in court and said, 'Look, it's not just us against him that we are trying to, you know, get him out now…it's as much for his own safety'. (Hogan et al, 2007: 60)

In Ireland, domestic violence legislation protects spouses, civil partners and children and offers legal remedies to dependent persons and persons in other domestic relationships where their safety or welfare is at risk because of the conduct of the other person in the relationship. The courts can issue a:

- Safety order - prohibits the person against whom the order is made (the respondent) from engaging in violence or threats of violence. It does not oblige that person to leave the family home.
- Barring order - requiring the respondent to leave the family home and stay away from the family home of the applicant and/or dependent children.
- Protection order - a temporary safety order that gives protection to the applicant until the court decides on a safety or barring order application.
- Interim barring order - a temporary barring order that is intended to last until the barring order application is heard in court and a decision made.

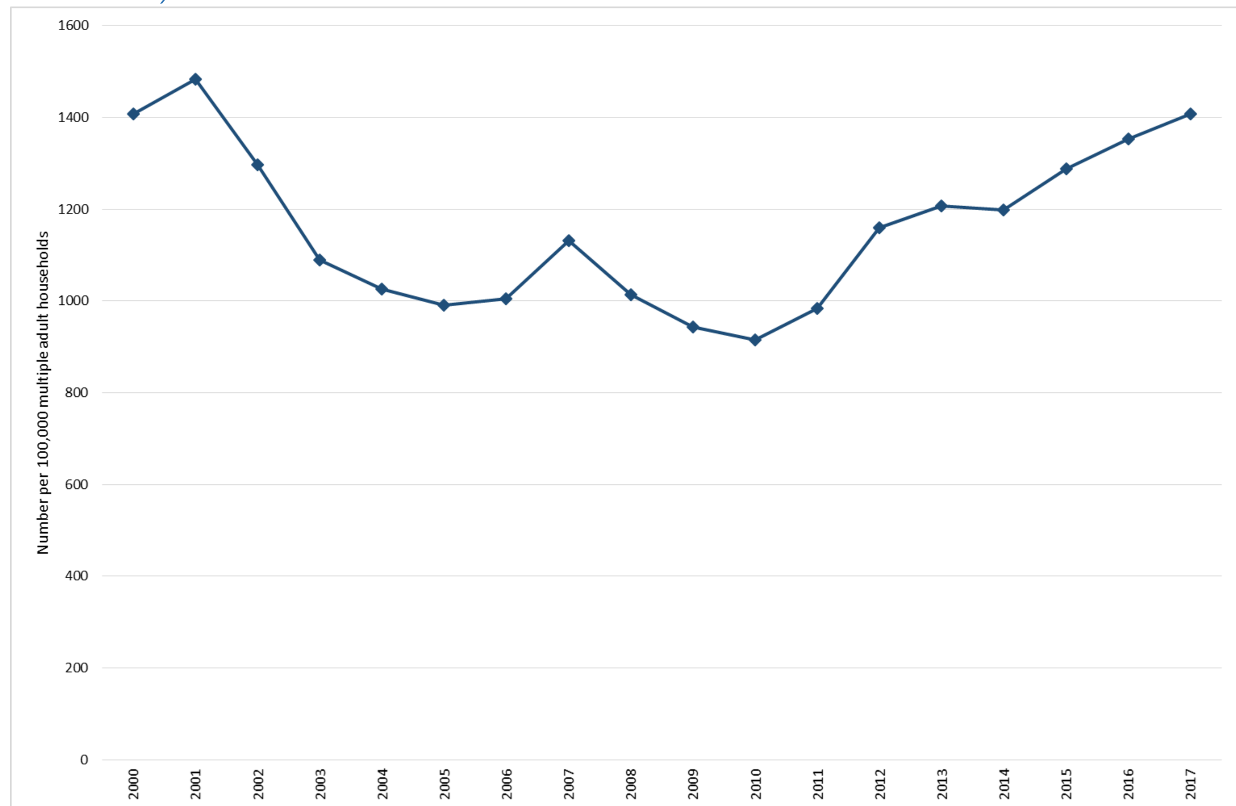
The number of court applications under domestic violence legislation provides some evidence of how physical violence shapes the context within which some children live. (The reported data does not distinguish between households with children and households without children.)

In 2017, there were just over 15,960 applications for Orders under domestic violence legislation. Over the last two decades, the number of applications:

- *decreased* from an average of just over 12,030 applications in 2000-02 to
- an average of 10,000 applications in 2008-10 (-17%) *but then increased* to
- almost 15,190 applications in 2015-17 (+52% relative to 2008-10 and +26% relative to 2000-02).

In order to take into account changes in the number of households, Figure 10 examines the number of applications under domestic violence legislation taking account of the number of households with more than one adult.[56]

Figure 10 – Domestic Violence – Applications for Court Orders (per 100,000 multiple adult households)



Source: Author's calculations based on data from (a) Numbers of Applications for Court Orders relating to Domestic Violence - Courts Service. Various. *Annual Report*; (b) Rates calculated based on estimation of the number of multiple adult households[57] and extrapolation of that number for each year – Central Statistics Office. Various. *Census*.

When change in the number of multiple adult households is taken into account, over the last two decades, the number of applications under domestic violence legislation per 100,000 multiple adult households:

- *decreased* from an average of 1,397 applications in 2000-02 to
- an average of almost 960 applications in 2008-2010 (-31%) *but then increased* to
- an average of 1,350 applications in 2015-17 (+41% relative to 2008-10 but -3% relative to 2000-02).

[56] Over the last couple of decades the number of households with more than one adult has increased from just under 862,000 at the turn of the millennium to almost 1,125,000 in more recent years. (Over this period, the percentage of multiple adult households with children has decreased from 67% in 1996 to 58% in 2016.)

[57] This estimate is based on an aggregation of the number of households that are classified as married and cohabiting couples and two or more family units, including those living with other persons, as well as non-family households containing related persons and households comprised of unrelated persons only.

Poverty

Poverty is frequently understood as having a structural and life-cycle quality which can be difficult to break, especially when it occurs over different generations within the same family. Families may have a lack of income and other resources because of unemployment which may be related to lower levels of education.[58] Children and young people living in disadvantaged areas are more likely to encounter a double burden of being exposed to multiple adversities (e.g. family problems, unsuitable housing) but not the protective factors that could enhance their coping or resilience in the face of such difficulties (e.g. social capital, education, positive relationships with peers, carers and significant adults). The well-being of both parents and children is associated with the health of the parent and the child as well as with socio-economic factors (i.e. household deprivation and financial difficulties). Supports for these families are important in terms of promoting the well-being of children because parents essentially act as a buffer between the child and these wider influences.[59]

How a child interacts with their environment shapes their understanding of how the world works and what to expect from those around them.[60] A stabile social and physical environment is one that provides the child with a sense of coherence, it is predictable and consistent. When a child's social and physical environment is not safe or stable it can result in stress. Chaotic, threatening, and unpredictable situations can contribute to the chronic activation of a child's stress response systems. In the absence of a responsive adult this can lead to toxic stress which can in turn disrupt the healthy development of brain architecture in children and, in later years, have a negative impact on learning, behaviour and health.[61]

In Ireland, irrespective of the measure of poverty, households composed of one adult with children are more likely to experience poverty than any of the other household types.[62] On average over the last few years, 37% of these households are at risk of poverty, 52% have experienced deprivation and 23% are in consistent poverty.[63]

Households composed of one adult with children when compared with their counterparts in:

- Households composed of two adults and up to three children are:
  - About 3 times more likely to be at risk of poverty;
  - Twice as likely to experience deprivation; and
  - About 3 times more likely to be in consistent poverty.

- Households composed of one adult aged 65 years or older are:
  - About 3 times more likely to be at risk of poverty;
  - About 3 times more likely to experience deprivation; and
  - About 7 times more likely to be in consistent poverty.

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[58] Family Support Agency, 2013: 18.
[59] Family Support Agency, 2013: 10-14.
[60] Centers for Disease Control and Prevention, 2008: 3-4; Ainsworth, 1985; Bowlby, 1988; Widom and Maxfield, 2001.
[61] Center on the Developing Child, 2017: 6-7.
[62] At risk of poverty: The share of persons with an equivalised income below 60% of the national median income; Deprivation rate: The share of persons who are excluded and marginalised from consuming goods and services (11 list items) which are considered the norm for other people in society due to an inability to afford them; Consistent poverty: The share of persons identified as being at risk of poverty and who are living in households deprived of two or more of the eleven basic deprivation items.
[63] CSO SIA16: Income and Poverty Rates by Household Composition, Year and Statistic, 2014-2017.

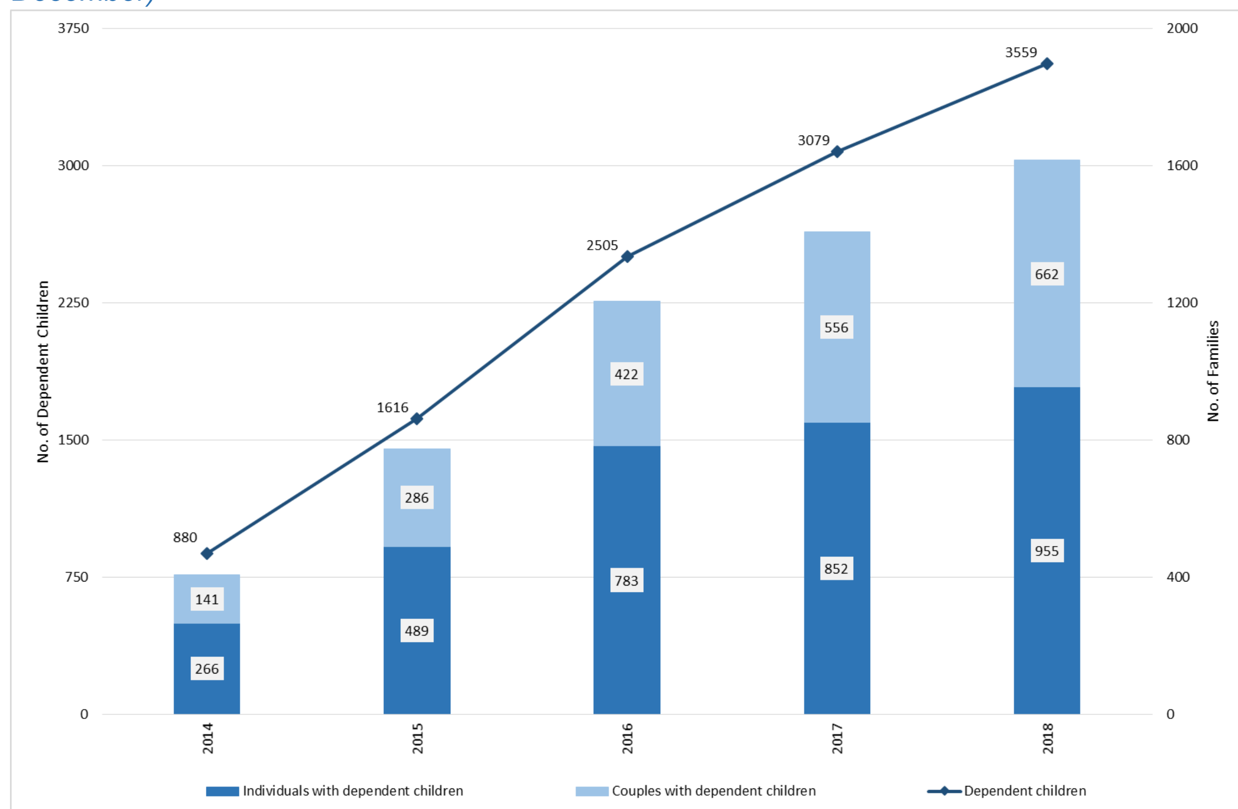
- Households composed of two adults with at least one aged 65 years or older are:
  - About 4 times more likely to be at risk of poverty;
  - About 5 times more likely to experience deprivation; and
  - About 12 times more likely to be in consistent poverty.

Homelessness

Homelessness is associated within instability and unpredictability. In Ireland, over the last number of years there has been a substantial increase in the numbers of families with dependent children who are homeless. From Figure 11, it is evident that since 2014:

- The number of dependent children who are homeless has increased fourfold;
- The number of homeless individuals with dependent children has increased by more than 3½ times; and
- The number of homeless couples with dependent children has increased by more than 4½ times.

Figure 11 – Homelessness – family composition and dependent children (Number at December)



Source: Department of Housing, Planning & Local Government. Various (December). *Homeless Report*. https://www.housing.gov.ie/node/5498 *Accessed*: 25 February 2019.

Unauthorised Halting Sites

Poor quality living conditions reflect a physical environment that is chaotic and unpredictable. In Ireland, about 10% of traveller families are living on unauthorised halting sites (i.e. living on the roadside, most likely with no access to toilets or running water). While the number of families living in such conditions had declined from 524 in 2008 to 327 in 2011 (-37%), since then it has increased to 585 in 2017 (+79% since 2011 and +12% since 2008).[64]

Census data indicates that Irish Travellers are more likely to live in overcrowded conditions (40% of Irish Travellers live in households where there is more than one person per room) as compared with the population as a whole (just over 5% of the population live in households where there is more than one person per room).[65]

Indicators of Consequences likely to be Associated with Experiences of Adversity in Childhood

Health Risk Behaviours

In Ireland, the long-term trends suggest that children aged 10-17 years are now less likely to abuse alcohol or smoke than was previously the case.[66] At the turn of the millennium about a third of Irish young people reported that they had "ever been drunk" but this had decreased to just over a fifth in more recent years. That said, there is evidence that about 60% of 15-19 year olds in Ireland have engaged in binge drinking in the past 12 months.[67]

The proportion of Irish young people who admit to being a smoker is now about a third of what it was in the late 1990s. (An international study found that about 12% of people aged 10-24 years smoked on a daily basis in Ireland.[68])

However, it is also evident that there has been little change in the share of Irish young people who report that they have used cannabis in the last 12 months. While there has been a decrease in the percentage saying that they have used cannabis, it remains at around 1-in-10 young people.

Figure 12 examines the relationship between a variety of factors that shape how young people live and whether or not they smoke. First, there is a correlation between young people's engagement in different types of health risk behaviours. Young people who have consumed cannabis in the last month are nine times more likely to smoke than young people in general. Those who consumed alcohol in the last month are 3½ times more likely to smoke than young people on average. On the other hand, those young people who are less likely to smoke than young people on average are those who do not engage in other health risk behaviours and live in households where there are low levels of tolerance for such behaviours.

Second, young people who have poor relationships with their peer group (i.e., the young person engages in bullying on a regular basis) are four times more likely to smoke than young people in general. Young people who have a negative body-image (i.e., too thin / fat) are also more likely to smoke than young people in general. Those young people who are less likely

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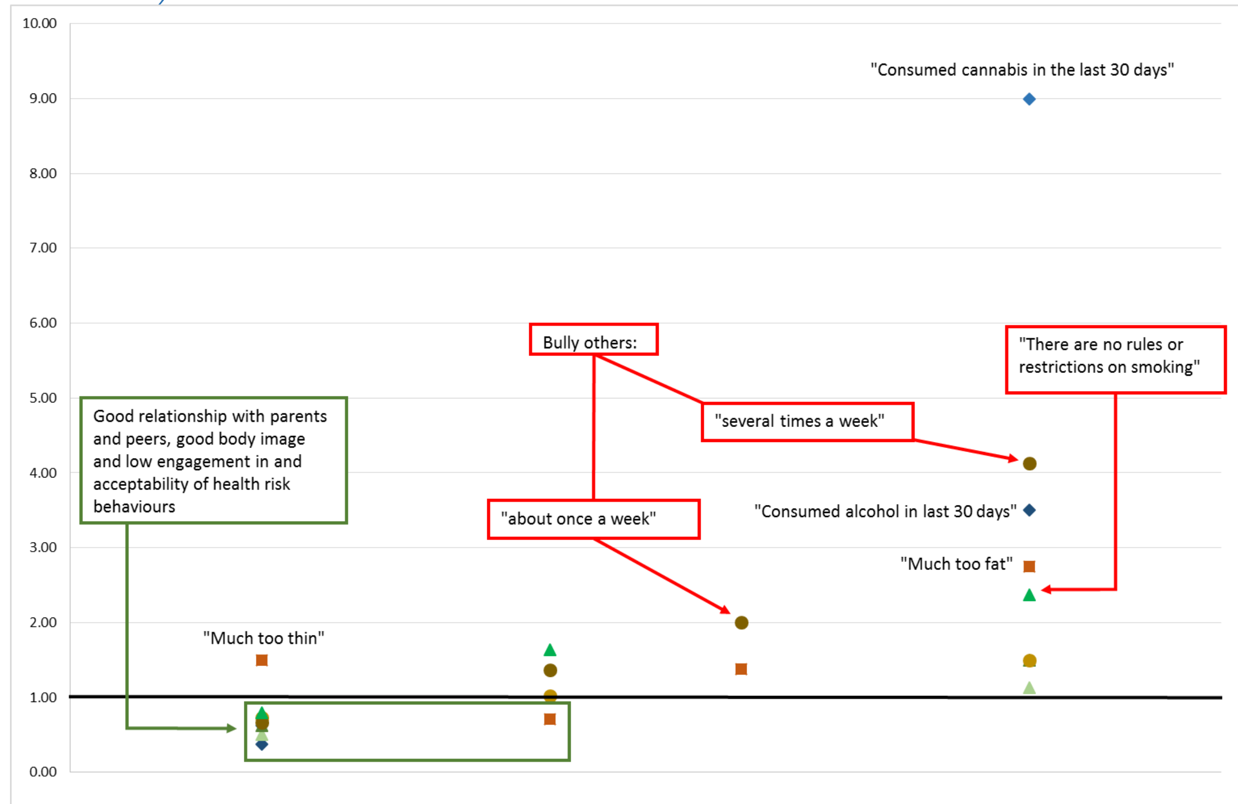
[64] Department of Housing, Planning & Local Government. Various. *Traveller Families in Local Authority and Local Authority Assisted Accommodation and on Unauthorised Halting Sites.* https://www.housing.gov.ie/node/6481 *Accessed*: 25 February 2019.
[65] https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8itseah/ Accessed: 8 March 2019.
[66] Keane et al, 2017: 12, 14 and 16.
[67] Azzopardi et al., 2019.
[68] Azzopardi et al., 2019.

to smoke than young people on average are those who have good relationships with their parents and peers and have a positive body image.

Figure 12 – Family and Social Context of Young People who Smoke (For given contextual factors the ratio of % of young people who smoke relative to average % of young people who smoke)



Source: Author's own calculations based on data published in Keane et al. 2017. *Trends in Health Behaviours, Health Outcomes and Contextual Factors between 1998-2004: findings from the Irish Health Behaviour in School-aged Children Survey*: 12, 14 and 16.

Sexual Behaviours

In addition to engaging in health risk behaviours, young people who have experienced adversity may be more willing to accept risk in their sexual behaviours.

In 2017, just over 210 females aged 17 years or younger gave birth.

Compared to the turn of the millennium, there has been a notable decrease in the number of young females giving birth: from an average of 786 young females in 2000-02 to 240 young females in 2015-17 (-69%).

When change in the size of the population is taken into account, there has been a sizeable decrease in the number of births amongst this cohort: from an average of 336 per 100,000 young females in 2000-02 to 98 per 100,000 young females in 2015-17 (-71%).[69]

However, the available evidence suggests that there is an increasing trend in the number of sexually transmitted infections amongst people aged 19 years or younger: from 935 infections in 2015 to almost 1,020 infections in 2016 to almost 1,150 in 2017. The data indicates that

[69] Central Statistics Office. Various. *Vital Statistics*.

over this period there has been an average of 50 infections amongst children aged 14 years or younger and almost 1,020 infections amongst those aged 15-19 years.[70]

Self-Harm and Suicide

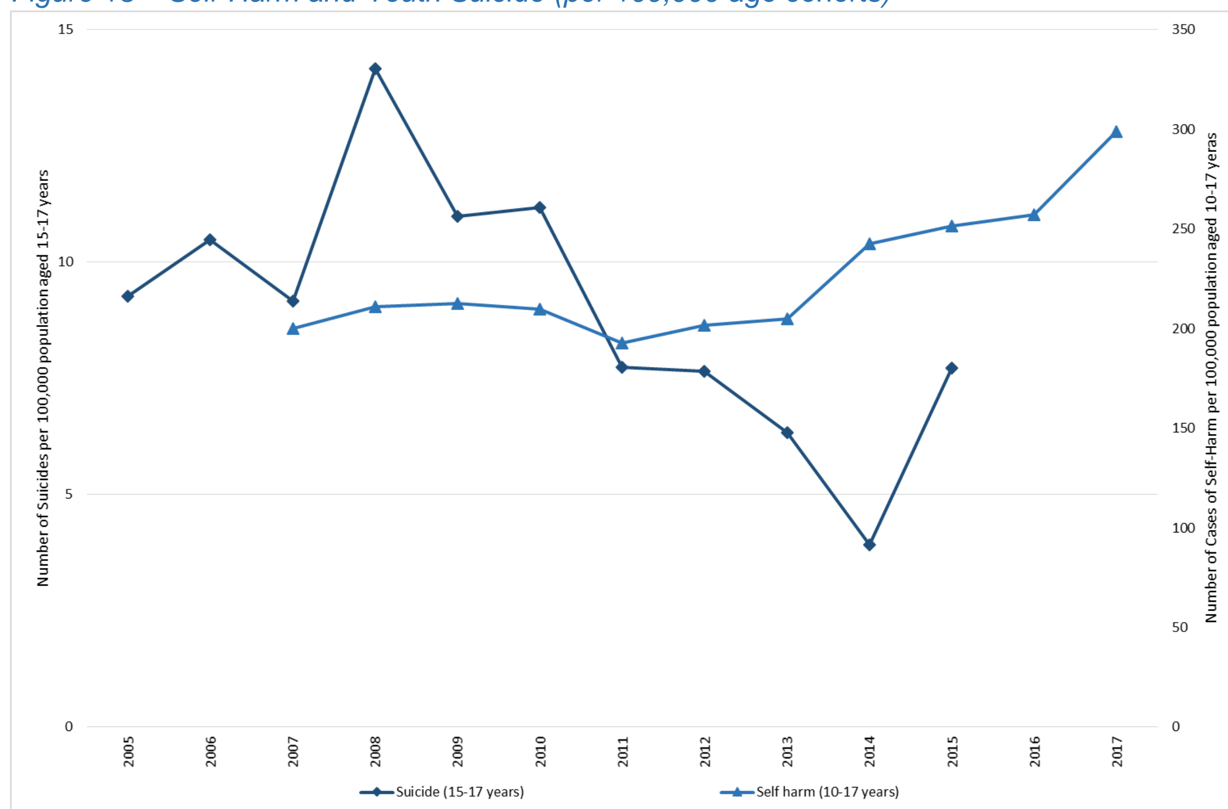
It may also happen that adverse experiences in childhood may only become manifest through a child's or young person's behaviour that poses a direct risk to their life. In 2017, 1,523 young people aged 10-17 years of age presented to emergency departments with self-harm. The number of cases of self-harm has increased from an average of 953 in 2007-09 to an average of 1,353 in 2015-17 (+42%).

When change in the size of the population is taken into account, the increase in the number of cases of self-harm from an average of 208 cases per 100,000 young people in 2007-09 to 269 cases per 100,000 young people in 2015-17 (+29%). (See Figure 13.)

In 2015, the deaths of 14 young people were recorded as being by suicide. The number of cases of suicide by young people has decreased from an average of 20 in 2007-09 to an average of 11 in 2013-15 (-47%).

When change in the size of the population is taken into account, the decrease in the number of cases of suicide from an average of 11 cases per 100,000 young people in 2007-09 to 6 cases per 100,000 young people in 2013-15 (-48%). (See Figure 13.)

Figure 13 – Self-Harm and Youth Suicide (per 100,000 age cohorts)



Source: Department of Children & Youth Affairs. Various. *State of the Nation's Children*. Data for 2016 and 2017 on self-harm provided by the National Self-Harm Registry Ireland.

[70] Health Protection Surveillance Centre, Various.

Resources

The 2019 Spending Review has examined the public resources provided to Tusla.[71]

In 2019, Tusla's budgetary allocation was €785m. Since 2014, expenditure by Tusla has increased year-on-year and the 2019 allocation is 27% greater than the outturn for 2014 (€619m).

In terms of setting out expenditure by the services delivered, Tusla has noted that there are a number of issues with the data and, as a consequence, expenditure data by service is not comparable over time. Tusla anticipates that more accurate expenditure data will be available from 2019.[72]

With these caveats in mind, Tusla has provided some indication of expenditure by service and these are set out in Table 1. Given the focus of this paper, Table 1 sets out expenditure on Prevention, Partnership and Family Support services (including Meitheal) and grants to Family Resource Centres. Based on the data reported by Tusla, between them these services account for an average of 6% of overall expenditure by Tusla.

Tusla also provides grants to service providers and bodies delivering services on behalf of Tusla under Section 56 of the Child and Family Agency Act 2013.

Table 1 also includes expenditure on Child Protection and Welfare Services as well as the Emergency Out-of-Hours Service and expenditure on Children in Care (including residential services). Based on the data reported by Tusla, between them these services account for an average of 57% of overall expenditure by Tusla.

Table 1 – Tusla Expenditure by Selected Services (€m)

	2014	2015	2016	2017	2018
Prevention, Partnership and Family Support (including Meitheal)	33.2	18.0	24.4	24.2	26.5
Family Resource Centres (Grants)	7.0	22.4	16.3	20.4	22.4
Total	*40.2*	*40.4*	*40.7*	*44.6*	*48.9*
% of Overall Expenditure	6%	6%	6%	6%	7%
Section 56 Grants	93.4	59.4	58.5	58.6	58.8
% of Overall Expenditure	15%	9%	9%	8%	8%
Child Protection and Welfare Services	54.0	54.7	56.9	58.2	63.4
Emergency Out of Hours Service	1.4	1.6	1.9	1.9	2.1
Children in Care (including residential services)	298.7	329.9	329.3	335.3	352.8
Total	*354.1*	*386.2*	*388.1*	*395.4*	*418.3*
% of Overall Expenditure	57%	58%	57%	55%	56%
Overall Expenditure	**619**	**663**	**679**	**713**	**752**

Source: Tusla (Kane, 2019)

[71] Kane, 2019.
[72] Kane, 2019: 9.

Tusla employs almost 4,000 whole time equivalents. Of these, around 55% are employed in roles relating to child protection service, children in care service and residential service and almost 9% are assigned to Prevention, Partnership and Family Services.

Outputs and Services[73]

Parents are the primary carers of children and young people. Parents can have a significant influence on their children, particularly in the early years of children's lives, and as such are the foundation for good child outcomes.

Tusla's prevention and early interventions in family support are intended to offer advice and support that address the needs of families and, where necessary, to work in partnership with families and professionals to identify and respond quickly to the needs of children.

Tusla states that:

> Integrated, high-quality services to children and families must be provided at the earliest opportunity across all levels of need. These services are delivered on the basis of low, medium or high prevention.[74]

Low Prevention Services

In cases where a child or young person is identified as having additional needs that may require some additional support (e.g. health, social, educational issues), without which they would be at risk of not reaching their full potential, developmental family support (or primary family support) aims to strengthen the social supports and coping capacities of children and their families. The focus is on strengthening developmental opportunities for the child and family rather than on specific problems.[75]

At the low prevention level, Tusla provides for a range of parenting and family supports through the funding of community and voluntary sector programmes and services. Tusla also leads on Meitheal, which is a national early intervention practice model to ensure that the needs and strengths of children and their families are effectively identified, understood and responded to in a timely way so that children and families get the help and support needed to improve children's outcomes and realise their rights.[76]

Medium Prevention Services

Sometimes parents face problems that hinder their ability to parent effectively (e.g. poverty, relationship problems with partner or children, addiction). Compensatory family support (or secondary family support) aims to support parents in their parenting role to better parent their children with targeted and intensive parenting and therapeutic supports. The intervention often is part of a specialised programme that seeks to address the factors which threaten the well-being of parents and children and improve the family's capacity to provide a nurturing environment. Where problems are more entrenched, clinical guidance from social care and health care professionals can be provided.[77]

[73] See: Department of Children & Youth Affairs, 2011; Health Services Executive, 2011.
[74] Tusla, Undated 1 and 2.
[75] Tusla, Undated 1: 7; Family Support Agency, 2013: 22.
[76] Tusla, 2013: 1.
[77] Tusla, Undated 1: 7; Family Support Agency, 2013: 22-23.

Tusla's High Prevention Services are outlined in Appendix A.

While accessing Family Support services can be through social work, a progressive universalism approach means that families themselves, or professionals acting on their behalf, may seek to access such services (e.g. community-based interventions provided without the involvement of social work services or Meitheal; see below).[78]

In addition, anyone who has concerns about the welfare or safety of a child may make a referral to Tusla.

Screening and Preliminary Enquiry

On receipt of a referral, the first consideration for social work staff working on intake teams is the immediate safety of the child and whether immediate protective action is required.[79] These actions include making:

- Preliminary enquiries - to determine if the concern meets the need for social work intervention.
    - Referrals not requiring social work intervention are closed or diverted to other more appropriate services (e.g. family support services).
    - Referrals requiring social work intervention are assigned to a social worker who conducts an initial assessment (and further assessment, where required) and works with the child and family to ensure the child(ren) is protected and safe.

Between 2013 and 2017, on average 45,780 preliminary enquiries were completed each year. (On average about 97% of referrals have received a Preliminary Enquiry.)[80]

Up until recently, Tusla's standard business processes for the management of referrals had recommended that Preliminary Enquiries should be completed within a 24 hour timeframe of referral to Tusla.[81] Between 2014 and 2016, on average 65% of Preliminary Enquires were completed within the recommended 24 hour timeframe.[82]

If, on the basis of the reported concern and/or any existing information, there is reason to believe that a child has been harmed or is at risk of further harm or ongoing neglect, or that their safety and welfare are at risk, an immediate response is required. (See Appendix A.)

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[78] Some services are provided at a universal level to all children and families with other services provided on the basis of assessed need to families with additional needs up to and including children and parents who are experiencing multiple difficulties and require more intensive and specialist interventions.
[79] The actions to be taken by staff on receipt of a referral are outlined in the national guidelines set out by the Department of Children & Youth Affairs (2017) in *Children First: National Guidance for the Protection and Welfare of Children* (based on the Children First Act 2015)) and Tusla's standard business processes for Child Protection and Welfare Services' Social Work Departments along with other supplementary protocols and procedures implemented by the areas.
[80] Tusla. Various. *Quarterly Performance and Activity Data*.
[81] With the transition to *Signs of Safety*, the timeframe is now within 5 days. *Signs of Safety* is being implemented as Tusla's national approach to practice and reflects Tusla's best practice principles, which are fundamentally underpinned by the principles of 'Children First'. As an approach to practice, children and families will be at the centre of assessment and decision-making and the approach will be strengths-based, evidence-based and outcome-focused.
[82] Tusla. Various. *Quarterly Performance and Activity Data*.

Initial Assessment

The purpose of an Initial Assessment is to determine whether the child's needs are being adequately met and whether there is any other help the family may need in order to care adequately for the child. Tusla assesses the child's situation through engaging with the family and other professionals to decide what response is most appropriate to protect or support the child.

Over the last few years, an average of 20,115 Initial Assessments were recommended each year as an outcome of the Preliminary Enquiry (accounting for an average of about 43% of referrals to Tusla).[83]

Of these, about one-in-six Initial Assessments were completed within the 21 day timeframe that (until recently) was recommended in Tusla's standard business processes. (The timeframe is now 40 days.)

When the assessment is finished, there are a number of outcomes:

- Report closed which may also include diversion to a more relevant service;
- Response Pathway 1 – Family Support Early Intervention Response;
- Response Pathway 2 – Child Welfare Assessment and Response;
- Response Pathway 3 – Child Protection Assessment and Response;
- Response Pathway 4 – Alternative Care; or
- Emergency Admission to Care.[84]

In each of the recent years for which data is available, of the total number of referrals received, an average of 8,970 Initial Assessments (19% of total referrals) have recommended that an action should be taken. Of these, on average, just over 1,000 have recommended a Child Protection Assessment and Response (2% of total referrals).[85]

Family Support

Family Support is used to cover a broad range of interventions provided to children and their families in their own homes and communities. The primary focus is on early intervention and prevention. The services provided vary in terms of their:

- target group (e.g., mothers, fathers, young children, teenagers);
- professional background of service provider (e.g. family worker, social worker, childcare worker, youth and community worker, public health nurses, psychologist);

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[83] Tusla. Various. *Quarterly Performance and Activity Data*.
[84] Department of Children & Youth Affairs, 2017: 60-61: Tusla, 2017: 13-14 and 23-24.
[85] Tusla. Various. *Quarterly Performance and Activity Data*.

- orientation of service provider (e.g. therapeutic, child development, community development, youth work);

- problem addressed (e.g. parenting problems, family conflict, child neglect, educational underachievement);

- programme of activities (e.g. home visits, pre-school facility, youth club, parenting course); and

- service setting (e.g. home-based, clinic-based or community-based).[86]

Tusla provides services directly and commissions and funds a wide range of community and voluntary agencies to provide services on its behalf on a local, regional and national basis. (This is in accordance with the provisions of Sections 56 - 59 of the *Child and Family Agency Act 2013*.)

Between 2014 and 2017, on average, about 29,675 children were referred to Family Support Services each year. There has been an increase in this number from around 23,740 children in 2014 to 39,065 children in 2017 (+65%).[87]

In 2017, of those who had been referred to Family Support Services just over 28,560 children (or 73%) received a service during the reporting year.[88]

Response Pathway 1 - Early Intervention

In cases where a child is not at risk of harm but where there are unmet needs, early intervention by family support services may help prevent any deterioration of a family's current difficulties and may encourage the positive factors in place in the family. Tusla provides and works with a range of community-based support services that deliver practical supports to children and their parents.[89] The main focus of these services is on early interventions to promote and protect the health, well-being and rights of all children, young people and their families, with particular attention given to those who are vulnerable or at risk.

Response Pathway 2 - Child Welfare

In some cases, the reported concern falls below the threshold for child protection intervention by Tusla but the child is found to have welfare needs. While the response and intervention may involve a number of different agencies, it is led by a Tusla social worker or social care worker. In these cases, a Child Welfare Plan / Family Support Plan may be made. This plan will outline the steps to be taken to support the child and family (e.g. helping the parent through direct one-to-one work, parental modelling and assistance, a play or afterschool programme for the child, psychological or psychiatric assessment of the child and / or parental assessment for mental health or addiction problems).[90]

If a social worker has concerns that progress is not being made under the Child Welfare Plan / Family Support Plan the case may be progressed through child protection pathways. (See Appendix A.)

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[86] Tusla, 2019: 67.
[87] Tusla. Various. *Quarterly Performance and Activity Data*.
[88] Tusla. Various. *Quarterly Performance and Activity Data*.
[89] Department of Children & Youth Affairs, 2017: 43-44.
[90] Department of Children & Youth Affairs, 2017: 44-45; Tusla, 2017: 13.

Prevention, Partnership and Family Support

The aim of Tusla's Prevention, Partnership and Family Support (PPFS) is to transform child and family services in Ireland by embedding prevention and early intervention into the culture and operation of Tusla. The PPFS programme operates across Tusla's continuum of care and provides the framework for developing a stronger focus on prevention and early intervention (rather than crisis management) by seeking to make all services more preventive, integrated, evidence informed and participatory.

The key initiatives within the PPFS include the Area Based Approach to Prevention, Partnership and Family Support (includes the development of Child & Family Support Networks (CFSNs) and the Meitheal Model) and the provision of an optimal service delivery framework for PPFS (includes the Area Based Childhood and Family Resource Centres programmes).

Child & Family Support Networks

The local Child & Family Support Networks (CFSNs) consist of all services that play a role in the lives of children and families in a given area. The CFSN is a partnership that recognises that supporting families and keeping children safe is everyone's business.

As CFSNs develop, all areas throughout the country should have an integrated, cohesive and consistent approach to working with children and families. Children and families are most likely to do well if they are provided with appropriate support in a timely and coordinated fashion, and when there is good communication and partnership working between professionals. CFSNs will also capitalise on families' own help seeking networks.

The effective functioning of the CFSN will depend on members being clear and informed on each other's roles. This will allow for better signposting/ referrals to services and supports within each area, as well as help build a sense of shared ownership in the group and collaborative working. To be successful, CFSNs need to work effectively in partnership with families to ensure:

- There is 'no wrong door' for families; and
- All families in their locality receive easily accessible support, appropriate to meet their identified needs.

Within each county, Children and Young People's Services Committees (CYPSC) support the development and sector participation. The CFSNs are the local coordinating structure for promoting parenting and family support in a number of CYSPC plans.

At end-2018, there were 106 CFSNs operational nationwide.

Meitheal

Meitheal is an agreed practice approach that aims to ensure that the needs and strengths of children and their families are effectively identified and understood and responded to in a timely way so that children and families get the help and support needed to improve children's outcomes and realise their rights. It is an early intervention, multi-agency (when necessary) response, tailored to the needs of the individual child or young person.[91]

The Meitheal Model is designed to look at all aspects of a child's development: their health and development, parenting capacity and role of extended family and the community. As a process, Meitheal is designed to ensure that the needs and strengths of children and their families are effectively identified, understood and responded to in a timely way. It has been designed to create a balance between national standardisation and local responsiveness to need.[92]

Meitheal provides parents with the opportunity to share their own knowledge, expertise and concerns about their child and to hear the views of practitioners working with them. The ultimate goal is to enable parents and practitioners to work together to achieve a better life for the child and this is supported through:

- Working with a Lead Practitioner who the parents / carers have a good relationship with and who is best placed to identify the child's needs and strengths. Meitheal is a process rather than a service and existing practitioners working with children and families are trained so they can lead a family a family through the process effectively;

- Sharing of information - by enabling improved information sharing across agencies reduces the number of times a family is required to repeat its story and facilitates a shared understanding across service providers; provides for a robust approach to documenting and reviewing supportive interventions across agencies;

- Focusing on outcomes for the individual - focuses on the outcomes to be achieved for children/ young people secured through front-line services working together more effectively to meet the needs of children, young people and their families and encourages practitioners to see the child/young person holistically by expressing children's strengths in positive terms rather than focusing only on problems or deficits, providing practitioners and families with the opportunity to work collaboratively in developing a collective solution to issues/difficulties; and

- Empowering families – they are centrally involved in a process that can only be carried out with their informed written consent.

In 2017, there were almost 1,410 Meitheal processes requested.[93]

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[91] See: Tusla, 2013*;* Tusla, 2015.

[92] The Meitheal Model is influenced by the Limerick Assessment of Needs System (LANS) and the Identification of Need (ION) Project operated in Sligo, Leitrim, West Cavan and previously in Donegal. These initiatives, in turn, were influenced by the Common Assessment Framework (CAF) in England and Wales, and the My World Triangle and National Practice Model as part of Getting it Right for Every Child (GIRFEC) in Scotland.

[93] A family can access support through Meitheal in a number of ways: (a) *Directly* (52% of supports accessed in this way) - A parent and a practitioner initiates a Meitheal by completing the Meitheal Request Form and forwarding it to the Child and Family Support Network Coordinator; (b) *Diversion* (40%) - When a referral under Children First is deemed to not reach the threshold necessary for the involvement of the Child and Family Agency Social Work Department but there is an outstanding unmet need that requires child and family support services. The child may be diverted, with the consent of the parent, for a Local Area Pathways Response. This may result in a single agency response or a Meitheal; and (c) *Step down* (8%) - When a referral is accepted to the Child and Family

Creative Community Alternatives

Creative Community Alternatives (CCA) is a tool for innovative high-level prevention work aimed at delivering wraparound supports for children and families within their own community. CCA aims to provide alternative responses to children and young people who are either on the edge of alternative care or currently in alternative care due to complex factors that may include abuse, neglect, parental separation, attachment issues, alcohol and /or drug misuse, mental health and economic disadvantage.

The PPFS also provides an organising framework to other Family Support activity, including:

Area Based Childhood Programme

The Area Based Childhood Programme is being incorporated within Tusla and this programme includes a wide range of early interventions that focus on parenting, child development and children's learning.[94] (See below for further details.)

Family Resource Centre Programme

The funding by Tusla of the Family Resource Centre Programme (FRC Programme) supports the delivery of both universal and targeted community-based family support services and developmental opportunities within the disadvantaged communities in which they are based. There are 121 Family Resource Centres around the country as well as two outreach centres.[95]

The Family Resource Centres work with children and their parents to combat disadvantage and improve the functioning of the family unit. Furthermore, the FRC Programme emphasises the involvement of the local community and the FRCs support community participation and social inclusion in tackling the problems they face and help create community level partnerships between voluntary and statutory agencies. This approach is to ensure that each FRC is embedded in the community. FRCs vary in terms of size and the range of services that they provide (e.g. delivering community-based services; providing active learning opportunities; delivering evidence-based programmes with a focus on parenting and family interaction; establishing and supporting positive networks and development groups that may facilitate peer support).

In 2016, Family Resource Centres delivered 285 evidence based parenting programmes (with some 960 adults and 329 children participating). The Family Resource Centres also delivered active learning opportunities (with 17,166 adults and 6,229 children participating) and a range of support networks and community groups (with over 67,000 people participating.[96]

Targeted Family Support Services

In addition to the above programmes, Tusla has continued the practice of funding family support services either internally by directly providing family support services as a separate service to its social work services or indirectly through funding to the Community and Voluntary Sector. In both instances these preventative family support services are managed locally

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Agency Social Work Department, assessed by the Social Work Department and is deemed suitable for closure either after assessment or after a period of intervention but has outstanding unmet need that requires child and family support services and is stepped down with the consent of the parent, via the Child and Family Support Network Coordinator for a Local Area Pathways Response. This may result in a single agency response or a Meitheal. (Tusla. Various. *Quarterly Performance and Activity Data.*)

[94] See: Hickey et al., 2018.

[95] Family Resource Centres may receive funding from sources other than Tusla.

[96] Tusla, 2018: 85.

under the PPFS programme of work. Interventions from these services can occur as standalone interventions, coordinated through the Meitheal Model, or be part of supports offered where a child is in receipt of an assessment or intervention from the Tusla social work service. Many of these family support services also participate in the delivery of various parenting programmes.

Counselling Services

Tusla provides funding to voluntary organisations offering counselling and psychotherapy services. For children, Tusla supports:

- Child counselling - the 22 larger funded community-based counselling organisations provided counselling to 2,136 children aged 18 years or younger in 2016 (1,916 children in 2015); and

- Rainbows Ireland peer support programme for children which facilitates group-based supports for children (aged 6-12 years) who have experienced a bereavement or parental separation. Over the last number of years, Rainbows Ireland has supported an average of 2,250 children each year with a third of these children having experienced loss by bereavement.

Tusla also supports the provision of marriage and relationship counselling and bereavement counselling and support on the death of a family member.

Child and youth participation

The purpose of child and youth participation is to enhance all levels of their engagement with Tusla to ensure that every time a decision is taken that directly affects a child or young person (or children and young people collectively) their views are taken into consideration in the decision-making process.[97] Tusla has published its *Child and Youth Participation Strategy 2019-2023*.

The participation of children and young people is fundamental to a child-centred, rights-based approach to working with children and young people. As an organisation, Tusla believes that children, young people and communities should be actively involved in the decisions that affect their lives. Tusla is committed to supporting, nurturing and celebrating a culture of participatory practice in both Tusla and Tusla-funded services. Activity is this area of work involves:

- Annual national conferences delivered in partnership with children and young people;
- A nationwide training programme in child and youth participatory practice;
- The continued promotion and investment in Child and Youth Participation including seed funding grants;
- The rolling out of the Investing in Children award given to services that can demonstrate dialogue with children and young people that leads to change;
- The continued implementation of the National Children Charter and National Young People's Charter (launched June 2017) which set out what children can expect from Tusla services and how they can expect to be treated by Tusla staff. The Charters were developed by children and young people throughout Ireland across the continuum of care and have been disseminated to Tusla staff and partners; and

[97] Section 9 of the Child and Family Agency Act 2013 requires that Tusla give consideration to the views of children in planning and reviewing the provision of services and in the performance of its functions under the Child Care Act 1991, the Education (Welfare) Act 2000 and the Adoption Act 2010.

- The development and operation of participation fora for children in care.

Parenting support and participation

Tusla is committed to strengthening and developing parenting supports and services and ensuring that supporting parenting is a priority of the PPFS Programme through:

- The implementation of the *Parenting Support Strategy*;
- The commissioning of parenting supports and services, including parenting programmes, in every Tusla area using the National Parenting Commissioning Framework (NPCF)[98] as a guide;
- The continued promotion and investment in Parental Participation including seed funding grants;[99]
- The Parenting Support Champions project including a Parenting Newsletter[100];
- The promotion of 50 Key Messages for practitioners, and Parenting24Seven for parents[101];
- Annual Parenting Conferences[102]; and
- Ensuring alignment with Department of Children & Youth Affairs' Parenting Support Policy Unit and *First 5* actions.

[98] The aim of the National Parenting Commissioning Framework (NPCF) is to help co-ordinate the investment in parenting supports and services and to ensure that supports are available at all stages in children's development and across all circumstances and challenges that parents are encountering. The framework is a guide for the commissioning of evidence informed and evidenced based services and programmes both within Tusla (e.g. through the Family Resource Centres) and in partnership with the CYPSC, other agencies, non-Government organisations and the Community and Voluntary sector.

[99] Parental participation initiatives include the dissemination of a Toolkit for Parental Participation, seed funding for Tusla areas to encourage innovative and best practice models in relation to the engagement of parents, particularly 'seldom heard' parents, and the development of an eLearning Module. These initiatives are enhanced by the involvement of Parenting Support Champions (PSCs).

[100] Parenting Support Champions are practitioners who are already involved in parenting in their local and regional areas and they have proven to play a key role in shaping services to better support parents. There are 106 PSCs from a variety of disciplines currently helping to promote parental participation and the promotion of the 50 Key Messages. The dissemination of a bi-annual newsletter Parenting Support Matters helps with this process.

[101] The 50 Key Messages are parenting best practice messages from national and international research that include Parenting24seven, an online resource for parents offering evidence-informed key messages on what works best for children and families at different stages of childhood and in different situations.

[102] A series of annual National Parenting Conferences, which include the participation of parents and the showcasing of parenting projects and practices throughout the country, provide opportunities for parents, practitioners, academics and policy makers to share and reflect on parenting issues.

Goals and Achievements

This is a very complex policy issue. There are layers of influences that envelope parents and children in ways that shape how policy can effectively achieve its intended outcomes in meeting the various needs of families.

Firstly, the policy interventions are not only focussed on children but are also concerned with their parents or carers and the family group within which they live and interact.

Secondly, the needs of children and their parents are shaped by household characteristics and by the area within which they live.

Promoting the well-being of children and their families is a cross-government responsibility that requires collaboration between the various departments, agencies, community and voluntary organisations as well as with the individual families themselves (e.g. health, education, early learning, housing, social supports and so on).[103]

Finally, the complexity of the policy area and the diversity of challenges that children and their families face means that a specific focus is required to articulate policy goals in ways that are amenable to measuring the impact of services on the lives of children and their families.

A number of key strategy documents set out the overall goals of policy in this area:

- In *Better Outcomes, Brighter Futures* one of the transformational goals is to "support parents" so that they feel more confident, informed and able to parent;

- A national outcome under *Better Outcomes, Brighter Futures* is that children and young people are "safe and protected from harm", that is, they should have a secure, stable and caring home environment; be safe from abuse, neglect and exploitation; protected from bullying and discrimination; and be safe from crime and anti-social behaviour;

- Under *First 5*, one of the objectives is that parents will benefit from high-quality, evidence-based information and services to support child development and positive family relationships along a continuum of need; and

- In the *High-Level Policy Statement on Supporting Parents and Families*, the Department of Children & Youth Affairs has stated that the primary focus of parenting and family support services is on early intervention aiming to promote and protect the health, well-being and rights of all children, young people and their families. At the same time particular attention is given to those who are vulnerable or at risk.

In addition to these policy documents, under Section 8 of the Child and Family Care Act 2013, Tusla has statutory responsibility to support and promote the development, welfare and protection of children, support and encourage the effective function of families and provide for the protection and care of children in circumstances whether there parents have not given, or are unlikely to be able to give, adequate protection and care. In carrying out its responsibilities, Tusla provides a range of services that offer advice and support in order to address the needs of families and each of these set out policy aims, including:

- Prevention, Partnership and Family Support (PPFS) Programme – an initiative that aims to prevent risks to children and young people arising or escalating through

[103] Family Support Agency, 2013; Center on the Developing Child, 2017.

building sustainable intellectual capacity and manpower within Tusla and partner organisations such as community and voluntary sector as well as other statutory bodies.[104] It also provides an organising framework to all Family Support activity including the Family Resource Centre Programme, the ABC programme and targeted family support offered both by Tusla and the Community & Voluntary sector;

- Family Support - The aim of the early intervention element of Tusla's family support initiative is to promote and protect the health, well-being and rights of all children, young people and their families (in particular, those who vulnerable or at risk). Preventing avoidable entry of children into the care system is a key aim of the family support service;[105] and

- Family Resource Centres Programme - The aim of the Family Resource Centres is to combat disadvantage and improve the functioning of the family unit.[106]

In their evaluation of Tusla's Prevention, Partnership and Family Support Programme, Malone and Canavan (2018: 30) have stated that:

> Our strong conclusion is that the organisational culture of Tusla is changing such that it is becoming more preventative in focus and more inclusive of parents and children. … The organisation is committed to working in an evidence-informed way and has developed some capacity to do so through the Commissioning and Parenting Support and Parental Participation Work Packages, but much work is required in relation to data, analysis, and outcomes and evidence frameworks.

The Department of Children & Youth Affairs has launched its *What Works* initiative which takes a coordinated approaching to enhancing capacity, knowledge and quality in prevention and early intervention for children, young people and their families. The initiative is aimed at ensuring that key groups working with children, young people and their families know what works, how it works and will provide an evidence supported approach to applying this work. This initiative also offers opportunities for connections and learning across policy areas relating to the *Better Outcomes, Brighter Futures* National Outcomes for children, young people and their families.

Furthermore, as part of *First 5*, the Department of Children & Youth Affairs has established a Parenting Support Policy Unit. The purpose of this Unit is to provide cross government co-ordination of policy direction and activity relating to parenting support for parents of children aged between 0 and 18 years. In carrying out its work, the Parenting Support Policy Unit will work closely with Tusla, the HSE and other stakeholders to develop a national model of parenting services.

[104] See: https://www.tusla.ie/services/family-community-support/prevention-partnership-and-family-support/ *Accessed*: 19 July 2019.
[105] See: https://www.tusla.ie/services/family-community-support/family-support/ *Accessed*: 19 July 2019.
[106] See: https://www.tusla.ie/services/family-community-support/family-resource-centres/ *Accessed*: 19 July 2019.

Outcomes associated with Evidence-Based Interventions

There is a wide range of international and national evidenced-based universal and targeted services for children, young people and families. From 2019, the Department of Children & Youth Affairs Area Based Childhood programme is being integrated into Tusla.[107]

Between 2013 and 2017, the Irish Government and Atlantic Philanthropies co-funded the Area Based Childhood (ABC) Programme. (Since 2018 the Department of Children & Youth Affairs has been the sole funder of the programme.) The aim of the programme was to test and evaluate innovative prevention and early intervention approaches to improve outcomes for children and families at risk of poverty. It was informed by the learning emerging from the earlier evaluations of the *Prevention and Early Intervention Initiative* and the *Prevention and Early Intervention Programme*.[108] Policies and programmes that intervene early in childhood in order to support families and early childhood development, or early in the onset of an issue or difficulty, are seen as important ways of addressing the problems associated with long-term disadvantage and intergenerational social problems.[109]

There is a wide range of manualised, evidence-based early interventions available. While some of these might be categorised in terms of focusing on one of parenting, child learning and child behaviour, the nature of these programmes is that they often support positive results across more than one outcome domain. The approach that is adopted to how interventions should be delivered tends to be in line with a progressive universal approach across the continuum of need or the tiered approach outlined in the Hardiker Model.[110] These programmes differed from each other in a number of ways as some programmes are: universally available (e.g. Triple P Parenting Programme and Life Start) while others are by referral only (e.g. Functional Family Therapy); home-visiting programmes (e.g. Life Start and Preparing for Life) while others are group-based programmes (e.g. Incredible Years, Odyssey, Triple P); multi annual programmes (e.g. Preparing for Life is a five-year programme) while others are of much short duration (e.g. Incredible Years' programmes vary from 12-18 weeks); and focused on babies and very young children (e.g. Preparing for Life focuses on families with children from aged 0-5 years), young children (e.g. Doodle Den is for

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[107] Hickey, O'Riordan, Huggins and Beatty, 2018; Sneddon and Harris, 2013; Sneddon and Owens, 2012; Statham, 2013.

[108] The Centre for Effective Services has published a series of *On the Right Track* reports that synthesises the learning available from the individual evaluations conducted as part of the *PEII / PEIP*. While the PEII and PEIP were two different programmes of investment, their purpose was the same in terms of examining and evaluating innovative methods of improving outcomes for children in an integrated way with a focus on mainstreaming evidence-based programmes. The focus on prevention and early intervention was predicated on an understanding that intervening early in a child's life, or early in the onset of a difficulty supports the achievement of more positive outcomes for children and their families. In 2004, Atlantic Philanthropies commenced their *Prevention and Early Intervention Initiative* (2004-2013) which sought to change the course of children's lives and alter the approach to working with some of the most vulnerable children and young people living in Ireland. As part of its work, Atlantic Philanthropies funded existing organisations to provide a range of prevention and early intervention services to build a track record of effective prevention and early intervention services and demonstrate the way of working that it was advocating. In order to ensure the sustainability of both the overall approach and the various services, Atlantic Philanthropies sought to develop co-funding arrangements with the Irish Government. During 2008-2013, a number of evidence based programmes and practices were trialled in Irish contexts. In particular, the *Prevention and Early Intervention Programme for Children* (PEIP) was jointly funded by the Department of Children & Youth Affairs and Atlantic Philanthropies.

[109] Munro, 2011; Allen, 2011.

[110] Some services are provided at a universal level to all children and families with other services provided on the basis of assessed need to families with additional needs up to and including children and parents who are experiencing multiple difficulties and require more intensive and specialist interventions.

children aged 5-6 years) and older children (e.g. Odyssey – Parenting Your Teen is for parents of children aged 11-18 years).

Hickey et al. (2018: x) have concluded that:

> Overall, the national evaluation found evidence that the ABC Programme made a positive and significant contribution to improved outcomes for children and families, changes for practitioners and service managers participating in the programme, and changes to local service planning and delivery.

More generally, Devaney et al. (2013: 28-50) have reviewed the research evidence of many of these interventions and have set out the outcomes that many of these types of programmes initiatives seek to achieve. (See Table 2.)

Devaney et al. (2013) also identified a number of common themes that are likely to either promote or undermine positive outcomes. Those factors that are likely to promote positive outcomes include:

- Relationships between service users and providers is usually perceived as positive by participants (sense of trust develops between individuals);
- Tackle difficulties before they become too severe;
- Both strengths-based and needs-led and tailored to the individual needs of families;
- Highly structured and manual-based programmes need to maintain a high level of fidelity to the implementation of the programme.
- Comprehensive training is needed to ensure adequate levels of knowledge.
- Programmes that are based on a theoretical model of change are most likely to show effective outcomes; and
- For those with more complex problems longer term interventions appear to add to positive outcomes.

They also noted that there are a range of other factors that are likely to reduce effectiveness, including:

- Generic parenting programmes appear to have little effect for families who are at higher levels of risk and have more complex problems;
- Single focus and / or time-limited interventions are unlikely to affect other difficulties being experienced by families, so all potential areas of difficulty need to be addressed in interventions;
- Can be a perceived stigma attached to attending which is difficult to overcome in some families;
- Services which are aimed at mothers and children and do not include fathers in their interventions; and
- Location and timing of programmes can sometimes be inaccessible or restrictive for some families.

Table 2 – Summary of Outcomes Associated with Service for Children, Young People and Families

	Children	Parents
Health	*Improve* Eating habits Child immunisation *Reduce* Risk of alcohol and drug use	*Improve* Overall health *Reduce* Prenatal smoking Closely spaced subsequent pregnancies
Safety	*Reduce* Child abuse and neglect Cases of child maltreatment Cases of child hospitalisation due to maltreatment Injuries in children Infant mortality due to premature birth, sudden infant death syndrome and injuries Need for child placement	
Parenting		*Improve* Knowledge, competence and parenting skills Use of positive parenting methods Attitudes towards parenting (including positive parenting attitudes) Understanding of infants Involvement of fathers in childcare *Reduce* Harsh discipline practices Coercive parent practices
Socio-emotional	*Improve* Mental health Social / emotional competence Empathy Pro-social behaviour (e.g. sharing, helping) Emotional regulation Willingness to discuss problems with a teacher or another adult Self-esteem Hopefulness about the future Sense of efficacy in relation to the future *Reduce* Risky behaviour Behavioural problems Levels of aggression (verbal or physical) in home and school Externalising behaviours Levels of anxiety	*Improve* Life satisfaction Well-being Enhanced self-esteem *Reduce* Levels of hypertension / stress Depression Anger
Home environment	*Improve* Home learning environment	*Improve* Quality of life in their home environment

	Reduce Chaotic home environment	*Reduce* Marital conflict
Education	*Improve* Language development Vocabulary scores Levels of reading Arithmetic achievement School attendance Complete education (especially for 'hard to reach' marginalised families) School readiness for pre-school children	*Improve* Parent involvement in school activities
Societal	Improve Formal and informal networks in the community Feeling of being better supported Sense of social acceptance School liking *Reduce* Anti-social behaviour Juvenile crimes or involvement with the criminal justice system	
Parent-Child Relationship	*Improve* Parent responsiveness Reading to children Overseeing homework Parent – teenage relationship Teenager's perception of parental competence *Reduce* Levels of stress in parent – teenage relationship Parent's feelings of guilt	

Appendix A – Summary of Child Protection and Alternative Care

The Department of Children & Youth Affairs (2017: 11-12) has set out a range of factors in a child's life that may place them at greater risk of abuse or neglect.[111] Other research has highlighted the problems most commonly associated with the occurrence of child abuse and neglect, and identified in families involved with child protection services:

- Parental alcohol and other drug use;
- Domestic violence; and
- Parental mental health problems.[112]

High Prevention Services

In some cases a child or young person may be at risk of harm and require specialist assessment from a collaboration of experience professionals. Protective family support (or tertiary family support) falls within the remit of the child protection system and aims to protect the child and family from problems that have already developed, particularly where there is child neglect or abuse. These types of interventions can include actions to remove a child from their parents / carers in order to protect them from an immediate risk or to prevent the reoccurrence of an incident. It is usually highly directive, sometimes based on a court order.[113]

Response Pathway 3 - Child Protection

In cases of a child at ongoing risk of significant harm who is still residing with his or her parents/carers, a Child Protection Case Conference (an interagency and inter-professional meeting) is convened to discuss the case. The Child Protection Case Conference facilitates the:

- sharing and evaluation of information between professionals and parents/carers,
- consideration of the evidence as to whether a child has suffered or is likely to suffer significant harm, and

[111] See also: Runyan et al. (2002) and National Research Council (1993). It is worth noting that there are a variety of theories and models that have been developed to explain the occurrence of abuse within families. Of these, the most widely adopted explanatory model is the ecological model. The ecological model considers a number of factors, including the characteristics of the individual child, those of their family, caregiver or perpetrator and the social, economic and cultural environment in which they live.
[112] Commonwealth of Australia, 2009; Hutchinson et al., 2014. In this context, it is also worth noting that school transitions have been identified as a period of risk for children experiencing abuse or neglect. When children and young people are either beginning primary or secondary school, they may be at greater risk because the move between different service systems is associated with a change in the level of surveillance; the period around the transitions may be associated with increased levels of stress for the children and young people as well as their families; and the ability of children to successfully negotiate the transitions can impact on their academic performance as well as their well-being and development including how well they engage with peers, teachers and the school more generally. (Anderson, Jacobs, Schramm and Splittgerber, 2000; Brady et al., 2012; Akos and Galassi, 2004; Stewart, Livingston and Dennison, 2008.)
[113] Department of Children & Youth Affairs, 2017: 46.

- decision as to whether a child should be listed on the Child Protection Notification System. If a child is listed, a specific Child Protection Plan must be developed for them.

Child Protection Notification System

The Child Protection Notification System is a secure database that contains a national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern.[114]

At end-2017, about 1,300 children were listed as active on the CPNS. On average, the number of children active on the CPNS at the end of each year is just over 1,330 (2014-2017). Of these, almost half of children are recorded as active for 6 months or less with almost a quarter of children recorded as active for between 6 and 12 months. About 13% of children are recorded as active for more than 18 months.[115]

When it is decided that the child is no longer at ongoing risk of harm, the child's record is changed from active to inactive.[116]

Child Protection Plan

A Child Protection Plan applies to those children who are listed on the Child Protection Notification System. It is an interagency plan that sets out what changes need to happen to make sure that the child or young person is safe and that their needs are met. It will also list the support and help to be given to the family by the different agencies and what the family is expected to do to make the changes happen so that the risks can be reduced or removed and a decision can be made to list the child as 'inactive' on the CPNS.

Children who are on Child Protection Plans continue to live at home, unless it emerges that a child is at ongoing risk, or if the Child Protection Plan is deemed not to be working. These cases may result in a decision to remove the child from the home.

Response Pathway 4 – Alternative Care

Alternative Care is State provision of care for children who cannot remain in the care of their parents.

Interventions involving the separation of children from their parents / guardians can only be carried out by Tusla social workers. This may be done by voluntary agreement (with the consent of the parents / guardians) or by Court Order under the Child Care Act 1991. It must be borne in mind that the removal of children from their parents/carers or their homes can be very stressful and requires sensitive handling. The likely effects of separation must be balanced against the danger of leaving the child at home.[117]

The main types of alternative care services provided to address the needs of children requiring State care and protection include:

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[114] Department of Children & Youth Affairs, 2017: 46.
[115] Tusla, Various. *Quarterly Performance and Activity Data*.
[116] Department of Children & Youth Affairs, 2017: 46.
[117] The starting point is the Constitutional presumption that a child is best placed within their family, and any decision to remove a child from their parent / guardian takes this into account as well as the actual or potential harm that may result if they remain within the family environment.

- Foster care (around 90% of children in care) - full-time or part-time substitute care of children outside their own home by people other than their biological or adoptive parents or legal guardians:-

    - Relative foster care (over a quarter of children in care) – is provided by a person who is a friend, neighbour or relative of the child or person with whom the child or family has had a relationship prior to the child's admission to care.[118]

    - General foster care (about two-thirds of children in care) – is provided by a person approved by Tusla, having completed a process of assessment and who has been placed on the panel of approved foster carers to care for children in State care in accordance with the Child Care Act 1991 and the Child Care (Placement of Children in Foster Care) Regulations 1995.

  The majority of children in foster care have an allocated social worker who is responsible for the coordination of the care of the child. Details regarding the supports they will receive, their on-going education and the contact they will have with their families will be documented in their care plan which is tailored to their individual needs.

  The majority of foster families have an allocated link (social) worker and their key role is to supervise and support carers in their task of providing foster care.

- Residential care (about 5% of children in care) - is any home or institution for the residential care of children in the care of Tusla or other children who are not receiving adequate care and protection. The purpose of residential care is to provide a safe nurturing environment for individual children and young people who cannot live at home or in an alternative family environment.

- Special care (about 2% of children in care) - provides for a short-term, stabilising intervention that prioritises safe care in a secured therapeutic environment for children at risk and with challenging behaviour.[119]

[118] These carers are subject to the same assessment and approvals process as general foster carers. There is a 12 week period following the placement when the assessment can be completed if it is not done prior to the placement.
[119] Tusla. 2019: 45, 55 and 62.

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