SOCIAL INFORMATION SYSTEMS LTD

Review of Special Care Applications

July 2008

An Bord Comhairleach um Achtanna na Leanaí
Children Acts Advisory Board

REVIEW OF SPECIAL CARE APPLICATIONS

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FOREWORD

I am delighted to welcome this research report commissioned by the Special Residential Services Board (now the CAAB) and undertaken by Social Information Systems (SIS). This research explores the experience of the childcare system in operationalising the *Criteria for the Appropriate Use of Special care Units* and the *Standardised Application Form* which were both developed in co-operation between the SRSB and the HSE.

The objective of the criteria and the standardised forms was to bring clarity to the process of accessing special care and ensuring that its utilisation would indeed be as a matter of last resort.

The steering group for this research included officials from the Department of Health and Children, the HSE, CAAB and SIS. The research was commissioned and conducted at a time of significant change across all agencies engaged in the process. The research commenced in tandem with the new standardised Application Form and a new process of applying to a central office in the HSE, and to the Special Residential Services Board, (now CAAB). The research explored the case profiles of the children subject to the applications for special care during the research period and it reviewed the new process and Application Form.

The findings of the research have been categorised under practice, process and management headings and will, I believe, be helpful in ensuring that the changes currently underway in the Special Care service will be optimised. To assist the child care sector, the CAAB will be leading an Implementation Group comprising of the members of the Steering Group to ensure that the findings and conclusions are used to promote better practice and outcomes for children. Furthermore, the CAAB now proposes to commission a longitudinal study to track the progress and outcomes of the children involved in this research.

I would like to thank Mark Brierley and Dr. Henri Giller of Social Information System for their excellent work and contribution in the continuing development of better practice in the child care sector. I would also like to thank all those involved in the research, in particular the practitioners in the HSE and Family Welfare Conferencing Service, and the chairs of the CAAB Review Panels and the members of the steering group.

Aidan Browne
Chief Executive

Children Acts Advisory Board

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Introduction

This report provides an overview of the applications for admission to special care made by the Health Service Executive Local Health Offices between January and June 2007. This research has been undertaken by Mark Brierley and Dr. Henri Giller of **Social Information Systems Ltd (SIS)** on behalf of the Children Acts Advisory Board (CAAB) and the Health Service Executive (HSE).

It is important to note that this research was conducted in an evolving environment. The HSE only came into existence as a single national structure in 2005, the CAAB has been subject to change during the research period (changing its name from the Special Residential Services Board and now dealing with both welfare and juvenile justice), the infrastructural arrangements for applications were all new, and in the summer of 2007 Judge MacMenamin made a number of rulings in the High Court that will have a significant impact in the future on applications for special care and impacted on the decision-making for some of the later cases within the cohort.

Context

The Child Care Act 1991 (as inserted by s.16 Children Act 2001) provides for a statutory special care scheme where a court can make a special care order (s.23A) or an interim special care order (s.23C), if it is satisfied that the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare, and the child requires special care or protection which he or she is unlikely to receive unless the court makes such an order. Special Care Units (SCUs) are secure placements for children who are in need of special care or protection with the explicit objective of providing a stabilising period of short term care which will enable the young person to return to less secure care as soon as possible.

In preparation for the anticipated implementation of the sections of the Child Care Act 1991 (as amended) relating to special care in January 2007, substantial infrastructural changes were made. The criteria for special care were modified through discussion between the HSE and the CAAB. A single *Special Care Information and Application Pack* was developed including the criteria, guidance on key parts of the process, a Referral Form for family welfare conferences, and a special care Application Form. Within the HSE, a single National Special Care Admission and Discharge Committee (NSCADC) was established, comprising the former Chairs of the admissions committees of the three SCUs in Ireland, the managers of the three SCUs, and an independent Chair. The CAAB also has a statutory role to offer its view on special care applications and put in place internal procedures to support this.

Sections in the Child Care Act 1991 (as amended) which provide for the District Court to hear applications for Special Care were not operationalised as anticipated in January 2007, due to the need for revised regulations. The Department of Health and Children is currently drafting a Bill to amend these provisions to provide, inter alia, a statutory basis for the High Court to hear such applications for Special Care. It was decided, however, to continue to implement the new infrastructural

arrangements and for SIS to continue as planned to review applications made under these revised arrangements.

This report covers the 36 applications for special care made between January and June 2007. For 34 of these applications, SIS had full background information (the CAAB removed the child and family names before the information was sent to SIS ensuring anonymity) and was able to examine both case characteristics and the application process; for two applications in exceptional circumstances, SIS did not have the full range of papers and therefore considered only relevant aspects of the application process.

Conclusions and recommendations are divided to reflect issues relating to:

- Management of practice.
- Processes.
- Monitoring.

Management of Practice

The case profiles were analysed according to a range of factors, including age, gender, ethnicity/nationality, Local Health Office (LHO), the case being made against each of the special care criteria (see Appendix A for criteria), care placement history, offending history, education, health and previous interventions. These factors were all cross-reference with the outcome of the application: that is, whether or not the child was admitted to special care

As in previous research, there were gender variations in terms of a higher likelihood of females being both the subject of applications and the subject of admissions. There were other gender variations too:

- One of the criteria for special care relates to whether the behaviour of the child poses a "real and substantial risk to his/her health, safety, development or welfare unless placed in a Special Care Unit." Such risks can be summarised as *Risks posed to self* and *Risks posed by others:* both of these had a much stronger likelihood of resulting in an admission to special care for females than for males.
- Of these same factors, 80% of applications for females had factors related to *sexual risks*, compared to only 29% of the applications for males.
- Under the criteria for special care relating to "a history of impaired socialisation and impaired impulse control", the report considers the extent to which *Risk-taking behaviour* was cited in the application as a reason for seeking admission to special care. Where such behaviour was present, it had a much higher likelihood of resulting in an admission to special care for females than for males.
- Successful applications for females were much more likely to be linked to those who had had a previous experience of special care or for whom consideration of high support[1] had been demonstrated.
- Females with high support as their planned onward placement were four times more likely to be the subject of a successful application than males with high support as their onward placement.

[1] High support is a form of care within Ireland that differs from special care primarily in the level of security, with children in a Special Care Unit being detained and requiring a Court Order to be placed there, whereas children in a High Support Unit are not detained and do not require a Court Order to access the placement.

- 50% of the males were assessed as having a low/mild/borderline disability whereas this was only true for 25% of the females.
- The information provided on the Application Form by Social Workers suggested that 50% of the females agreed with, or reluctantly agreed with, the application for special care, compared to only 14% of the males.

There are potential practice issues here in terms of whether risk-taking behaviour is more likely to be tolerated in males than in females, particularly behaviours relating to sexual behaviours and risks. Is the behaviour of the females more risky than for the males or is the same behaviour in a female considered to be more risky?

RECOMMENDATION 1: The Health Service Executive (HSE) should consider the development of guidance on Risk Management Strategies to address risk assessment and risk management, with particular emphasis on gender issues and expectations of what resources might be employed locally prior to making an application for special care.

RECOMMENDATION 2: Within practice, social work professionals need to be mindful of whether they respond differently, or in the same manner, to the same risky behaviour displayed by females and males, particularly in relation to sexual risks.

For some of the applications, the child was missing at the time of the application. If a child is missing from home rather than from care, this situation provides an additional complication.

RECOMMENDATION 3: The HSE should draw up practice guidelines on options for responding where there are significant concerns about a child who is not in care, who appears to meet the criteria for special care, but is missing.

For seven applications, the child was felt to be at risk from a known individual (usually an older boyfriend). 71% of such applications resulted in an admission to special care. In such circumstances it should be imperative to focus on the risks posed by the adult.

RECOMMENDATION 4: Protocols for agencies working together where a child being considered for special care is deemed to be at risk from a known adult need to be re-examined to identify any policy, practice and legislative implications.

For seven applications, there were concerns that the child was endangering other children by inciting them to criminal or anti-social behaviour. 71% of these applications led to an admission to special care. It should be questioned whether special care is the optimum method of separating children in these circumstances.

RECOMMENDATION 5: Where there are concerns about the risks the child poses to other children through incitement to criminal, anti-social, and/or negative behaviour, there should be a substantive body of evidence to demonstrate that all efforts have been taken to reduce this risk before special care is considered as an option.

Every application identified absconding as a risk factor. Absconding is specifically mentioned in this criterion for special care relating to *Impaired socialisation/impulse*

control. In addition, in *Health Service Executive v. DK, a minor*[2] Judge MacMenamin noted that an established pattern of absconding is not sufficient to justify deprivation of liberty without evidence about the underlying reasons for the absconding.

RECOMMENDATION 6: Specific guidance on 'absconding' is required to emphasise that absconding alone is insufficient reason for an application for special care.

The majority of applications stated that a less secure structured environment would not be appropriate because of the level of containment required (31 applications). However, only 17 (50%) made reference to any specific interventions or outcomes that they wished the placement to achieve. More of the applications (20) made reference to the fact that the young person had not been engaging with support services than made reference to interventions that they wished for the child while in special care. In addition, some of the applicants stated that they felt that three months was too short a time period to achieve much more than containment of the child, and some were unsure about the different models of care being utilised in the three SCUs. The short-term nature of special care emphasises the need for a long-term vision of the interventions and supports that the child may require: some such needs may only be identified during the placement. This in turn emphasises the importance of the discharge plan and of the SCUs and Social Workers working closely together to identify next steps. It is not within the remit of this research, however, to comment on the effectiveness of discharge plans from special care over the medium-term. Nevertheless, improved information on the models of care operational in the three SCUs would aid Social Workers in considering the purposefulness of their application.

RECOMMENDATION 7: Information on the models of care provided under special care should be made available to Social Workers.

Nine children were remanded to a Children Detention School at the time of the application to special care (although this was not always clear on the application form) and 13 applications had ongoing criminal proceedings before the District Court.

Prior to 2007, the HSE could apply to the High Court for a child to be detained in a Children Detention School for 'welfare reasons'. Since January 2007, this has not been possible: children can only be remanded (by District Courts) to a Children Detention School where there are criminal charges against them. However, more often than not, the Social Workers stated in interview that they regarded the motive for remand to a Children Detention School as being for welfare reasons, in several instances pending the application to special care.

In June 2007, while this research was underway, in *Health Service Executive v. S (S) (A Minor), (2007, paragraph 19)*[3], Judge MacMenamin made a number of significant statements in his judgement. He stated that "detention [in a Children Detention School] would be inappropriate for a young person in the absence of a criminal

[2] *Health Service Executive v. DK, a minor* represented by his solicitor and next friend Rosemary Gantly and OK-D, 18th July 2007 unreported, MacMenamin J.

[3] *Health Service Executive (Southern Area) v. S (S) (A Minor)* represented by his Guardian Ad Litem and Next Friend ML, and MS, SC and The Special Residential Services Board (Notice Parties) (2007) IEHC 189, unreported MacMenamin J.

conviction or sentence". He also expressed concern about cases being before courts for both civil and criminal proceedings simultaneously and stressed that the latter must have priority and prevail. Many applications were not supported by the NSCADC on the basis of the ongoing criminal proceedings and the above ruling by Judge MacMenamin should help to clarify matters in the future.

Thus, this has been an area that has been subject to change, both in the period preceding this research and during the latter stages of the research, and this clarified position needs to be addressed in revised guidance.

RECOMMENDATION 8: Guidance on applications for special care should be amended to take into account what *Health Service Executive v. S (S) (A Minor) 2007* says in relation to cases being before courts with both civil and criminal jurisdictions simultaneously.

The report also considers decision-making processes within LHO Social Work Departments. External influence on the Social Work Department, pressing for an application for special care, was present for 10 of the applications: this might come from District Courts, parents, An Garda Síochána or Guardians *ad Litem.* In six of these cases, the Social Work Department was in full agreement with the need for special care; in four applications, the Social Work Department initially felt that other options could still be tried but came to believe that special care was appropriate. Seven of these ten applications resulted in an admission to special care: the CAAB supported all the applications where the Social Work Department was in full agreement, and none of the applications where the Social Work Department was initially unconvinced.

The criteria for special care requires that a number of specific reports from allied professionals should be submitted to support the application. Social histories and care plans were usually less than a month old. Educational and psychological reports were more likely to be more than three months old.

RECOMMENDATION 9: The HSE and the CAAB need to agree what defines an "up-to-date" report for each of the report types required, and to provide guidance on what actions should be taken where an "up-to-date" report is unavailable or cannot be obtained. The Application Form should be amended to ask for explanations where attached reports do not meet this requirement.

The likelihood of an application to special care being successful appears to be increased if Alternative Care Managers, Residential Managers and the General Manager have been involved in the process. The former two groups were more likely to have been directly involved in the process whereas the latter were more likely to have provided 'informed approval' of the application. It is important to involve more directly local budget holders in decisions about special care in order to optimise the chances of finding alternative solutions.

Additionally, almost half of the applications from the HSE South seemed to have involved some confusion about roles and responsibilities locally. However, only applications from the South and the West appear to have actively sought and obtained signatures from senior management in support of the application. It is important that, where a child is potentially to be deprived of their liberty, there is a clear and defensible audit trail of decision-making within the Local Health Office.

RECOMMENDATION 10: The HSE should refresh the understanding of internal staff as to their relative roles and responsibilities in progressing a special care application.

RECOMMENDATION 11: The HSE and the CAAB should make clear their expectations of evidence from the applying Local Health Office that key senior personnel were aware of, and supportive of, the decision to apply for special care.

The application form requires the applying LHO to state what the views of parents/carers and the child were on the application for special care. Parents/carers were reported by Social Workers to be generally supportive of the application, although only 10 of the applications were signed by the parents/carers. However, applicants said that only 12 (35%) of the children expressed any support for the application, albeit reluctantly. Five children were unaware of the referral through fears on the part of the Social Work Department that the child's behaviour would deteriorate if they knew about the application (in particular, the risk of increased absconding or increased self-harm); 13 children knew that the application was happening but were not informed of its progress, for similar reasons. There may be children's rights issues in progressing an application that aims to deprive a child of their liberty without their knowledge. Concerns about the child's safety are understandable but this may be dubious ground.

RECOMMENDATION 12: The HSE should consider the children's rights implications of progressing an application for special care without the knowledge of the child.

It is a requirement of the revised procedure for either a family welfare conference to be held, or, if it cannot be held, a letter provided by the local Family Welfare Conference Service confirming this, prior to an application for special care being made. Six applications failed to comply with this requirement at all, while 11 applications made a parallel application to the Family Welfare Conference Service at the same time as their application for special care.

RECOMMENDATION 13: The HSE needs to further emphasise the requirement for compliance with the family welfare conference process in future training and briefing sessions.

The views of both the NSCADC and the CAAB have an important role in the revised application process. The report considers the views expressed by both bodies on the applications to special care.

For 21 (62%) of the applications, the CAAB and the NSCADC came to the same conclusion about the application, supporting 17 of these and not supporting four.

Three applications were supported by the NSCADC but not by the CAAB. In all of these, the CAAB did not feel that all placement options had been explored nor that a case had been made that a less secure environment would not work.

Ten applications were supported by the CAAB but not by the NSCADC:

- In four applications, there had been two previous placements in special care. This is not currently part of the criteria for special care (hence would not be

considered by the CAAB) but is a valid issue for consideration by the NSCADC (see Recommendations 16 and 17).

- In five applications, there were ongoing criminal proceedings. Judge MacMenamin's summer 2007 rulings should clarify this situation: again, amendments to the criteria for special care might be made (see Recommendation 8).
- In four applications, the length of time that the child had been detained in a Children Detention School was taken into account by the NSCADC but was not part of the criteria being considered by the CAAB. Again, it seems a valid reason for divergence in opinion (see Recommendation 21).

For most of the applications, therefore, there were generally logical explanations for the divergence of opinion and we have made recommendations relating to these circumstances that might promote convergence in the future. Nevertheless, where the views of the NSCADC and the CAAB were divergent, the applicants were often confused about the role of the two bodies within the process. In Recommendation 30, we propose that the HSE and the CAAB should meet on an ongoing basis to discuss issues arising from the application process: this should include a discussion of those cases where there was a divergence of opinion.

RECOMMENDATION 14: Revised guidance should more clearly state the relative roles and powers of the HSE and the CAAB in the application process for special care.

Despite the child being 'in crisis', most admissions to special care took place in a planned manner. Where an application progressed relatively smoothly, the average length of time between the date of application and the date of admission was 31 days. This was the situation for 13 of the 19 successful applications. The HSE and the CAAB need to consider whether this is an acceptable average time. The CAAB generally achieved its target turnaround time of five working days for responding to an application. The NSCADC generally (excluding exceptional applications) averaged 21 calendar days for their first decision from date of application (i.e. excluding any subsequent appeals). In Recommendation 30, we propose that the HSE and the CAAB should meet together on an ongoing basis to discuss issues arising from the application process: this should include monitoring of the time taken between date of application and date of admission to special care.

In addition, there appears to be an unwritten procedure for 'emergency' applications, while those applications defined as an emergency by Social Workers are not necessarily seen the same way by the NSCADC and the CAAB. In order to provide an effective and timely response to emergencies, with robust gatekeeping at local and national level, guidance should be provided on what should happen in an emergency situation.

RECOMMENDATION 15: Guidance should be drawn up for applications that are an 'emergency', including local and national management and gatekeeping arrangements.

Processes

Nine of the applications were for children who had been admitted to a Special Care Unit on a previous occasion. All but one of these applications was supported by the CAAB on the basis of the criteria as they are currently written, but none of those with

two previous placements in an SCU was supported by the NSCADC. It is appropriate that the purpose of a further admission to special care should be documented and scrutinised as part of the decision making process.

RECOMMENDATION 16: The Application Form should be amended so that, where there have been previous admissions to special care, a case has to be made by the applicant with regards to the additional benefits of a further admission.

RECOMMENDATION 17: Consideration should be given as to whether the criteria for special care and/or supporting guidance should be amended to reflect a higher threshold for applications to special care where there have been two or more previous admissions to special care.

Applications that were not supported were most likely to fail because the application had not convincingly proven that all other placement options had been tried or considered.

RECOMMENDATION 18: The Application Form should be amended to more explicitly guide applicants in stating what placement options have been tried, what have been considered, and reasons for such options to not be appropriate. Social work practitioners should pay particular attention to the criterion relating to other placement options in constructing evidence in support of their application.

Only 19 of the applications had an agreed, secured onward placement. Where an onward placement to high support or mainstream residential care had been secured, 73% of applications were successful. Where high support or mainstream residential care was identified as a placement option but *not* secured, only 38% of applications were successful. In addition, research has shown that it is better for the child to have a clear idea of where they will be after a placement such as special care has ended.

RECOMMENDATION 19: The Application Form should be amended to more explicitly capture information on whether the planned onward placement has been secured or not. Social Workers should pay particular attention to securing an onward placement, even though that placement may change in the light of the child's response to special care.

Although the Application Form asks for details of the child's Social Worker and the Social Work Team Leader, it does not ask how long the Social Worker has been the child's Social Worker. This is important in order to prevent drift in the case, particularly with regards to implementing an effective discharge plan.

RECOMMENDATION 20: The Application Form should be amended to ask how long the Social Worker has been the child's allocated Social Worker.

Recommendation 21 addresses changes to the Application Form that would be complementary to Recommendation 8.

RECOMMENDATION 21: The Application Form should be amended so that, where a child is remanded to a Children Detention School, details are recorded on the date of detention, the charges, and details of the Court.

Currently in the *Hospital Admissions* section of the Application Form, Social Workers complete information on all such hospital admissions rather than limiting this to those admissions that have some relationship to the reasons being given to support the application for a special care placement.

RECOMMENDATION 22: The *Hospital Admissions* section of the Application Form should be amended so that it guides applicants to only provide that information which is relevant to the reasons being given to support a placement in special care.

Recommendation 23 addresses changes to the Application Form that would be complementary to Recommendation 13.

RECOMMENDATION 23: The Application Form should be amended to include, where a family welfare conference has not happened, both the date of the referral to the FWC Service, and a prompt to attach a letter from the FWC Service stating the reasons if a family welfare conference was not convened.

The family welfare conference paperwork does not currently record specifically whether the child was in attendance.

RECOMMENDATION 24: Paperwork for the family welfare conference should be amended to record specifically whether the child was in attendance.

13 applications were subject to an 'appeal': 10 appeals were made to the NSCADC, and five to the CAAB. The NSCADC changed its view on two applications, and the CAAB changed its view on two applications (these were four different applications), leading to a convergence of views on three of these applications. Applicants whose application was not supported also often wished for more detail on the reasons than they are currently receiving. There is a need for a more robustly defined appeals process, addressing:

- Grounds for an 'appeal'.
- How to appeal.
- To whom to appeal (should it be the same body or a different body?).
- How often the Social Work Department can appeal.
- Opportunities to consult prior to the appeal.
- Opportunity to present an appeal in person, if felt desirable.
- When to re-apply rather than appeal.
- The role of updates/additional information where a case deteriorates significantly.

RECOMMENDATION 25: The HSE and the CAAB should respectively define and publish "appeals procedures" for applications for special care.

Although the majority view from interviewees was that the Application Form and the revised process were acceptable, there were concerns about the length of the Application Form. Even if the interviewee regarded it as "long but all needed", any streamlining of the information being asked for would help. The inclusion of the criteria on the form was generally seen as positive. SIS will separately make recommendations with regards to the form.

With regards to the overall process, many interviewees found the unified national process an improvement on previous processes. However, there was a distinct

regional pattern to these views. No applicant from the HSE South felt that the revised processes were an improvement, and six of the seven applicants who felt that the revised processes were worse were from the South.

Monitoring

Within the research period, 15 Local Health Offices made an application for special care and 17 did not. There were no applications from the areas of either the former Mid-Western Health Board or the former South Eastern Health Board, both of which are relatively well provided for in terms of local High Support Units.

RECOMMENDATION 26: The pattern of applications for special care by Local Health Offices should be monitored on an ongoing basis.

71% of applications were for children whose nationality and ethnicity was *White Irish*, and 75% of these applications were successful in gaining admission to special care. This compares to a 22% success rate for other nationalities/ethnicities (*Irish Travellers*, *Mixed Irish/English*, and *English*). No procedural bias for or against any nationality/ethnicity was detected, however. In addition, there were no applications for children from any new immigrant communities. However, applications should be monitored according to nationality and ethnicity on an ongoing basis.

RECOMMENDATION 27: The profile of applications and the success rates of those applications should be monitored against nationality/ethnicity on an ongoing basis.

There is a substantial body of research that suggests that the actual experience of children on discharge differs from the discharge plan, with variability both in the effectiveness of both the onward placement itself and in post-placement experiences.

RECOMMENDATION 28: Further research should be conducted, using a cohort of cases, on the medium-term outcomes for children who have experienced a special care placement.

SIS outline a 'model' application process within the report. The premise is, that if a case follows all the correct procedures and meets all the requirements, it would follow this 'model'. However, only three applications actually went through the process in such a model manner. Learning points and practice issues derive from those applications where this model process does not occur and many of the recommendations made within this report aim to address these issues. This suggests a need to repeat the review process again in the future, in order to determine whether there is increased conformity to a 'model' process as a result of any changes made in response to this report.

In addition, the environment for this research itself changed during the research period (e.g. the High Court judgements made in the summer of 2007) and will continue to evolve in the future in the light of changes to services and legislation. This suggests a need for the HSE and the CAAB to meet on an ongoing basis (with a frequency to be determined by both parties) in order to make adjustments to the application process in the light of both changes to the operating environment and lessons that might arise from the applications themselves.

RECOMMENDATION 29: The HSE and CAAB should periodically repeat the exercise to review special care applications, as per this current research.

RECOMMENDATION 30: The HSE and CAAB should meet on an ongoing basis to discuss issues arising from the application process.

The speed of convening family welfare conferences was generally within documented standards for Family Welfare Conference Services. However, Social Workers often had a negative view of the role of family welfare conferences in the special care application process, believing that usually by this stage all options within the extended family would have been exhausted and that the requirement for a family welfare conference slowed the process down. Many Social Workers who were not convinced of the value of a family welfare conference within the special care process found value in family welfare conferences in other contexts. The Family Welfare Conference Co-ordinators shared some of the views of the Social Workers. There is clearly a continued exercise required to emphasise the role of family welfare conferences as a means of taking one last attempt to prevent an admission to special care. There should also be an ongoing review of whether family welfare conferences are achieving their intended preventive aim within the process.

RECOMMENDATION 31: The HSE should monitor on an ongoing basis the outcomes of applications for which a family welfare conference was held as part of the decision making process for special care, with particular emphasis on identifying the number of cases where an application for special care did not follow (within 3 months) and the outcome of applications where a family welfare conference was held in terms of numbers of applications admitted.

During the research, a question was asked by Social Workers about what should happen where their Local Health Office wishes to place a child, who might require special care, in a placement outside Ireland. This raises two issues:

- A HSE national policy on placement of children abroad, who might require special care, is needed. In these circumstances should the criteria for special care be applied?
- The HSE needs to monitor the number of children who *might* fit the Criteria for special care and who are placed abroad.

RECOMMENDATION 32: The HSE should monitor the numbers of children placed abroad who *might* fit the Criteria for special care and develop a national policy regarding such placements. This should incorporate the function of the CAAB in giving its view.

INTRODUCTION

1. This report provides an overview of the applications for admission to special care made by the Health Service Executive (HSE) Local Health Offices between January and June 2007. This research has been undertaken by Mark Brierley, Executive Director, and Henri Giller, Managing Director, of **Social Information Systems Ltd (SIS)** on behalf of the Children Acts Advisory Board (CAAB) and the HSE. SIS has previously conducted research on behalf of the CAAB into the criteria for both special care (*Review of Admissions Criteria and Processes for Special Care)*[4] and high support *(Definition and Usage of High Support in Ireland)*[5].

2. The *Review of Admission Criteria and Processes for Special Care* (2005) recommended that the HSE and the CAAB should define an appropriate business process for use in the future for children being considered for admission to special care. It also recommended that the paperwork required to make a special care application should be standardised and rationalised, to make it easier for applicants to compile and to make it more informative to those who receive it.

3. It is important to note that this research was conducted in an evolving environment. The HSE only came into existence as a single national structure in 2005; the CAAB has been subject to change during the research period (changing its name from the Special Residential Services Board and now dealing with both welfare and juvenile justice); the infrastructural arrangements were all new; and in summer 2007 Judge MacMenamin made a number of rulings in the High Court that will have a significant impact in the future.

4. Note also that, although the applications that were the subject of the research were for children aged between 12 and 17, we have called them "children" rather than "young people" or "adolescents" as only the former is used in Irish legislation.

Special Care

5. The original provisions of the Child Care Act, 1991 did not permit access to secure treatment accommodation for children and hence detention in a secure facility. Secure detention heretofore could only be accessed through a statutory route where the young person had committed a criminal offence. Faced with this lacuna in the statutory framework, the High Court began exercising its constitutional prerogative to extend its inherent jurisdiction over children to secure their welfare, if necessary, by detention, for the purposes of treatment[6].

[4] Social Information Systems (2005), Review of Admissions Criteria and Processes for Special Care, Dublin: Special Residential Services Board.

[5] Social Information Systems (2003), Definition and Usage of High Support in Ireland, Northwich UK: Social Information Systems

[6] The European Court of Human Rights, however, has held that such detention in the case of a non-offending child must be in an appropriate "educational supervisory regime" and not detention per se (DG v Ireland, 2002); Caul, Tara, "Summary of Caselaw Relating to Children's Rights and Secure

> "…the courts have found that the constitutional rights of certain children can only be vindicated by the provision of facilities in which they can be detained or contained for the purposes of treatment. Given that the courts have come to this conclusion, it is clear that the State has no option but to provide secure facilities"[7].

6. Currently, applications are made by the HSE to the High Court, for an order of detention of a child to be placed in a special care unit. The High Court is using its inherent jurisdiction for the welfare of the child with the provision of educative and therapeutic services.

7. The Child Care Act, 1991 (as inserted by s.16 Children Act, 2001) provided for a statutory special care scheme where a court can make a Special Care Order (s.23A) or an Interim Special Care Order (s.23C), if it is satisfied that the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare, and the child requires special care or protection which he or she is unlikely to receive unless the court makes such an order. The order of the court involves the detention and secure placement of a child in a special care unit (s.23K) which is under the management of the Health Service Executive. Within such accommodation the HSE is authorised to provide appropriate care, education and treatment for the child (s.23 (B) (2)). In so doing, the HSE is empowered to take such steps as are reasonably necessary to prevent a child in special care causing injury to themselves or others or from absconding from the unit (s.23 (B) (3)).

8. The provision of Special Care Units (SCUs) by the HSE is subject to approval and certification by the Minister (s. 23K), following inspection. Special Care Units are secure placements for children who are in need of special care or protection with the explicit objective of providing a stabilising period of short term care which will enable a child to return to less secure care as soon as possible.

9. The specific objectives of special care are to:

Provide a short-term period of safe and secure care in an environment for young persons whose emotional and behavioural needs can only be met at this time in a special care setting.
Stabilise an 'extreme' situation which has been persistent and severe, following on a risk assessment.
Provide a controlled and safe environment in which care and appropriate intervention with young people who satisfy the admission criteria is undertaken.
Improve the welfare and development of young people in a model of care based on relationships, containment and positive reinforcement.
Provide a model of care which promotes consistency, predictability, dignity, meaningful controls and external structure which will assist young people in developing internal controls of behaviour, self-esteem, personal abilities and strengths, and capacity for constructive choice and responsibility.

Accommodation", Children's Law Centre, 2003; Shannon, Geoffrey, "Children Act 2001: South Western Health Board Seminar Paper", 2004.

[7] Durcan, Gerry, "Secure Accommodation in the Child Care System: The Legal Background", in *Secure Accommodation in Child Care – Papers from a Seminar organised by the Children's Legal Centre,* 1997.

10. The three Special Care Units operational in Ireland are:

    Ballydowd Young People's Centre: a mixed gender unit in County Dublin with a maximum capacity of 15.

    Gleann Alainn Females Special Care Unit: a females only unit in County Cork, with a maximum capacity of five places.

    Coovagh House Special Care Unit: a mixed gender unit in County Limerick, with a maximum capacity of five.

11. In contrast, High Support Units (HSUs) provide support to children with complex and often long-standing needs in a non-secure environment. The essential difference between special care and high support is in the level of security, with children in an SCU being detained and requiring a Court Order to be placed there, whereas children in an HSU are not detained and do not require a Court Order to access the placement.

Context

12. In 2005 the Health Service Executive came into existence as a national structure, replacing the existing ten independent Health Boards and the Eastern Regional Health Authority. Special care and high support were to be addressed under the new structure as a priority. The three Special Care Units (SCUs) had previously had their own individual admissions and discharges committees and these were brought together into a single National Special Care Admission and Discharge Committee (NSCADC), comprising the former Chairs of the admissions committees for the three SCUs, the managers of the three SCUs, and an independent Chair. In addition, in November 2006 the HSE post of National Manager for Special Care and High Support was filled (initially on an interim basis).

13. Provisions of the Children Act, 2001 also introduced a role for the Special Residential Services Board in offering a view to the Court on each application for special care. The Board was also given a remit for research in the area of special care. The Board has a pool of reviewers for applications to assist it in reaching its view, and usually reviews each application using a panel of three. During the course of this current research, the Act was amended and as a result the name of the Board changed to the Children Acts Advisory Board (CAAB), the name that we use throughout this paper. The amendments also added to the remit of the Board a responsibility for publishing the criteria for special care, in consultation with the HSE.

14. The Children Act, 2001 also introduced a requirement for the convening of a family welfare conference (FWC) prior to an application being made for special care. The purpose of the family welfare conference in such circumstances is to bring together the child, parents, relatives and professionals in an attempt to come up with a family plan to prevent the seeking of a Special Care Order.

15. It was expected that the full provisions of the Children Act, 2001 with regards to special care would be implemented from January 2007. The research

covered by this paper was intended to consider the revised application process that would be implemented from that date.

16. In preparation for the anticipated implementation of the sections of the Child Care Act, 1991 (as amended) relating to special care in January 2007, substantial infrastructural changes were made. A single Application Form was developed, based on the existing application forms of the SCUs, the perceived requirements of the CAAB and the anticipated requirements for the research that is the subject of this report. National forms were also developed to support family welfare conferences where the reason for the conference was special care. Process charts were developed detailing the requirement to hold a family welfare conference prior to application and to seek the views of the CAAB. The criteria for special care were modified through discussion between the HSE and the CAAB. A single *Special Care Information and Application Pack* was developed by the HSE and the CAAB, supported by SIS, including the criteria, guidance on key parts of the process, a Referral Form for a family welfare conference, and a special care Application Form. During 2006, briefing sessions were undertaken throughout the country, by what was then known as the HSE National Special Care and Children Act Committee (set up for the purpose of planning implementation of the relevant sections of the Children Act, 2001), to introduce the revised process to HSE social work staff. The CAAB also held a networking event to provide information on issues relating to special care in early 2007.

17. Sections in the Child Care Act, 1991 (as amended) which provide for the District Court to hear applications for Special Care have not been operationalised due to the need for revised regulations. The Department of Health and Children is currently drafting a Bill to amended these provisions to provide, inter alia, a statutory basis for the High Court to hear such applications for Special Care. It was decided, however, to continue to implement the new infrastructural arrangements and for SIS to continue as planned to review applications made under these revised arrangements. Children admitted to special care therefore were admitted under detention orders under the High Court's inherent jurisdiction, as before.

18. In June and July of 2007, there were also three significant judgements in the area of special care delivered by the High Court:

    Health Service Executive (Southern Area) v. S (S) (A Minor) represented by his Guardian *Ad Litem* and Next Friend ML, and MS, SC and The Special Residential Services Board (Notice Parties) (2007) IEHC 189, unreported MacMenamin J.

    Health Service Executive v. DK, a minor represented by his solicitor and next friend Rosemary Gantly and OK-D, 18th July 2007 unreported, MacMenamin J.

    Health Service Executive (South Eastern Area) v. WR (a minor) represented by his solicitor and LR and The Special Residential Services Board (Notice Parties) 18th July 2007 unreported, MacMenamin J.

19. As we will demonstrate within this report, these judgements will impact in the future on the application process. They partially impacted on decision-making for some of the later applications within the cohort.

Methodology

20. Research covered the 36 applications for special care made between January and June 2007. For 34 of these applications, SIS had the full range of background information (the CAAB removed the child and family names before the information was sent to SIS ensuring anonymity) and were able to examine both case characteristics and the application process; for two applications in exceptional circumstances, SIS did not have the full range of papers and therefore considered only relevant aspects of the application process. Most of the research therefore relates to the 34 applications for which the full range of detail was available, with the two exceptional circumstances only referred to when the specific issues that they raised are pertinent.

21. Data for the research derived from several sources:

The application paperwork. SIS participated in the redesign of the Application Form and the forms for the family welfare conferences to be used where the reason for the FWC was to consider special care. SIS was sent all copies of the Application Form and supporting paperwork by the CAAB, with the names of children and their families removed to preserve anonymity.

Interviews with the applicants. SIS conducted interviews with those workers in the HSE Local Health Office (LHO) Social Work Departments who had made the application. The purpose of the interviews was two-fold: to clarify information contained in the application paperwork and to gain the applicants' perceptions of the process. Ideally, the interview was to be conducted with both the Social Worker and their Team Leader together, but this was not always possible (staff turnover, maternity leave, or last minute calls to court). Interviewees were generally comfortable, where a fellow applicant could not attend, that the views of both parties were largely as one. On some occasions, the interviewee was the applicant for more than one application. The profile of interviewees was:

- 17 applications: interview with Social Worker and Team Leader.
- 10 applications: interview with Social Work Team Leader only.
- 6 applications: interview with Social Worker only.
- 2 applications: interview with Principal Social Worker and Social Worker.
- 1 application: interview with Principal Social Worker only.

Names of the interviewees are not recorded in this report to further protect the anonymity of the children.

Data supplied by the CAAB: This included data on the deliberations of the CAAB, a questionnaire on the operation of the review panel completed by members of the CAAB review panel pool, and a group discussion with the three review panel chairs.

Data supplied by the NSCADC: This included key dates plus a response to SIS queries on individual applications.

Data supplied by Family Welfare Conference Services: This included data on dates for stages of the process, plus two group discussions, one with Dublin-based co-ordinators, and one with co-ordinators from the South (these

were the two areas where most family welfare conferences occurred for the cohort under consideration).

22. Within this report we will consider first the case profiles for the 34 applications in the cohort for which there were full background application papers, then the application process itself.

CASE PROFILES

23. The key determinant for deciding whether an application may be eligible for special care is the criteria (Appendix 1). We specifically consider the profile of risks associated with each of the criteria within this part of the report on Case Profiles. However, we begin by looking at some basic background information about the application: gender, HSE Area and Local Health Office, care status, ethnicity/nationality, and placement when the current application was made. Then we consider actual outcomes of the application, by age and gender. This provides a useful backdrop when we begin to consider the criteria themselves.

Demographic Details

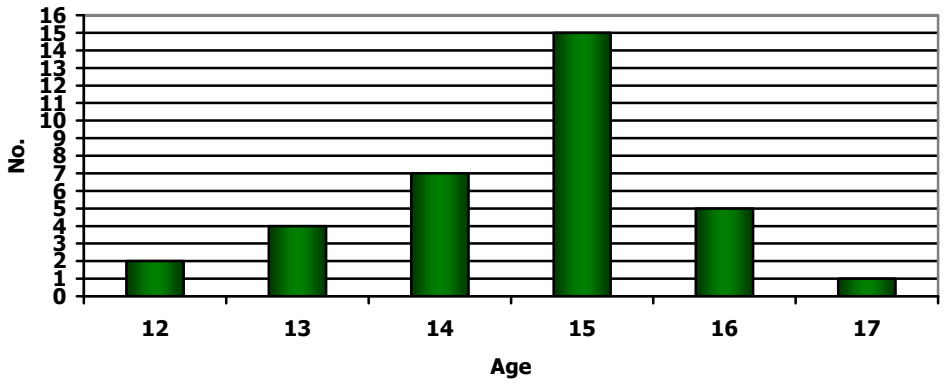
Gender

24. The *Review of Admission Criteria and Processes for Special Care* (2005) noted that, of applications for admission to special care in 2004, 53% were for females and 47% were for males. Within the cohort for this study, 20 (59%) of the applications were for females and 14 (41%) were for males. As with previous research, this shows a gender difference with regards to applications made.

Age

25. Almost half of all applications were for children aged 15. 22 of the 34 applications were for children aged 14-15.

Figure 1: Age (at application)

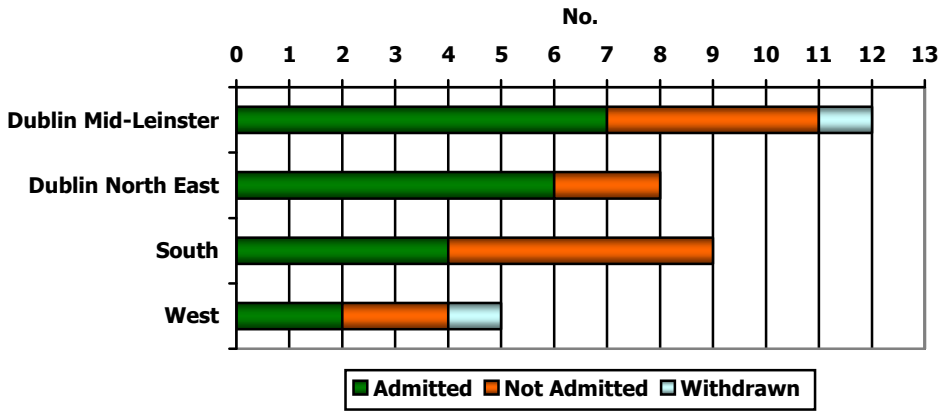


Health Service Executive (HSE) Area and Local Health Office (LHO)

26. There are four HSE Areas: Dublin Mid-Leinster, Dublin North East, South, and West. Dublin Mid-Leinster made the most applications for admission to special care within the cohort, Dublin North East and the South made a similar number of applications, with the West having fewer applications. Dublin Mid-Leinster and Dublin North East were both more likely to have an application result in an

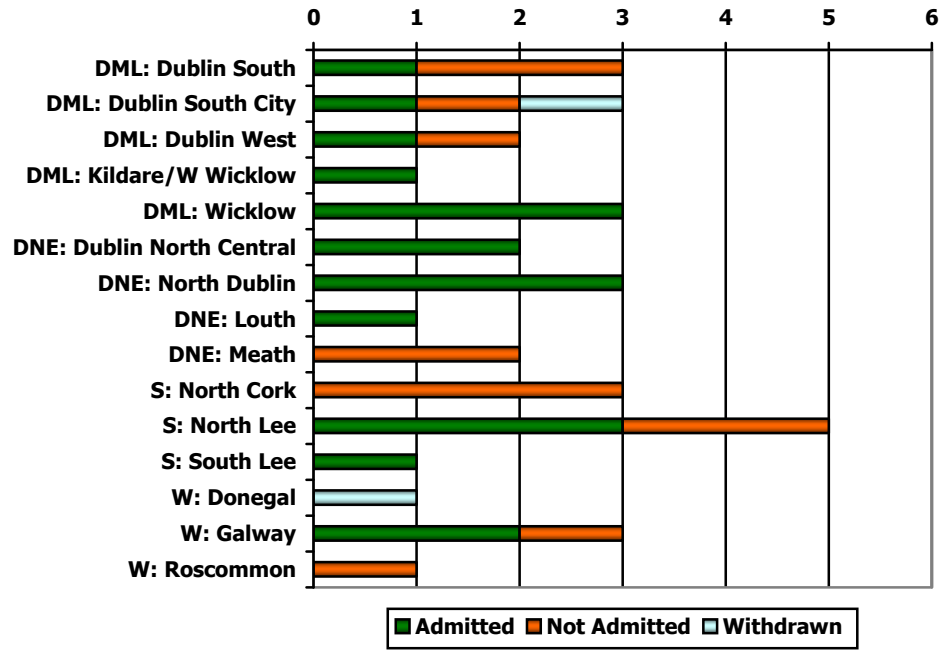
admission (58% and 75% success rates respectively); whereas the South and West were more likely to have an application not result in an admission (45% and 40% respectively).

Figure 2: Applications x HSE Area



27. The four HSE Areas are divided into 32 Local Health Offices (LHOs). 15 of the 32 LHOs made an application for special care within the cohort, with five LHOs making three or more applications (Dublin South, Dublin South City, North Dublin, North Cork and North Lee). Some LHOs had a high success rate with their applications, albeit based on small numbers, while others have poor success rates.

Figure 3: Applications x Local Health Office

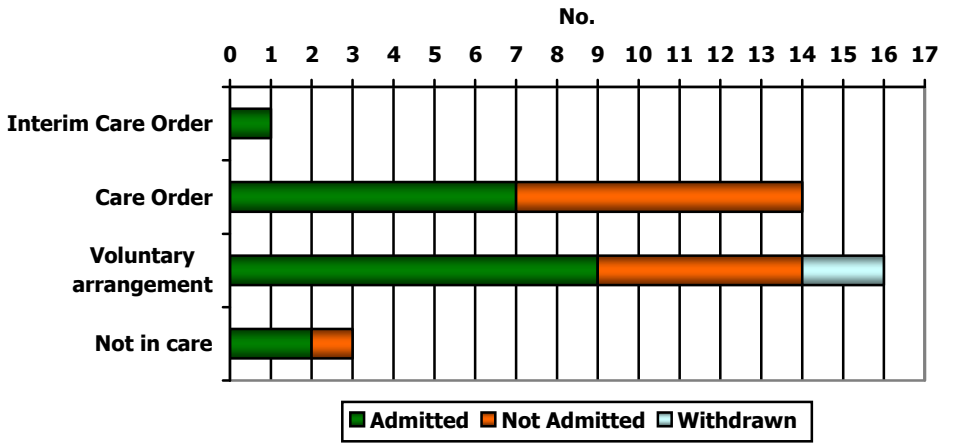


28. Within the period, therefore, slightly more LHOs did *not* make an application than those that did. If considered according to the former Health Boards, there were no applications from the former Midland, Mid-West or South Eastern Health Board areas. Both the Mid-West and the South East are well-provided for locally in terms of High Support Units: this may be coincidental but suggests that applications should be tracked by LHOs over time by either the CAAB or the HSE.

Care status

29. 56% of applications for children in care under a voluntary arrangement were successful in gaining admission, compared to 53% for children in care on a Care Order or Interim Care Order. Three applications were for children who were not in care at all, two of which were admitted (67%).

Figure 4: Applications x Care status



Ethnicity and nationality[8]

30. 24 (71%) of the applications were for children whose ethnicity/nationality was recorded on the Application Form as *White Irish.* Five were *Irish Travellers* (around a fifth of the number of applications for *White Irish*), two were *Mixed Irish/English*, two were *White English*, and ethnicity/nationality was not stated for one. The age and gender profile of the Irish Travellers did not have any pattern. No applications were received for new immigrant communities in Ireland.

31. There does appear to be variation according to whether the application was for a child who was *White Irish* or another ethnicity/nationality. 75% of *White Irish* applications resulted in admission, whereas only 22% of applications for other ethnicities/nationalities resulted in admission. However, we did not detect any procedural bias for or against different groups.

Placement when current special care application made

32. Applicants were asked to select, from a list of placement types, the placement that the child was in at the time of the application. This suggested the following:

- 6 children were in a secure placement.
- 8 children were in a High Support Unit.
- 8 children were in a mainstream residential unit.
- 5 children were in a residential service for young homeless people.
- 6 children were at home or in foster care.
- 1 was missing from home.

[8] NB categories of ethnicity and nationality shown here are compatible with those used in the National Census of 2006.

33. However, it became clear from the interviews that this can be misleading. 8 children were actually remanded to a Children Detention School and two had been missing from home for a significant length of time.

34. Prior to 2007, the HSE could apply to the High Court for a child to be detained in a Children Detention School for 'welfare reasons'. Since January 2007, this has not been possible: children can only be remanded (by District Courts) to a Children Detention School where there are criminal charges against them.

35. This was reinforced by Judge MacMenamin's rulings. In *Health Service Executive v. S (S) (A Minor)*, Judge MacMenamin stated that:

> "As a matter of law, such detention [in a Children Detention School] would be inappropriate for a young person in the absence of a criminal conviction or sentence." (paragraph 19)

36. In addition, in *Health Service Executive v. S (S) (A Minor)*, paragraph 71, Judge MacMenamin stated that the Court of Human Rights rejected any use of detention as a preventive measure.

37. However, more often than not, the Social Workers stated in interview that they regarded the motive for remand to a Children Detention School as being for welfare reasons, in several instances pending the application to special care. We shall return to the issue of ongoing criminal proceedings later in this report.

38. With the adjustments mentioned above with regards to children in a remand placement or missing from home, a relationship between placement at the time of the application and the success of the application emerges. All children who were in a High Support Unit were the subjects of a successful application. All children who were missing from home were also the subjects of a successful application. For all other placement types, successful applications were between 40% and 50% of the applications made.

Table 1: Placement when current special care application made

	Total Applications	**Admitted**	**Not Admitted**	**Withdrawn**	**% of Children in this Placement Type that were Admitted**
Remand	**9**	4	5	-	**44%**
High Support Unit	**5**	5	-	-	**100%**
Mainstream residential unit	**8**	4	3	1	**50%**
Residential service for youth homeless	**5**	2	3	-	**40%**
Foster care/Home	**5**	2	2	1	**40%**
Missing from home	**2**	2	-	-	**100%**

39. With regards to gender, all of those who were placed, at the time of the application, in High Support Units or who were missing from home were females, while the most successful applications for males were for those whose current application was in a mainstream residential unit. Two thirds of the males were either in a mainstream residential placement or in a remand placement.

Table 2: Placement when application made x Gender[9]

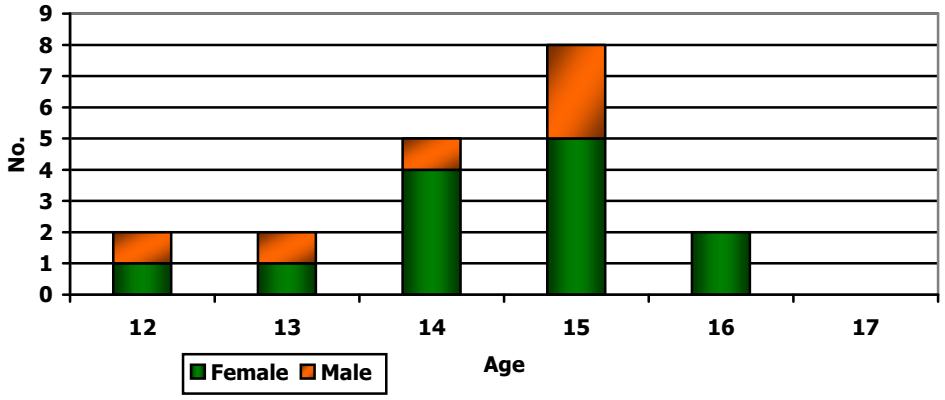
	Total	Females (20)	Females Admitted	% of Females in this Placement Type who were Admitted	Males (14)	Males Admitted	% of Males in this Placement Type who were Admitted
Remand	**9**	4	2	**50%**	5	2	**40%**
High Support Unit	**5**	5	5	**100%**	-	-	**-**
Mainstream residential unit	**8**	3	1	**33%**	5	3	**60%**
Residential service for youth homeless	**5**	4	2	**50%**	1	0	**0%**
Foster care/Home	**5**	2	1	**40%**	3	1	**33%**
Missing from home	**2**	2	-	**100%**	-	-	**-**

Application Outcomes By Gender

40. 19 of the 34 applications resulted in an admission to special care. The *Review of Admission Criteria and Processes for Special Care* (2005) noted that there was a gender difference in terms children admitted to special care, a ratio of almost 2:1 in favour of females. This was consistent with previous research into special care in Ireland. This current research again reflects that pattern: 13 females were admitted to special care and six males.

41. The age of children admitted to special care, by gender, is shown in Figure 5. Most of the females who were admitted to special care were aged 14 or 15, and most of the males who were admitted to special care were aged 15.

Figure 5: Age (at application) of children placed in special care

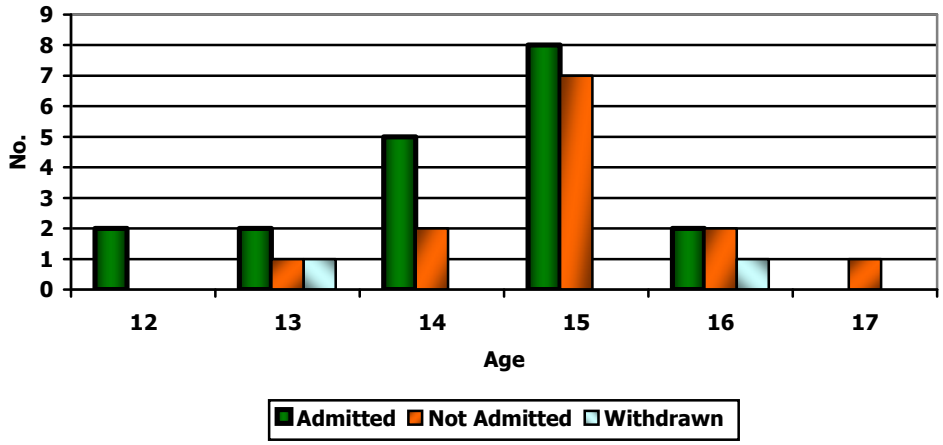


42. Outcomes for all applications are shown in Figure 6. Note that the peak age for applications for special care within the period was age 15 (15 applications), more than twice as many as for 14 year-olds (seven applications) and three-times as many as for 16 year-olds (five applications). Applications for 12-14

[9] Unclear at present how long one female has been known to HSE

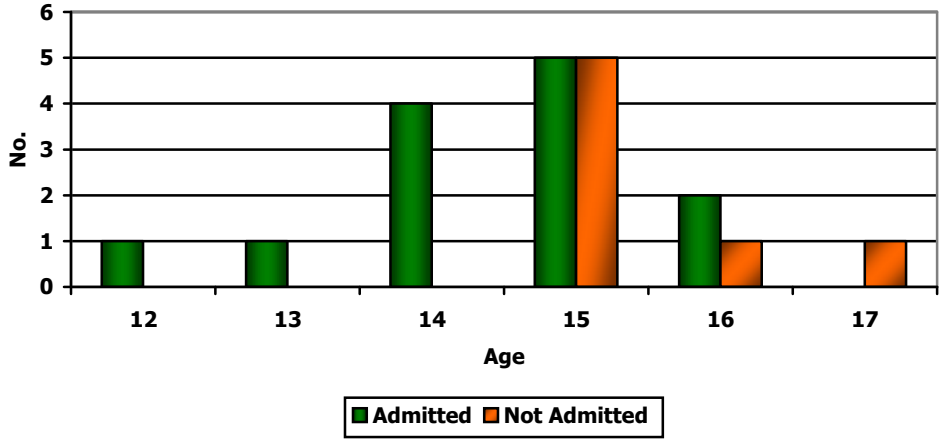
year olds had a very high success rate in being admitted to special care; the success rate for 15 year-olds was more evenly balanced; and few applications for 16-17 year olds were successful.

Figure 6: Outcomes for all applications to special care x Age at application



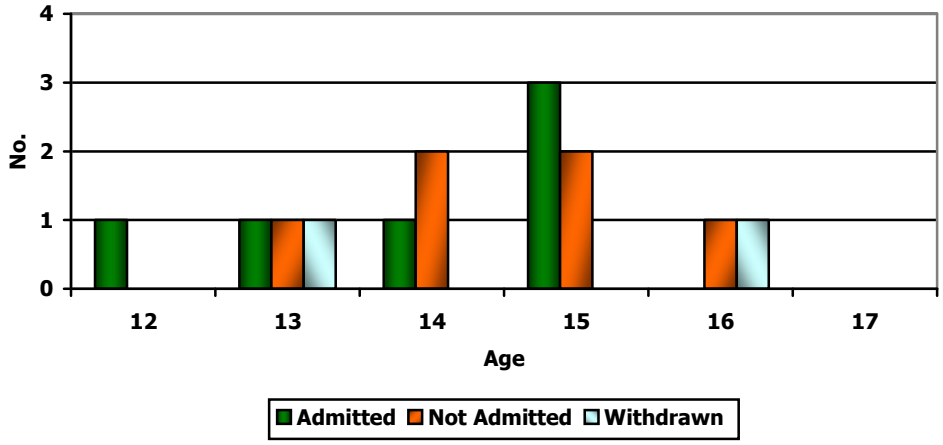
43. Outcomes for females only were as shown in Figure 7. There was a marked relationship with age, with all the unsuccessful applications for females at age 15-17:

Figure 7: Outcomes for applications for females to special care x Age at application



44. Outcomes for males only were as shown in Figure 8. Although numbers were small, for males there was, as with the females, more likelihood of a successful admission between age 12-15. However, unlike the situation for the females, unsuccessful applications were also prominent at age 14.

Figure 8: Outcomes for applications for males to special care x Age at application



Special Care Criteria

45. In this section we consider the features present in each application for special care against each of the Criteria for special care, and their relationship with successful or unsuccessful applications. The full list of Criteria, as contained in Section 3, C of the HSE's *Special Care Information and Application Pack* is in Appendix 1 and is also available to download from www.caab.ie.

Criterion 1: Age at admission

> **Criterion 1. The young person is aged 11-17 at admission**[10]

46. All applications were for children who were aged 12-17 when the application was made.

Criterion 2, first part: Real and substantial risks to self

> **Criterion 2: The behaviour of the young person is such that it poses a real and substantial risk to his/her health, safety, development or welfare unless placed in a Special Care Unit**, and/or on "an objective basis" is likely to endanger the safety of others.

47. (Note also that Criterion 4 "If placed in any other form of care, the young person is likely to cause injury to self or injury to other persons" does not have

[10] Associated footnote in the criteria: *"It is the view of the Health Service Executive and the Children Acts Advisory Board that given the intense nature of special care placement, it is generally preferred that the lower age limit be 12 years of age, but there may be exceptional circumstances where a younger child might be considered for a special care intervention".*

a separate section on the Application Form and tends to be considered alongside Criterion 2).

48. Criterion 2 has two alternative elements, and the Application Form asks the applicant to comment on both the real and substantial risks to self (as in bold above) and risks to others. The features quoted most commonly with regards to real and substantial risks to self are shown in Table 3. All 34 applications aimed to secure admission to special care on the basis of perceived risks related to this part of Criterion 2.

Table 3: Real and Substantial Risks x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
Total risks posed to self (i.e. the eight features listed immediately below)	**33**	**19**	**13**	**1**	**58%**
- Alcohol and/or substance misuse	28	18	10	-	66%
- Risks to sexual health	13	8	5	-	62%
- Self-harm	13	8	4	1	62%
- Suicidal ideation	11	6	4	1	55%
- Sexualised behaviour	10	7	3	-	70%
- Personal hygiene	2	-	2	-	0%
Total risks posed by others (i.e. the four features listed immediately below)	**26**	**13**	**11**	**2**	**50%**
- Engages with unsafe/ inappropriate adults	19	13	5	1	68%
- Risk of sexual exploitation/ prostitution	12	8	4	-	67%
- At risk of aggression/ threatened by others/ victim of assault	10	5	4	1	50%
- Involvement with a negative peer group	8	4	4	-	50%
Total risks through lack of engagement	**22**	**14**	**8**	**-**	**64%**
- Refusing to engage with services	18	11	7	-	61%
- Significant concerns about education/ training[11]	13	7	6	-	54%
Total at risk of, or engaging in, criminal activity	**20**	**9**	**11**	**-**	**45%**
Total at risk from youth homeless culture/has made use of crisis intervention service	**7**	**4**	**3**	**-**	**57%**

[11] As will be seen later in the report, most of the children in the cohort had some education/training issues; those counted here as of "significant concern" are those for whom the applying Social Worker expressed this concern against this criterion within their the application.

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
Total concerns about unaccounted money	**4**	**2**	**2**	**-**	**50%**
Total mental health concerns: *General mental health concerns + self-harm + suicidal ideation*	***16***	*8*	*7*	*1*	*50%*

49. Note that there are three categories of risk related to sexual behaviour and we have interpreted these as follows:

    - *Risk of sexual exploitation/prostitution* is used where the application specifically noted these concerns, or it stated concerns relating to (usually) an older or adult boyfriend/man (older or adult girlfriends/women were never mentioned in the applications).
    - *Risk to sexual health* is used where the application made specific reference to concerns about high risk of sexually transmitted infections (STIs) or risk of pregnancy.
    - *Sexualised behaviour* is used where this was explicitly raised as a concern in the application.

50. The above suggests that there was more than a 60% chance of admission to special care if the child's risks included:

    - Sexualised behaviour (70%).
    - Engaging with unsafe/inappropriate adults (68%).
    - Risk of sexual exploitation/prostitution (67%).
    - Alcohol and/or substance misuse (66%).
    - Risks to sexual health (62%).
    - Self-harm (62%).
    - Refusing to engage with services (61%).

51. We also noted where there were significant child protection concerns in relation to a contact of the child who was known by name to the Social Work Department (usually, again, an older or adult boyfriend). This was a feature of seven applications, of which five applications were successful (71%): a higher success rate than any other of the above risk factors. This raises issues about the responsiveness of agencies to risks posed by others: is it right that a child should have their liberty deprived as a result of the undue influence of adults?

52. When considered according to gender, there were some variations, albeit at times on small numbers. For females, *Risks posed to Self* and *Risks posed by others* have a much higher likelihood of a successful admission than for males. For males, there was a strong relationship of successful admissions to *Lack of engagement*.

Table 4: Real and Substantial Risks x Gender

	Total	Females[12] (20)	Females Admitted	% of Females with this Risk Feature who were Admitted	Males (14)	Males Admitted	% of Males with this Risk Feature who were Admitted
Total risks posed to self	**33**	**20**	**13**	**65%**	**13**	**6**	**46%**
- Alcohol and/or substance misuse	28	18	12	67%	10	6	60%
- Risks to sexual health	13	12	7	58%	1	1	100%
- Self-harm	13	8	6	75%	5	2	40%
- Suicidal ideation	11	6	4	67%	5	2	40%
- Sexualised behaviour	10	8	6	75%	2	1	50%
Total risks posed by others	**26**	**15**	**9**	**60%**	**11**	**4**	**36%**
- Engages with unsafe/ inappropriate adults	19	12	9	75%	7	4	57%
- Risk of sexual exploitation/ prostitution	12	10	8	83%	2	0	0%
- At risk of aggression/ threatened by others/victim of assault	10	7	4	57%	3	1	33%
- Involvement with a negative peer group	8	4	2	50%	4	2	50%
Total risks through lack of engagement	**22**	**13**	**8**	**62%**	**9**	**6**	**67%**
- Refusing to engage with services	18	10	6	60%	8	5	63%
- Significant concerns about education/training[13]	13	9	5	56%	4	2	50%
Total at risk of, or engaging in, criminal activity	**20**	**10**	**4**	**40%**	**10**	**5**	**50%**
Total at risk from youth homeless culture/has made use of crisis intervention service	**7**	**3**	**2**	**67%**	**4**	**2**	**50%**

[12] Number in brackets refers to total number of females and males in cohort

[13] As will be seen later in the report, most of the children in the cohort had some education/training issues; those counted here as of "significant concern" are those for whom the applying Social Worker expressed this concern in the application against this criteria.

	Total	Females[12] (20)	Females Admitted	% of Females with this Risk Feature who were Admitted	Males (14)	Males Admitted	% of Males with this Risk Feature who were Admitted
Total concerns about unaccounted money	**4**	**1**	**-**	**0%**	**3**	**2**	**67%**

53. The most striking difference between the genders related to the three factors associated with **sexual risks**. 80% (16) of the applications for females had one or more of these features present, compared to only 29% (4) of the applications for males. This raises the question of whether females are actually more at risk than males sexually or whether the same sexual behaviour in females and males is more likely to be seen as problematic in the former rather than the latter.

54. The spread of identified features by age generally reflected the overall age pattern within the cohort. For 12-14 year olds *Engages with unsafe/inappropriate adults* and *Alcohol/substance misuse* were a particularly prominent feature. *Involvement with negative peer groups* tended to be a concern with younger children, while *At risk from youth homeless culture/has made use of crisis intervention service* tended to be a concern for older children.

Criterion 2, second part: Risk of endangering others

55. The second part of Criterion 2 considers danger posed by the child to others and has its own section for commentary on the Application Form.

> **Criterion 2: The behaviour of the young person is such that** it poses a real and substantial risk to his/her health, safety, development or welfare unless places in a Special Care Unit, and/or **on "an objective basis" is likely to endanger the safety of others.**

56. Note that only three of the applications did not try to make a case for admission to special care on the basis of this part of Criterion 2.

57. As shown in the table below, few categories of risks relating to endangering others seem to have had a more than 50% likelihood of featuring in admissions to special care[14]. Features that endanger the family or other children have below average likelihoods, although inciting other children to negative behaviour stands out markedly as a feature of successful applications.

[14] Note that "assault" is used if this is specified within the application: occasionally this is described as a physical assault but it is not possible to be certain that the term consistently means this. Sometimes it may be intended to imply a verbal assault.

Table 5: Endangering Risks x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
General concern about risk of endangering others	**6**	**4**	**2**	**-**	**67%**
Endangering care staff	**21**	**11**	**8**	**2**	**62%**
- Assaulted care staff	13	7	4	2	
- Threatening/abusive behaviour towards care staff	8	4	4	-	
Endangering children	**18**	**10**	**8**	**-**	**56%**
Assaulted children	3	1	2	-	
Fights with other children	3	2	1	-	
Threatening/abusive behaviour towards children	7	4	3	-	
Sexually inappropriate behaviour with other children	3	-	3	-	
Incited other children to criminal or anti-social behaviour/negative influence on other children	7	5	2	-	71%
Endangering family/foster carers	**16**	**6**	**9**	***1***	**38%**
- Assaulted family/foster carers	8	2	5	1	
- Threatening/abusive behaviour towards family/foster carers	6	3	3	-	
Family fears child or company child keeps	2	1	1	-	
Arson + Damage to property	**12**	**6**	**6**	**-**	**50%**
- Arson	3	1	2	-	
- Damage to property	12	6	6	-	
Endangering Gardai	**7**	**3**	**3**	**1**	**43%**
- Assaulted Gardai	5	2	2	1	
Threatening/abusive behaviour towards Gardai	2	1	1	-	
Assaulted other adults/professionals	**8**	**5**	**3**	**-**	**63%**
Endangering with weapons	**9**	**4**	**5**	**-**	**45%**
Has carried a weapon	7	3	4	-	
Threat with weapons	3	1	2	-	
Endangering Social Worker	6	2	3	1	33%
- Assaulted Social Worker	3	2	-	1	67%
- Threatening/abusive behaviour towards Social Worker	3	-	3	-	0%

58. Note that almost all the males had *Endangering care staff* as a feature (12 out of the 14 applications for males). For the females, *Endangering adults/other*

professionals, Endangering care staff and *Endangering Children* were all features in applications where more than 50% of applications resulted in an admission to special care.

Table 6: Endangering Risks x Gender

	Total	Females (20)	Females Admitted	% of Females with this Risk Feature who were Admitted	Males (14)	Males Admitted	% of Males with this Risk Feature who were Admitted
Endangering care staff	**21**	9	6	**67%**	12	5	**42%**
Endangering children	**18**	10	6	**60%**	8	4	**50%**
Endangering family/foster carers	**16**	9	4	**44%**	7	2	**29%**
Arson + Damage to property	**12**	7	3	**43%**	5	3	**60%**
Endangering Gardai	**7**	4	2	**50%**	3	1	**33%**
Endangering Social Worker	**6**	4	2	**50%**	2	0	**-**
Endangering adults/ other professionals	**8**	4	3	**75%**	4	2	**50%**
Endangering with weapons	**9**	3	1	**33%**	6	3	**50%**

59. There were no distinctive patterns by age.

<u>Criterion 3: Impaired socialisation/impulse control</u>

60. Criterion 3 considers impaired socialisation/impulse control and has a separate section for commentary on the Application Form.

> **Criterion 3: The young person will present with a history of impaired socialisation and impaired impulse control, and may also have an established history of absconding which places them at serious risk.**

61. For every child, the application referred to a history of *Absconding*, although only 56% of applications with this feature were admitted to special care. There was a much stronger relationship with *Risk-taking behaviour*, and *Lack of remorse/empathy*, in terms of the likelihood of an application leading to special care.

Table 7: Impaired Socialisation/Impulse Control x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
Total Absconding	**34**	**19**	**13**	**2**	**56%**
- Absconds frequently	29	17	11	1	59%
- Absconds occasionally	3	-	2	1	-
- Goes missing from home frequently	2	2	-	-	50%
Total Poor anger management/challenging behaviour	**21**	**10**	**10**	**1**	**48%**
Total Risk-Taking	**19**	**12**	**6**	**1**	**63%**
- Cannot judge, impressionable, or seeks out, unsafe/risky situations	11	8	3	-	73%
- Poor insights into risks of current behaviour	9	6	2	1	67%
- Vulnerable to predatory individuals	10	5	5	-	50%
Total Social Skills	**18**	**8**	**8**	**2**	**44%**
- Struggles to form long-lasting/ healthy relationships	13	6	7	-	46%
- Lack social skills	11	6	4	1	55%
- Distances self from adults	1	1	-	-	100%
Total Boundaries	**14**	**7**	**6**	**1**	**50%**
- Will not conform to boundaries	6	4	2	-	67%
- Lack of boundaries/guidelines at home	6	2	3	1	33%
- Will not conform to boundaries in care settings	3	2	-	-	67%
- Will not conform to boundaries in school	2	1	1	-	50%
Total Poor impulse control/ quickly drawn into trouble/ highly influenced by peers	**11**	**4**	**6**	**1**	**36%**
Total Lack of remorse/ empathy/understanding	**5**	**3**	**1**	**1**	**60%**
Total Diagnosed conduct disorder	**3**	**-**	**2**	**1**	**0%**

62. The word 'absconding' may be given a more pre-eminent place in the criteria at present than it merits. Note that in *Health Service Executive v. DK, a minor,* Judge MacMenamin stated:

> "An order detaining a minor is not legally justified because that child has an established pattern of absconding from the family home, or other out of home placements… The court may only make an order for the detention of a minor where there is clear and convincing evidence as to the underlying reasons for that pattern of absconding and a clear, clinical view as to the anticipated therapeutic value to that child of a short period of detention in a secure unit. Detention in this context cannot be

used as a punishment for absconding, or simply a mechanism for the containment of that child." (paragraph 52).

63. There was a difference between males and females in relation to these factors. Each and every one of the features was more likely to be associated with a successful application for females than for males. *Risk-taking behaviour* in particular was associated with 79% of all successful applications for females but only 20% of successful applications for males. This raises questions about whether the same behaviour in females and males raises greater anxiety for the females on the part of professionals and family (remembering also the imbalance previously noted in terms of sexual risks), or whether the cases presented for the females within the cohort were simply stronger, with more detail and better presentation. From our analysis of the applications, we would suggest that it is a mixture of both of these.

Table 8: Impaired Socialisation/Impulse Control x Gender

	Total	**Females (20)**	**Females Admitted**	**% of Females with this Risk Feature who were Admitted**	**Males (14)**	**Males Admitted**	**% of Males with this Risk Feature who were Admitted**
Absconding	**34**	20	13	**65%**	14	6	**53%**
Poor anger management/ challenging behaviour	**21**	11	6	**55%**	10	4	**40%**
Risk-Taking	**19**	14	11	**79%**	5	1	**20%**
Social Skills	**18**	9	5	**56%**	9	3	**33%**
Boundaries	**14**	8	5	**62%**	6	2	**33%**
Poor impulse control/quickly drawn into trouble/highly influenced by peers	**11**	5	2	**40%**	6	2	**33%**
Lack of remorse/ empathy/understanding	**5**	3	2	**67%**	2	1	**50%**

Criterion 5: Placement options explored

64. Criterion 5 considers the extent to which other placement needs have been considered and has a separate section for commentary on the Application Form.

> **Criterion 5: Consideration has been given to placement history and the elimination of *all other* non-special care options, *based on the child's needs.*[15]**

65. Nine of the applications were for children who had previously been admitted to special care. Five of these had only had one previous admission, of which four (80%) were admitted again on their current application. Four had been admitted to special care twice before, and of these only one (25%) was admitted again on their current application.

[15] Emphasis as per the special care criteria.

66. All but one of the above nine applications was supported by the CAAB. On the other hand, while current criteria for special care does not include consideration of what might be gained by a further admission to special care, this has clearly been part of the NSCADC's decision-making: all four applications with two previous admissions, including the one actually admitted, were not supported by the NSCADC, on the basis that the added benefit to be gained from a further admission was not clear. Placement in special care needs to be purposeful. It seems sensible that the effectiveness of previous placement to special care, and the intentions of the latest application, should be considered during the application process. The current Application Form needs to be amended to address this.

67. Another six applications were for children who had been the subject of previous unsuccessful applications to special care. Five of these applications (83%) were successful in gaining admission via their current application and one was withdrawn.

68. The most successful applications demonstrated a previous attempt to apply high support, either in High Support Units or high support in the community.

Table 9: Placement Options Explored x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
Remand in past	**11**	**4**	**7**	**-**	**36%**
Special Care in past	**9**	**5**	**4**	**-**	**56%**
High Support Unit tried or considered in past	**17**	**11**	**5**	**1**	**65%**
HSU tried	10	7	3	-	70%
HS considered but no place or turned down	3	1	1	1	0%
HS considered but not appropriate	4	3	1	-	80%
High support in community tried or considered in past	**7**	**4**	**2**	**1**	**57%**
HS in community tried	2	2	-	-	100%
HS in community considered but not appropriate	4	3	1	-	75%
Special arrangement	1	-	1	1	0%
Residential placement tried or considered in past	**28**	**16**	**10**	**2**	**57%**
Residential unit tried	22	13	8	1	59%
Residential unit considered but not appropriate	6	3	2	1	50%
Private residential placement considered but not appropriate	3	1	2	-	33%
Foster placement tried or considered in past	**20**	**10**	**10**	**-**	**50%**
Foster placement tried	15	8	7	-	53%
Foster placement considered but not	5	2	3	-	40%

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
appropriate					
Private fostering tried	2	1	1	-	50%
Extended Family tried or considered in past	**9**	**4**	**3**	**2**	**44%**
Extended family placement tried	4	2	2	-	50%
Extended family placement considered but not appropriate	3	1	1	1	33%
No extended family options	2	1	-	1	50%
Respite/Shared Care tried or considered in past	**11**	5	5	1	**45%**
Respite tried	7	3	4	-	43%
Shared care tried	4	2	1	1	50%
Independent/ Supported Living tried or considered in past	**4**	**1**	**2**	**1**	**25%**
Independent living flats considered	1	-	1	-	0%
Semi-independent living considered	1	-	-	1	0%
Supported lodgings tried	2	1	1	-	50%
Boarding School – considered but not appropriate	**2**	**1**	**-**	**1**	**50%**
Travellers service – tried in past	**1**	**-**	**1**	**-**	**0%**
Drug treatment centre tried in past	**1**	**1**	**-**	**-**	**100%**

69. Again, there was a marked difference between males and females with regards to placement options tried or considered in the past. Many of the successful applications for females were for those who had experienced special care or had demonstrated consideration of high support as an option; this was not the case with the males, where such options were much less likely to be linked to a successful application.

Table 10: Placement Options x Gender							
	Total	**Females (20)**	**Females Admitted**	**% of Females with this Risk Feature who were Admitted**	**Males (14)**	**Males Admitted**	**% of Females with this Risk Feature who were Admitted**
Remand in past	**11**	5	2	**40%**	6	2	**33%**
Special Care in past	**9**	7	5	**71%**	2	-	**-**
High Support Unit tried or considered in past	**17**	9	7	**78%**	8	4	**50%**
High support in community tried or considered in past	**7**	6	4	**67%**	1	-	**0%**
Residential placement tried or considered in past	**28**	17	10	**59%**	11	6	**55%**
Foster placement tried or considered in past	**20**	15	8	**53%**	5	2	**40%**
Extended Family tried or considered in past	**9**	4	3	**75%**	5	1	**20%**
Respite/Shared Care tried or considered in past	**11**	7	4	**57%**	4	1	**25%**

70. In the applications that we have seen, Social Workers were much better at building a case around risks posed to the child's welfare or to others (the two parts of Criterion 2), but usually less strong in specifying the extent to which other options had been tried or considered. This was one of the areas that was most often failed against the criteria by both the NSCADC and the CAAB, and Social Workers should pay particular attention to demonstrating this when making their application.

Criterion 6: Less secure structured environment

71. Criterion 6 considers the extent to which it has been demonstrated that a less secure structured environment would not meet the child's needs. It has a separate section for commentary on the Application Form.

> **Criterion 6: It is clear a less secure structured environment would not meet the young person's needs at this particular time.**

72. The *Review of Admission Criteria and Processes for Special Care* (2005, paragraph 38) noted that the potential impact of special care on the child's

situation can be represented on a continuum which, in turn, reflects the potential objectives to be obtained by the service[16]:

73. The majority of applications stated that a less secure structured environment would not be appropriate because of the level of containment required (31 applications). Only three sought special care in order to assess the child's needs, and only 17 (50%) referred to any interventions or outcomes that they wished the placement to achieve. More of the applications (20) made specific reference to the fact that the child had not engaged with support services than made reference to interventions. Applications that referred to engagement and assessment were more likely to be successful than those referring to containment.

Table 11: Less Secure Structured Environment x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Risk Feature that were Admitted
Containment	**31**	**18**	**11**	**2**	**58%**
To deal with absconding	19	12	6	1	63%
Child needs a high level of structure and boundaries	21	10	10	1	48%
Need to stabilise an extreme situation	16	7	9	-	44%
Need for safety	16	7	7	2	44%
Need for a secure environment	9	4	5	-	44%
Separation	**5**	**4**	**1**	**-**	**80%**
From parent	2	2	-	-	100%
From other adults	2	2	-	-	100%
From peers	2	1	-	1	50%
Engagement	**20**	**14**	**6**	**-**	**66%**
Refusing to engage with services	14	10	4	-	71%
Past experience suggests child responds well in a structured environment	11	6	5	-	55%
Assessment	**3**	**3**	**-**	**-**	**100%**
Intervention	**17**	**10**	**6**	**1**	**59%**

74. The prominence of engagement as an aim suggests that the above continuum needs modifying as shown below:

[16] In the 2005 report, "therapy" was used instead of "intervention", but revisions to the criteria since then have replaced the one word for the other so we have also amended the language of the continuum to reflect this.

75. Given that special care needs to be purposeful, it is surprising how few applications were concerned that the placement would achieve something more than containment to keep the child safe and secure.

Applicants' views on the criteria for special care

76. 18 interviewees felt that the criteria for special care as they are written are acceptable, and a further 13 felt that they would be acceptable with some minor clarifications.

77. Almost all of the comments on clarification related to the exclusion contained within section 3, E of the *Special Care Information and Application Pack* that states that a placement is not appropriate "Where the primary reason for seeking that placement is that… The young person has been convicted of an offence or is part of ongoing criminal proceedings." We will explore this issue later in this paper when considering "Ongoing criminal proceedings."

Length of time applied for

78. S.23 (B) (4) of the Children Act, 2001 states "… a special care order shall remain in force for a period to be specified in the order, being a period which is not less than 3 months or more than 6 months." In addition, guidance on the application process states: "The placement should be for as short a term as possible, based on the child's needs. Any extension to the initial 3 month period should be reviewed monthly by the case management team."

79. Applicants applied for the following[17]:

- 16 applications were for a time period of 3 months.
- 13 were for a time period of 3-6 months.
- 5 were for a period of 6 months.

80. The *Review of Admission Criteria and Processes for Special Care* (2005) identified concerns from interviewees during that research that not all the objectives of special care might be attained within the 3-6 months time frame:

> "In particular, given the early part of the placement may simply involve attempts to engage the young person, this can limit the effectiveness of in-depth assessments and [interventions], with the result that the special care placement might provide principally containment or a breathing space." (paragraph 39)

81. The *Review of Admission Criteria and Processes for Special Care* (2005, paragraph 11) noted that:

> "Several HSE areas felt that the time limits for special care were inflexible or too short. This partly links to the above observations about the focus being on containment rather than therapy, but also reflects a view that special care might be for shorter, or intermittent periods, according to the young person's need, with a 'call-back' option should the situation in the subsequent placement deteriorate." (paragraph 42)

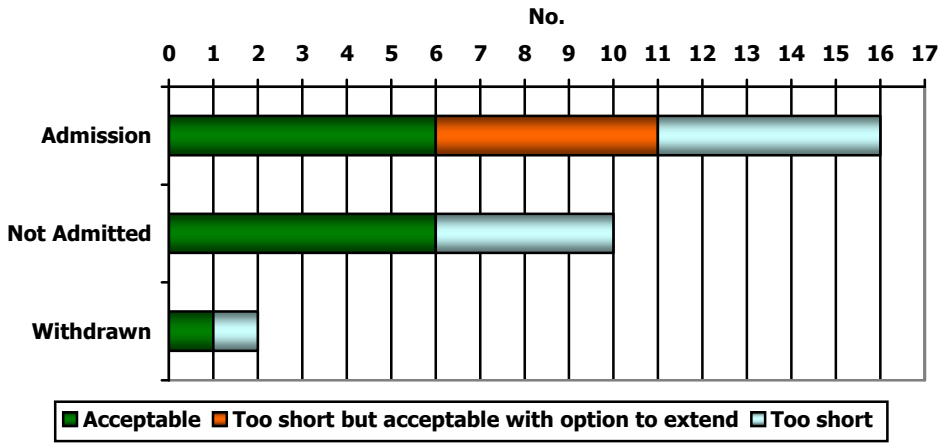
[17] Usually the High Court will make an initial Order of three months, with monthly reviews.

82. Out of the interviews conducted:

- 18 said that the time period was acceptable. This includes five interviewees who felt that the time period was generally too short but accepted it with an option to go back to court to extend the placement (as is currently possible).
- 15 said that the time period is too short: again, including the five who thought that the time period was too short but was acceptable with the option to review and extend the placement.
- One felt it was too long.
- Only one preferred a more flexible use i.e. to have the placement available over the period of the order for the child to "dip in and out of" as needs arose.

83. Applicant views on the length of time that can be applied for did not vary significantly according to whether or not the application was successful.

Figure 9: Applicant views on the length of time that can be applied for x Outcome



84. There were similar patterns across the four HSE Areas, although in the West the 3-6 months limit was more often regarded as acceptable.

85. Generally those who felt that the length of time was too short said that, with time for the child to settle in to the placement at the start, and two weeks to a month at the end to support transition to their next placement, little could be achieved in the first three months other than containment or the commencement of an assessment. Although some respondents expressed reservations about the extension process, saying that it can upset the child involved who thought that their time in secure was close to being over, those Social Workers also generally felt that a three month period was too short (implying they might have preferred to have had a longer period specified on the original Order). Several interviewees commented that it was impossible to determine in advance how much time was needed because it depended on how the child responded. Only a couple said that it would be useful to have step-down units on the sites of the Special Care Units to support the transition process. Two interviewees thought that there was value in having a containment-only facility, for a very short period, to avert immediate crises.

86. During the interview process, we also noted how many of the interview groups expressed concern about depriving the child of their liberty (interviewees were not prompted on this: we merely noted whether it emerged naturally in the interview). This concern was mentioned in all but four of the interviews, and in three of those four the interviewees felt that the time that can be applied for was acceptable (two of these children had had two previous placements in special care, one was currently on remand in a Children Detention School).

87. The emphasis on duration was specifically considered by Judge MacMenamin in *Health Service Executive v. S (S) (A Minor).* The judgement clearly stated that:

> "The re-balance or prioritisation of rights where the State intervenes pursuant to Article 42.5[18] [of the Constitution] may only be justified if of short duration. It must truly be in the words of the Article an "exceptional case"… Detention may be for a short period only." (paragraph 55)

88. In *Health Service Executive (South Eastern Area) v. WR (a minor),* special care was stated to have an:

> "… explicit objective of providing a stabilising period of short-term care to enable that young person to return to a less secure environment as soon as possible." (paragraph 25)

89. Additionally, from *Health Service Executive v. S (S) (A Minor):*

> "… to comply with rights under the [European convention of Human Rights] (and indeed the balance of rights under the Constitution of Ireland) the rationale or justification for an order of detention must be clearly identified, must have a therapeutic or welfare purpose, and be exercised *only* in circumstances where it is the minimum duration." (paragraph 58)

90. The emphasis is on ensuring a special care placement is as short as possible and that it is purposeful. A handful of interviewees, plus some of the members of the CAAB's pool of panel members, commented on their absence of knowledge of what the model of care was for each SCU, but also understood there to be variations between them. Given that a placement should be purposeful, this is essential knowledge for the applicant.

What will be different if special care is successful

91. Interviewees were asked to comment on what they felt would be different if the special care placement was a success:

- 12 felt that the child would be safe and would understand how to keep themselves safe. This includes safety arising from separation from certain individuals.
- 10 hoped that the child would engage with services and care workers. In addition, eight stated that they hoped the child would engage with education or training opportunities.

[18] The paragraph actually refers to Article 4.25 but this is likely to be a misprint as other paragraphs in the Judgement refer to Article 42.5.

- Eight hoped that the child would develop internal/self-regulatory controls, and four that the child would develop an understanding of their own behaviour and its consequences.
- Four hoped that the placement would provide stabilisation, structure and routine.
- Two hoped that the placement would provide access to specialist assessments.

Robustness of Onward Placement

92. We have already noted that special care is intended to be a short-term measure and should not be used as a long-term resource. The *Special Care Information and Application Pack* states:

> "At the pre-admission stage the young person's discharge plan and a provisional discharge date will be agreed. This plan will be subject to regular review as part of the statutory care plan review process while the young person is in special care."

93. It is essential that an application for special care has an onward placement identified at the outset in order to prevent the risk of drift in the case. It is equally essential, as exemplified above, that the child's needs are reviewed while placed in the Special Care Unit: the extent of progress within the placement, or the issues that may emerge, might lead to a rethink of, and change to, the planned onward placement.

Onward placement planned

94. All but one of the applications had an onward placement identified, although the detail and robustness of those placements were not always clear (we discuss the form of the discharge plan - i.e. whether it was a distinct, separate plan or it was in some other form – later within this report when considering the application process).

95. 18 of the applications identified high support as the desired onward placement, and 13 identified mainstream residential care. Only six of the 18 applications that identified high support as the onward placement had actually secured a place. Nine of the 13 applications identifying a mainstream residential unit as likely onward placement appear to have secured a place.

Table 12: Onward placement planned x Outcome

	Total Applications[19]	Admitted	Not Admitted	Withdrawn	% of Applications with this Onward placement planned that were Admitted
High Support	**18**	**10**	**6**	**2**	**56%**
HSU placement secured (existing placement)	5	4	1	-	80%

[19] NB Some discharge plans had more than one category as an option e.g. HSU and mainstream residential were both being considered, hence the total exceeds the number of cases.

	Total Applications[19]	**Admitted**	**Not Admitted**	**Withdrawn**	**% of Applications with this Onward placement planned that were Admitted**
HSU placement secured (not existing placement)	1	1	-	-	100%
HSU application has been made	5	2	2	1	40%
HSU being considered	8	4	3	1	50%
Mainstream residential	**13**	**7**	**6**	**-**	**54%**
Residential unit (same as before)	6	3	3	-	50%
Residential unit (different to previous)	4	4	-	-	100%
Residential unit (same as previous) plus shared care with mother	1	1	-	-	100%
Possible private sector placement	1	-	1	-	0%
Residential units being considered	1	-	1	-	0%
Return home/Foster family/Specialist fostering	**4**	**2**	**1**	**1**	**50%**
Return home if possible	2	1	1	-	50%
Specialist foster placement being considered	1	-	-	1	0%
Foster placement – unclear if same or different	1	-	1	-	0%
Residential unit (same as previous) plus shared care with mother	1	1	-	-	100%
Independent Living	**1**	**-**	**1**	**-**	**0%**
Placement abroad	**1**	**-**	**1**	**-**	**0%**
No onward placement in evidence	**1**	**1**	**-**	**-**	**100%**

96. There was a marked difference in the likelihood of males and females being admitted to special care according to whether they had high support or a mainstream residential unit as their onward placement. Females with high support as their onward placement were four times more likely to have a successful application than males with high support as their onward placement.

Table 13: Onward placement planned[20] x Gender

	Total	Females (20)	Females Admitted	% of Females with this Onward placement planned who were Admitted	Males (14)	Males Admitted	% of Males with this Onward placement planned who were Admitted
High Support	**18**	9	8	**89%**	9	2	**22%**
Mainstream residential	**14**	8	4	**50%**	5	3	**60%**

Robustness of onward placement

97. It was not always clear on the Discharge Plan or Application Form whether the planned onward placement was secured or in the process of being negotiated. According to our interpretation of this information, only 56% of applications had a secured onward placement. Applications with an onward placement secured were more likely to result in an admission to special care.

Table 14: Onward placement secured x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with Onward placement secured/not secured that were Admitted
Secured	**19 (56%)**	12	7	-	**63%**
Not Secured	**15 (44%)**	7	6	2	**47%**

98. When considered according to the planned onward placement type, there was a strong pattern[21].

- An onward placement to high support or mainstream residential care was secured for 15 applications, of which 11 were admitted – **73%.**
- For the 16 occasions[22] on which high support or mainstream residential care was identified but not secured in a discharge plan, only 6 applications were successful in gaining admission – **38%.**

99. There is a clear message here that the more secure the planned onward placement, the more likely the application will be successful. Research has also shown that it is better for the child to have a clear idea of where they will be going to once a placement such as special care has ended.

[20] NB A small number of discharge plans had both HSU and mainstream residential as options.
[21] Note that we only consider high support and residential care here as they constituted the discharge arrangements for 31 of the 34 cases.
[22] Note: where an onward placement was not secured, several options may be under consideration, hence one case might have two or more options.

100. There were significant variations between HSE Areas in terms of securing the onward placement:

- 88% of Dublin North East applications had a secured onward placement.
- 50% of Dublin Mid-Leinster applications had a secured onward placement.
- 44% of South applications had a secured onward placement.
- 40% of West applications had a secured onward placement.

101. One of the CAAB review panel members suggested that there should be more detail on the discharge plan: name of placement, contact details, and a letter of acceptance.

102. There remains a reluctance on the part of some Social Workers to specify and secure an onward placement, often on the basis that they want to see how the child responds to special care before making such an arrangement. The message from the research is clear: there needs to be at least a provisionally secured onward placement if the application is to succeed. This does not prevent that onward placement from changing according to how the child responds to secure care and emphasises the need for active and ongoing review of the case by the allocated Social Worker.

Involvement with the HSE

How long has the HSE been involved with the child?

103. 47% of the applications were for children who had been known to the HSE for five years or more. Eight out of 16 such applications led to an admission to special care. However, the length of time that the child has been known to the HSE generally does not seem to have any relationship to the likelihood of success of a special care application. 64% of the males who were subject to an application had been known to the HSE for five years or more, compared to 40% of the females.

How long has the Social Worker been the child's allocated Social Worker

104. Information on how long the current Social Worker had been the child's allocated Social Worker was not incorporated into the Application Form and could only be gathered through interview.

105. Although 16 children had been known to the HSE for five years or more, only two had had the same Social Worker for the same period. Similarly, 13 Social Workers had been the allocated Social Worker for less than a year (in contrast, only two children had been known to the Social Work Department for less than a year). This probably reflects both the difficulty of retaining staff within children's social work and the transfer of cases between duty/short-term teams and long-term/children in care teams.

106. One Social Worker was the allocated Social Worker for two of the applications within the cohort; all other Social Workers were allocated one application within the cohort. Team leaders might be responsible for more than one application, however, generally reflecting the pattern of applications by Local Health Office that we reported earlier.

107. For three applications there was no allocated Social Worker: two appear to have been held by the Social Work Team Leader and one was allocated long-term to a child care leader. This is an important issue: an allocated Social Worker will prevent drift in the case and ensure that an effective discharge plan is implemented. A question needs to be added to the Application Form asking who the allocated Social Worker is and how long they have been the Social Worker for the child.

Offending History

108. Only two applications within the cohort were for children reported as having previous convictions. Neither were admitted to special care.

109. 14 children had a juvenile liaison officer (seven admitted, six not admitted, one withdrawn). Nine of these were females (six, or 67%, were admitted) and five were males (one, or 20%, admitted). This may illustrate that males who have offended are more likely to enter fully into the criminal justice system.

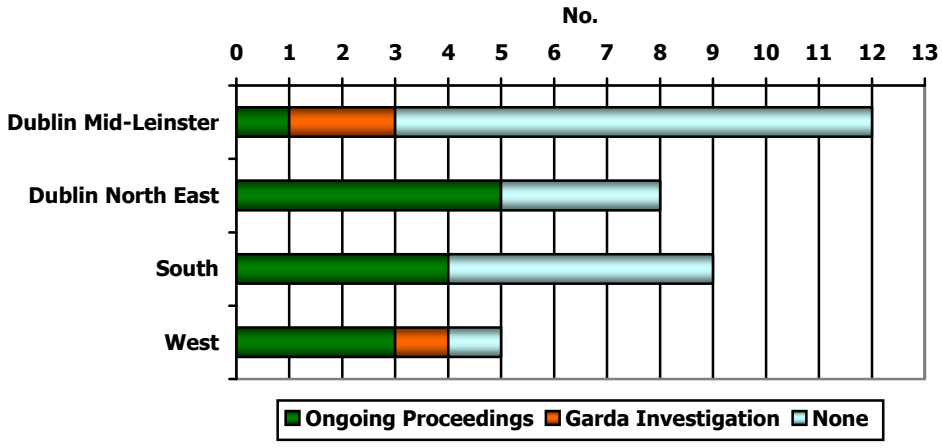
110. The presence of ongoing criminal proceedings has a significant effect on the likelihood of an application not succeeding.

Table 15: Ongoing criminal proceedings x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with Ongoing Criminal Proceedings that were Admitted
Ongoing criminal proceedings	**13**	5	8	-	**38%**
Investigation by An Garda Síochána	**3**	1	1	1	**33%**
None	**18**	13	4	1	**72%**

111. The presence of ongoing criminal proceedings appears to vary according to HSE Area, with almost none of the applications from Dublin Mid-Leinster having ongoing criminal proceedings, and the majority of applications from both Dublin North East and the West having them.

Figure 10: Ongoing criminal proceedings x HSE Area x Outcome



112. At the time of the application, the Social Work Department often did not know the likely outcome of these proceedings. Nine of the 13 with ongoing criminal proceedings were remanded to a Children Detention School. Of these nine, for six of them the Social Work Department stated in interview that the District Court preferred a welfare route to be pursued rather than a criminal justice route and the Social Worker interpreted the motive for the remand period therefore as being primarily "for welfare reasons" (although, as we have previously noted, all such applications were for children who had ongoing criminal proceedings against them at the time of the remand). Only one of these applications resulted in detention in a Children Detention School during the research period.

113. In addition to the 34 applications for which SIS received full details of the Application Form and supporting information, there was an additional case in the period where enquiries were made to the NSCADC about making an application, the NSCADC expected an application to be made, but one did not follow. The reason given to SIS by the Social Work Department was that the child (who was remanded in a Children Detention School) was deemed, on reflection by the Social Work Department, to be unsuitable because of ongoing criminal proceedings.

114. In *Health Service Executive v. S (S) (A Minor),* Judge MacMenamin expressed concern that the case of S.S. was before both a District Court on criminal charges and the High Court for welfare reasons on the same day, a fact that only came to light on the day. This went against the dictum of "one family, one court." Judge MacMenamin stated that:

> "Care must be taken to ensure that the invocation of civil jurisdiction does not stand in the way of the constitutional duty mandated upon the courts to exercise its criminal jurisdiction… insofar as there may be conflict between the general welfare rights of a minor, and rights delineated by the Constitution as being relevant to the trial of offences, it is clear the latter must have priority and prevail." (paragraph 80).

115. This should clarify the situation in the future. More recent briefing sessions by the HSE have emphasised this point: special care cannot replace criminal proceedings or be used to divert the child from the criminal justice system. Where there are ongoing criminal proceedings, an application for special care will not be successful until there is an outcome from the criminal proceedings. The implications of this ruling may need to be clarified between the HSE, the Children Detention Schools and Probation.

Education History

School inclusion

116. There appears to be more likelihood of an application to special care being successful if the child has an Education Welfare Officer (EWO) or has had frequent school moves.

Table 16: Education history x Outcome

	Total Applications for whom this was true	Admitted	Not Admitted	Withdrawn	% of Applications for which this was true that were Admitted
Non-attendance in last 12 months	**29**	16	11	2	**55%**
Has an education welfare officer	**18**	12	5	1	**67%**
Received out of school support	**18**	7	9	2	**39%**
Frequent school moves	**15**	10	5	-	**67%**

117. Educational difficulties were proportionally slightly more prominent for males than for females, particularly with regards the likelihood of having an education welfare officer.

Learning disability

118. Guidance on the special care application process states that a placement is not appropriate where the *primary reason* for seeking a placement is that "the young person has a moderate, severe or profound learning disability." No application was for a child with this level of learning disability. Ten children had a learning disability that was assessed as *Low/Mild/Borderline*, of whom 40% were admitted to special care.

119. There was, however, a gender difference. Only 25% of the females had been assessed as having a low/mild/borderline learning disability, whereas 50% of the males had been assessed as having this level of disability. This raises questions of whether females with learning disabilities are more likely to continue to be catered for within the education system than males.

Health

Hospital admissions

120. The Application Form asks for applicants to detail hospital admissions, including date of admission, hospital, reasons for admission, and admission period. With hindsight, we would suggest that the only information of relevance to the application process would be hospital admissions that relate to the criteria for special care.

121. With this in mind, 10 children had an admission to hospital in the last 12 months that could be related to the criteria for special care:

- Seven for mental health issues – five for suicidal ideation; two for self-harm; one for general psychiatric concerns (three admitted, or 43%).
- Six for alcohol/substance misuse (five admitted, or 83%).
- One for other related reasons (admitted).

122. Hospital admissions for alcohol/substance misuse in particular, therefore, had a strong relationship to successful applications.

123. Guidance on the application process states that a placement in special care is not appropriate where the *primary reason* for seeking a placement is "The young person has an acute psychiatric or medical illness requiring intensive medical intervention." No applications had this feature.

Previous Interventions

124. The current section on the Application Form on previous interventions and their outcomes was difficult to analyse and we will be making recommendations separately on how this section could be reformatted. Nevertheless, we are able to provide some headline information on previous interventions.

125. Child & Adolescent Mental Health Services (CAMHS)/counselling services had been previously attempted for 26 of the applications (76%), while community supports (e.g. Extern, Youth Advocacy Programme (YAP), family support) had previously been attempted in 25 of the applications (74%).

126. Other services were much less prominent:

- Services aimed at drug awareness/prevention or treatment were present for 11 of the applications, although invariably the child had not engaged with this service.
- Sexual health awareness programmes had been attempted for six of the applications.
- Family therapy/interventions had been attempted for seven of the applications.

127. In the section on Criterion 2, first part: *The behaviour of the young person is such that it poses a real and substantial risk to his/her health, safety, development or welfare unless placed in a Special Care Unit,* we noted that, for 22 applications (65%), the applicants specified lack of engagement of the child with support services or education as being a significant risk factor against this criterion. This lack of engagement was perceived as limiting the success of previous interventions. However, it also raises questions about how responsive services are to the needs of more vulnerable children, how effective those services are in connecting with the more 'hard-to-reach' and how accessible their services are. Exclusion of the most vulnerable children from services increases their vulnerability.

128. When interviewees were asked which previous services had been successful, therefore, they generally tended to be only during those intermittent periods when the child was engaged with the service, most commonly:

- For 13 applications, community supports (especially Extern and YAP), particularly with a 1:1 focus.
- For five applications, engagement with education and training.
- For five applications, continued engagement with the Social Worker.
- For three applications, engagement with a psychologist.

129. Interviewees were also asked what might have prevented the current situation from arising. However, there were no distinct patterns.

APPLICATION PROCESS

Model Process

130. If an application for special care followed a model process, with full compliance to the process and support from key agencies all the way through, it should follow a pathway as shown in Figure 11. Only three applications actually went through the process in such a model manner. Learning points and practice issues derive from those applications where this model process does not occur.

131. Note that we have used a series of traffic lights for 'C' Compliant, 'PC' Partially Compliant, and 'NC' Non-Compliant against each stage of the model process. Compliant applications will fulfil the text within the boxes of the flowchart. Interpretation of Partial Compliance and Non-Compliance varies according to stage of the model process and is shown in the Table 17.

132. Note also that the traffic lights show the levels of compliance for the 34 applications of which SIS had received full details: however, where the two other applications in the cohort are relevant to an individual stage of the model, we comment at that point on the specific characteristics of those applications.

Figure 11: A Model Application for Special Care

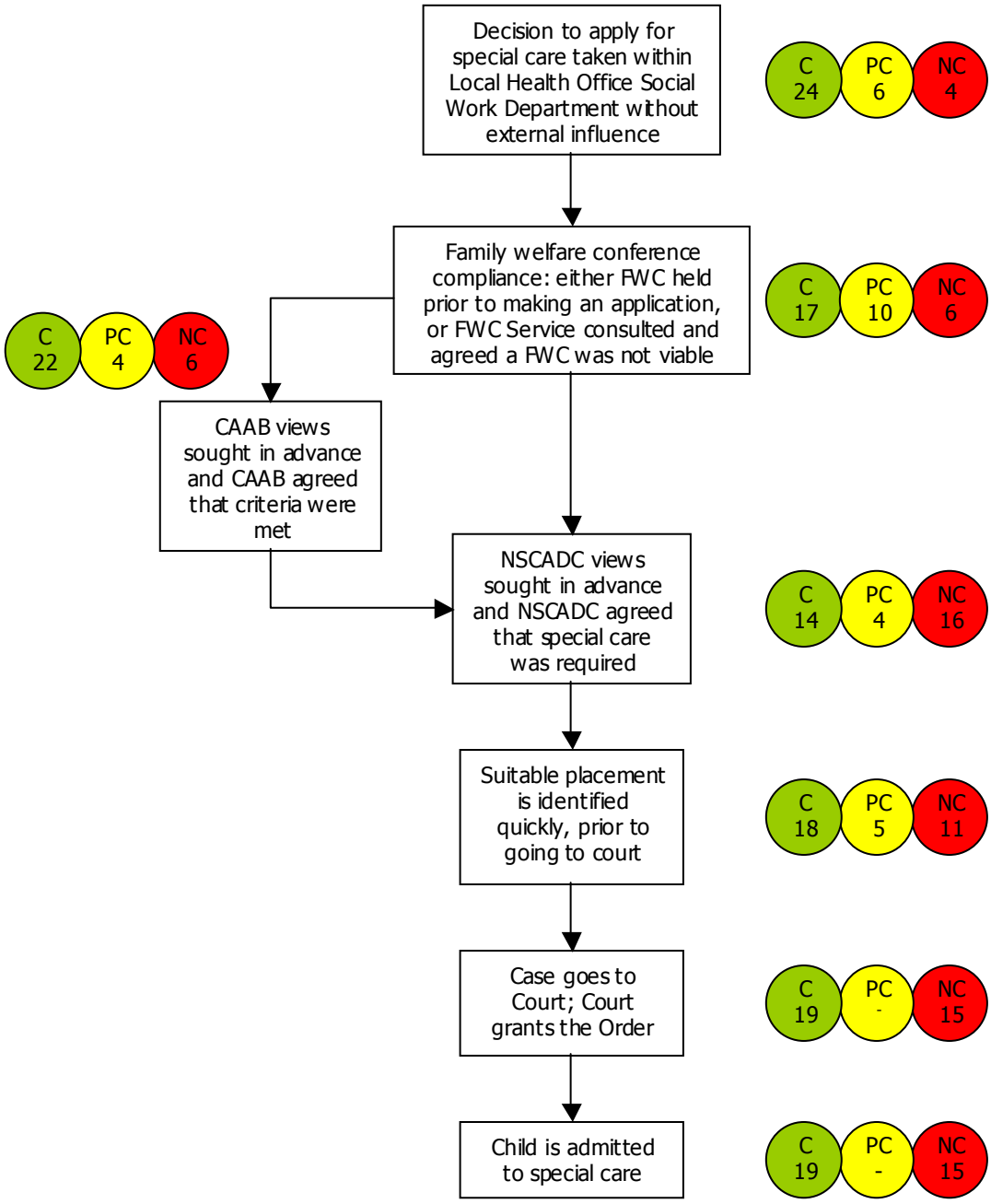


Table 17: Interpretation of *Partial Compliance* and *Non-Compliance* against the Model process

Stage of Model Process	PC Partially Compliant	NC Non-compliant
Decision to apply for special care taken within the Local Health Office Social Work Department without external influence	Significant external influence, but Social Work Department were in full agreement	Significant external influence, and Social Work Department felt at first that other options should be explored before making an application
Family welfare conference compliance	Application for a family welfare conference was made in parallel to the application for special care	No family welfare conference nor consultation with the Family Welfare Conference Service
CAAB agreement	CAAB agreed after appeal; or CAAB views sought on same day as going to Court, prior to Court appearance	CAAB did not support application; or CAAB views not sought in advance
NSCADC agreement	NSCADC agreed after appeal; or NSCADC initially supported application but withdrew support in light of further information/ stabilisation of case	NSCADC did not support application; or NSCADC's views sought after court appearance
Suitable placement is identified quickly, prior to going to court	Admission was 7-8 weeks from the date of the application	Admission was 9 or more weeks from date of the application; or NSCADC's decision was more than 6 weeks from the date of the application (where application did not result in admission to special care); or court appearance preceded identification of a suitable placement
Case goes to Court, Court grants order	Not applicable	Case does not go to Court
Child is admitted	Not applicable	Child is not admitted to special care

Decision Making within the Social Work Department

133. The first part of the Model process involves consideration of decision-making mechanisms within the local Social Work Department.

134. With regards to this issue, we will consider:

- External influence on the decision to initiate an application for special care.
- The currency of attached reports.
- The form of the discharge plan.
- How long ago special care was first considered.
- HSE personnel involved in the decision to apply for special care.
- Parent's views on the application for special care (as reported by the Social Work Department on the Application Form).
- Children's views on the application for special care (as reported by the Social Work Department on the Application Form).

External influence on the decision to initiate an application for special care

135. During interview, SIS asked the applicants whether there had been any external influence on the Social Work Department to initiate an application for special care.

136. The presence of external influence appears to be linked to the likelihood of an application for special care succeeding. It was present for ten applications, of which seven were admitted (70%). Note that in all four applications where the Social Work Department initially preferred to try other options first, the situation deteriorated during the process to the extent that the Social Work Departments involved all felt that special care was required.

Table 18: How significant was external influence in initiating the application for special care x Outcome[23]

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Feature that were Admitted
Significant and Social Work Department were in full agreement	**6**	4	2	-	**67%**
Significant but Social Work Department felt at first that other options should be explored before making an application	**4**	3	1	-	**75%**
Not significant	**24**	12	10	2	**50%**

137. The sources of this external influence were:

- Court: four applications (two of these children had previously been in special care, three were on remand in a Children Detention School at the time of the application).
- Parents: three applications (two of these children had previously been in special care).
- An Garda Síochána: two applications (none of these children had previously been in special care).
- Guardians *ad Litem*: two applications (none of these children had previously been in special care).

[23] In addition to the 34 cases where SIS received full background papers, one of the two other cases in the cohort was also subject to external influence that the Social Work Department felt was inappropriate on the basis of ongoing criminal proceedings.

138. The CAAB did not support any of the applications where the interviewees said that they were not convinced themselves at first that special care was merited.

Table 19: How significant was external pressure in initiating the application for special care x CAAB view

	Total Applications	CAAB supported application	CAAB did not support application
Significant and Social Work Department were in full agreement	**6**	6	-
Significant but Social Work Department felt at first that other options should be explored before making an application	**4**	-	4

Currency of attached reports

139. The guidance on applications to special care states:

> Applications for a placement in Special Care Units should be based on a comprehensive needs assessment including the following:
>
> a) A comprehensive and up-to-date social history.
> b) A detailed care placement history outlining all social services and other interventions.
> c) A Care Plan that supports the aims and objectives of this placement based on identified ongoing needs of the young person.
> d) A discharge plan, identifying the subsequent less secure placement or alternative, and identifying agency personnel with responsibility for actioning the plan.
> e) Up-to-date psychological and educational reports which comment upon the grounds for seeking admission to a Special Care Unit.
> f) Where there are concerns regarding a young person's mental health, a psychiatric report may be appropriate. Should a young person decline to participate in such a referral, the psychiatrist may report, having reviewed the young person's file.

140. Note that a previous requirement to supply a psychiatric report for all applications has been downgraded.

141. Most applications were submitted with social histories and care plans that were less than a month old. Educational reports and psychological reports were more likely to be more than three months old (eight of which were the same combined report supplied by a specialist assessment service): this is not surprising given that many of the children were not in school and/or not engaged with support services. While members of the CAAB's review panel understood that it might be problematic to obtain supporting reports in such circumstances, among their frequently cited issues was the age of, in particular, psychological or psychiatric reports that they had to use to come to a view on whether the application should be supported or not.

Table 20: Age of reports submitted to support the application

	Comprehensive and up-to-date social history	Statutory Care Plan	Educational report	Psychological report	Psychiatric report (optional)
< 1 Month old	28	25	8	6	6
1<3 Months	1	3	4	6	4
3<6 Months	3	4	4	5	2
6<12 Months	-	-	1	1	3
1<2 Years	-	1	2	4	7
2 Years or More	-	-	6	6	1
Undated	-	1	5	2	-
No report	*2*	-	*4*	*4*	-
% reports submitted aged Less than 3 Months	**85%**	**82%**	**35%**	**35%**	**29%**

142. Nevertheless, older reports tend to have a higher likelihood of being associated with an admission to special care than newer ones. This may be because these children have proven particularly difficult to engage because they have more problematic risk factors.

Table 21: Age of reports x Outcome

	Total Dated	Less than 3 Months Old	No. Admitted	% Admitted	3 or More Months Old	No. Admitted	% Admitted
Comprehensive and up-to-date social history	**32**	29	15	**52%**	3	3	**100%**
Statutory Care Plan	**33**	28	15	**50%**	5	3	**60%**
Educational report	**25**	12	6	**50%**	13	9	**69%**
Psychological report	**28**	12	5	**42%**	16	10	**63%**
Psychiatric report	**23**	10	5	**50%**	13	8	**62%**

143. In four of the applications where the application was not supported by the CAAB, the CAAB noted what it felt to be significant deficits in the background information provided. The absence of this information meant that the CAAB did not feel that a case for admission had been constructed robustly. Examples included:

- Failure to provide evidence against the individual criteria.
- Missing pages from the Application Form.
- Social history not being up-to-date.
- Care plan not being up-to-date.

Form of the Discharge Plan

144. One of the specified requirements of an application, according to the *Special Care Information and Application Pack*, is for:

"A discharge plan, identifying the subsequent less secure placement or alternative, and identifying agency personnel with responsibility for actioning the plan."

145. The Application Form asks *"What discharge/aftercare plan is in place for the follow on from Special Care"* and also asks for an up-to-date Discharge Plan to be supplied as a report to support the application. The CAAB generally accepted a specification of discharge arrangements within the Application Form as being compliant to the requirement for a report rather than needing a separate report. Applications that only had weak compliance to this requirement (i.e. in terms of supplying a separate, distinct discharge plan) were more likely to result in a successful application. However, against this should be balanced our previous finding that applications with a secured discharge arrangement have a higher likelihood of success: it is not the form of the discharge plan that matters, therefore, but its robustness.

Table 22: Form of Discharge Plan x Outcome

	Total Applications	Admitted	Not Admitted	Withdrawn	% of Applications with this Form of Discharge Plan that were Admitted
Specific Discharge Plan	**11**	6	3	2	**55%**
Within Application Form and Care Plan	**10**	5	5	-	**50%**
Within Application Form only	**8**	4	4	-	**50%**
Within Care Plan Only	**3**	2	1	-	**67%**
Within supporting letter	**1**	1	-	-	**100%**
No reference to discharge arrangements	**1**	1	-	-	**100%**

146. Where a specific Discharge Plan was produced, it generally mirrored the contents of the relevant section on the Application Form. The requirement to identify agency personnel responsible for actioning the plan is generally implicit rather than explicit i.e. as the result of a Social Worker being allocated to the case in the Care Plan or in the signatures of the team leader/Social Worker on the Discharge Plan.

147. Given the above, we would question whether a separate up-to-date Discharge Plan should continue to be within the "Reports Attached to Support Application" section of the Application Form. It is more important for the Application Form to prompt the applicant to comment on whether they have secured their onward placement.

How long ago was special care first considered?

148. Excluding applications where there had been a previous application or admission to special care, we asked during the interviews when the applicants had first considered applying for special care.

149. Most applications for special care were more likely to be part of a considered, planned process than a knee-jerk reaction (for only two cases was special care

first considered within a month of the date of the application). This also suggests that it takes time to build a robust justification for an application.

150. There were only two applications where special care was first considered within a month of the date of application.

HSE personnel involved in the decision to apply for special care

151. The *Special Care Information and Application Pack* states expectations of key HSE personnel at different stages of the decision making process that leads to an application for special care:

- With regards to the Strategy Meeting that establishes the purpose for considering an application to special care:
  - Social Worker (SW), Social Work Team Leader (SWTL), and Principal Social Worker (PSW) should attend the meeting.
  - The outcome should be discussed with the Child Care Manager (CCM) by the PSW and then sanction sought from the Local Health Manager (LHM) to proceed with the application.
- With regards to the family welfare conference (FWC):
  - The SW and SWTL should make the referral and attend the FWC.
  - Where special care is to be pursued, sanction should be sought from PSW, CCM, General Manager (GM), Local Health Manager (the exact posts may differ according to local structures but the principle is the same)
- The SW seeks the views of the CAAB, sends the application to NSCADC.
- CCM/GM, LHM provide sanction to instruct Law Agents and the SW instructs the Law Agent.
- Final sanction is provided by the Assistant National Director.

152. The Application Form asks who was involved in the decision to apply for special care and in interview we asked the nature of the involvement of these personnel, in terms of whether:

- They had *direct involvement* through strategy meetings, case conferences or family welfare conferences.
- They had *indirect involvement* through, for example, general discussion of cases of concern.
- They provided *informed approval/authorisation* of the application to special care (this does not imply that those only involved in this manner simply rubber-stamped the decision without questioning the details of the application; it merely makes a distinction in the nature of the involvement).

153. Personnel who were directly involved in the decision-making (in addition to the Social Worker) tended to be the Team Leader, Principal Social Worker, and Residential Managers. Child Care Managers were involved in 59% and General Managers for only 12%.

Table 23: Who was involved in the decision to apply for special care x Nature of involvement

	Total Applications	Direct involvement	Indirect involvement	Informed authorisation/ approval	Unclear	% of Applications with these Personnel Involved Directly
Team Leader	**34**	34	-	-	-	**100%**
Principal Social Worker	**33**	30	2	-	1	**91%**
Child Care Manager	**29**	17	4	7	1	**59%**
Local Health Office Manager	**18**	5	3	8	2	**28%**
Lead Local Health Officer	**3**	1	-	2	-	**33%**
Alternative Care Manager	**8**	4	-	1	3	**50%**
Residential Managers	**17**	15	-	-	-	**88%**
General Manager	**17**	2	-	14	1	**12%**
Other HSE personnel	**4**	3	1	-	-	**75%**

154. The likelihood of an application to special care being successful appears to be increased if Alternative Care Managers, Residential Managers and the General Manager have been involved in the process. Where the Alternative Care Manager was involved, 75% of applications were successful; where Residential Managers were involved, 65% of applications were successful; where General Managers were involved, 65% of applications were successful. More of the applications for males than for females involved Alternative Care Managers and Residential Care Managers. This is in keeping with what we reported on earlier in terms of the last placement of the children at the time of the application for Special Care, with more males than females in mainstream residential settings.

155. The process of obtaining authorisation from senior personnel within the HSE appears to be inconsistently applied:

- Almost half the applicants from the HSE South found their local process to be cumbersome because of the requirement to gain authorisation from senior managers. There appeared to be some lack of clarity about who was responsible for securing the necessary signatures from senior managers and ensuring that the application was sent off to the NSCADC and the CAAB in a timely manner, plus concerns that suggestions for minor amendments from managers (i.e. perceived to be minor by the Social Worker, such as spelling and typing mistakes) were significantly adding to delays.
- On the other hand, the HSE South and the HSE West were much more likely to obtain the signatures of the Principal Social Worker and other senior personnel than their counterparts in Dublin North East and Dublin

Mid-Leinster (see Tables 24 and 25). Some interviewees even queried the requirement to obtain signatures of CCMs, General Managers or Local Health Officers, given their perceived remoteness from the details of the case.

Table 24: Number of applications where Principal Social Worker's signature was obtained x HSE Area

	PSW Signed	PSW did not sign
Dublin North East	4	6
Dublin Mid-Leinster	3	7
South	7	2
West	5	-

Table 25: Number of senior manager's signatures obtained x HSE Area

	None	1	2	3
Dublin North East	6	4	-	-
Dublin Mid-Leinster	9	1	-	-
South	3	-	2	4
West	-	2	2	1

156. It is important that, where a child is potentially to be deprived of his/her liberty, there should be a clear, effective and defensible audit trail of decision-making within the LHO. There would be a benefit for all Areas in refreshing the knowledge of staff about local roles and responsibilities with regards to special care applications. The NSCADC and the CAAB also need to be clear with regards to their expectations of evidence from the applying Local Health Office that key senior personnel are aware of, and supportive of, the decision to apply for special care.

Parent's/carer(s) views on the application for special care

157. The Application Form includes a question for the Social Workers to complete on *"What are the parent(s)/primary carer's views on the application for special care?"* Social Workers reported that 28 parents/carers supported the application for special care. Of the other six applications,: the parent's/carer's views could not be obtained for three applications; there was a mixed response for one; for another, a decision was taken not to tell the parents/carers because of fears that the parents/carers might severely compromise this course of action; and for another application no reference was made to the parent's/carer's views.

158. On the other hand, only 10 of the special care applications were signed by a parent.

Children's views on the application for special care

159. The Application Form includes a question for the Social Workers to complete on *"What are the young person's views on the application for special care?"* As might be anticipated, the views of the children themselves about the special care application were much less supportive than the views of the parents/carers, with only 12 (35%) expressing any support for the application, albeit reluctantly in some instances. However, the more compliant the child seemed to be, the higher the likelihood of the application succeeding.

Table 26: Children's views on special care x Outcome

	Total	Admitted	Not Admitted	Withdrawn	% of Children who Agreed with the Application
Agree with referral to special care	**7**	4	3	-	**57%**
Reluctant to go into special care but generally understanding of the reasons	**5**	4	1	-	**80%**
Indifferent	**2**	1	1	-	**50%**
Does not want to go into special care	**14**	9	3	2	**64%**
Unaware of the referral	**5**	1	4	-	**25%**
Not Stated	**1**	-	1	-	**100%**

160. There was a marked difference between males and females in terms of willingness to go into special care. 50% of the females agreed with, or reluctantly agreed with, the application for special care, compared to only 14% of the males.

161. All the children who were reported by the Social Work Department to not want to go into special care had never had a special care placement before.

162. All five of the children who were unaware of the referral were deliberately not told because of fears that their behaviour would worsen (in particular, absconding or self-harm). All of these children were aged between 15 and 17.

163. In addition, interviewees said that 13 children knew that the application was happening but were not informed of its progress. Again, concerns that the child's behaviour (in particular absconding and, to a lesser extent, self-harm) were mentioned for nine of these applications as reasons for not keeping the child informed. In two applications there were concerns that the mothers might hide their child. In one application the child disengaged from all professionals, including their own solicitor, after they knew the application had been made.

164. For many of the applications, interviewees reported that the child's behaviour became more challenging during the course of the application process. However, this was equally true for those children who had agreed, or reluctantly agreed, to the application for special care, as it was for those children who did not agree or who were unaware of the referral.

165. Making an application while keeping the child unaware of this may have significant children's rights implications. The HSE needs to consider the legal and practice implications of such a course of action.

Family Welfare Conference (FWC)

Compliance with the requirement for a family welfare conference

166. The second component of the Model process that we outlined earlier involves compliance with the requirements relating to family welfare conferences.

167. Section 23 (a) of the Children Act, 2001 states that "before applying for a Special Care Order under this part of the Act, the Health Service Executive shall arrange for the convening of a family welfare conference".

168. The HSE's *Special Care Information and Application Pack* provides two options for complying with this requirement:

- "The holding of a family welfare conference.
- On confirmation by FWC Co-ordinator that no family willing to participate in FWC, revert to Child Welfare Protection Procedures." [sic]

169. These alternatives recognise that a family welfare conference is not always possible but require that the FWC Co-ordinator explores this rather than the Social Work Department making the decision alone.

170. Of the 33 applications where level of compliance was known:

- 17 applications were fully compliant with the above process (nine admitted, six not admitted, two withdrawn).
- Ten applicants made their referral to the FWC Service in parallel to their application for special care (six admitted, four not admitted).
- Six applications were non-compliant (three admitted, three not admitted).

171. Variations in levels of compliance do not differ significantly according to HSE Area.

172. The minimum requirement of consulting with the local FWC Service needs to be emphasised on the Application Form and in guidance. It is also questionable whether a parallel application meets the requirement.

Was a family welfare conference held prior to this application?

173. Family welfare conferences were held prior to *this* application (i.e. rather than prior to previous applications) for 11 applications. A decision was taken not to hold a family welfare conference for 16 applications. There was no particular difference between the genders.

Table 27: **Was a family welfare conference held prior to this application x Outcome**

	Total Applications	**Admitted**	**Not Admitted**	**Withdrawn**	**% of Applications with this Feature that were Admitted**
Yes, and parents/family involved	**11**	5	4	2	**45%**
No, but one is scheduled	**4**	2	2	-	**50%**
No, but referral for FWC has been made	**3**	2	1	-	**67%**
No, and none is scheduled	**16**	10	6	-	**63%**

174. Note that the existing FWC outcome form provides space for the child's name to be noted but does not ask whether the child was present so it was impossible to tell from the form alone whether the child was in attendance.

175. With regards to care status:

- Family welfare conferences were held prior to making the applications for **50%** of the children who were in care under voluntary arrangements (eight out of 16).
- Family welfare conferences were held prior to making the applications for **20%** of the children who were in care under Interim Care Orders or Care Orders (three out of 15).
- For all three of the children not in care, either an FWC was scheduled or a referral for an FWC had been made.

176. Children in care under Care Orders are more likely to have fractured family relationships and hence are also less likely to engage willingly with the Social Work Department.

Reasons why family welfare conferences might not be seen as appropriate

177. Reasons for not holding a family welfare conference prior to the application were:

- Parents/family unwilling to participate: four applications.
- Parents/family not engaged with Social Work Department: three applications.
- Family dynamics changed since last FWC: three applications.
- Perceived failure of last FWC: two applications.
- Parents still in agreement with special care: two applications.
- Decision taken in another forum with the family present: two applications.

178. There appears to be different perceptions of the need to have a family welfare conference between the two Family Welfare Conference Services that we interviewed, with the South interpreting the letter of the legislation and its implication that a Conference *shall* be held (emphasis laid on the word "shall" by the service in the South) even if only one parent was available to attend, and the Dublin region[24] being more flexible in interpretation. Both Services said, however, that it was their responsibility to consult with the family whether a family welfare conference should proceed and report back to the Social Work Department: a decision is then reached by the Social Work Department.

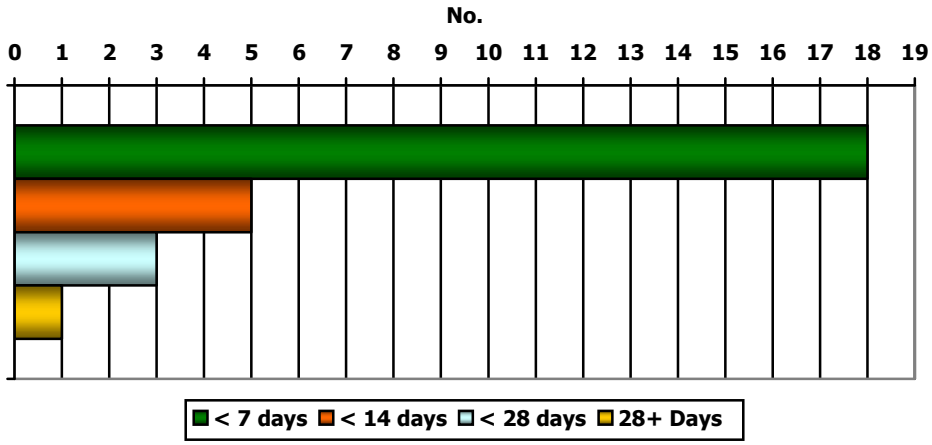
Speed of response in arranging a family welfare conference to support an application for special care

179. Family Welfare Conference Services currently prioritise FWCs for special care above FWCs for other reasons and have a timescale for completing the FWC of 28 calendar days (practice appears to differ in different Services according to whether this starts from the date that the referral is received by the service or from the date that the referral meeting is held between the service and the applying Social Work Department). This timescale is intended to be quicker than the timescale for a family welfare conference held for other reasons.

[24] The FWC Service for Dublin covers parts of Dublin North East and parts of Dublin Mid-Leinster: it is congruent with the boundaries of several LHOs in the greater Dublin area.

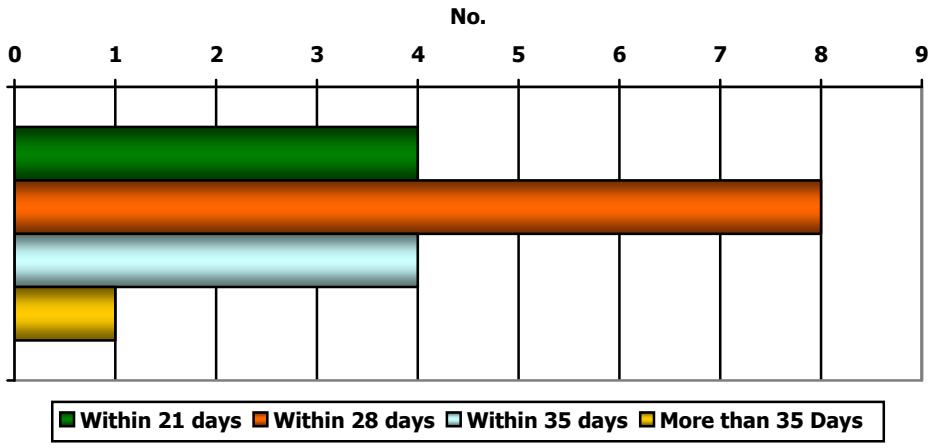
180. Of the 27 applications that were known to either be compliant with the FWC requirements or had made a parallel application to the FWC Service, 18 (67%) led to a referral meeting within a week.[25]

Figure 12: Date referral received by Family Welfare Conference Service x Date of four-way referral meeting



181. Of 17 applications where an FWC was actually held (including both those held prior to the application for special care and those held since via a parallel application), 12 were within 28 calendar days of the application date, and all the remaining five were within 28 calendar days of the referral meeting.

Figure 13: Date referral received by Family Welfare Conference Service x Date of family welfare conference



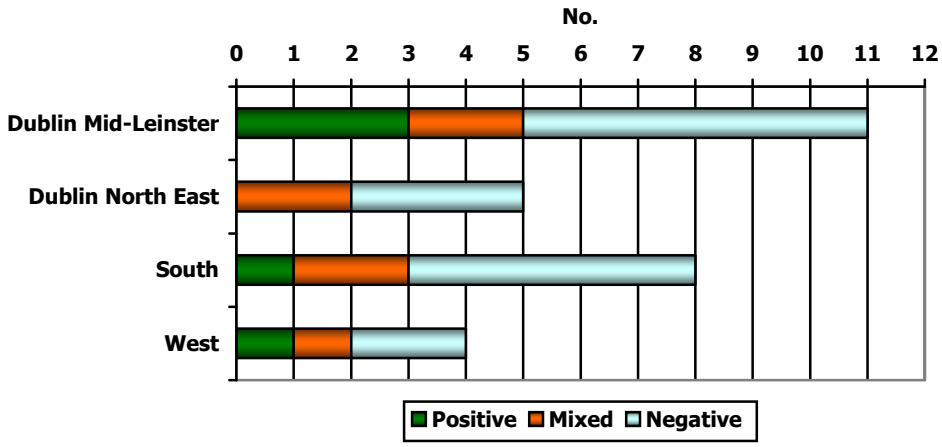
182. Ten interviewees felt that Family Welfare Conference Services were responsive in arranging the family welfare conference quickly. Speed of convening the conference was not an issue: however, as will be shown below, the necessity of having a family welfare conference (or consulting with the local Family Welfare Conference Service) was often regarded as a problematic delay to the speed of the overall process.

[25] This includes one case where a telephone consultation was held with the FWC Service but no referral meeting convened, for a case where there had been a previous FWC for welfare reasons. An FWC was convened later, after CAAB had advised that it be held.

Applicant views on the requirement for a family welfare conference

183. A positive view of the role of the family welfare conference in the special care application process emerged from only five interviews, with a negative view emerging from 16 interviews, more than three times as many. Although positive views were more likely to be expressed by applicants from Dublin Mid-Leinster, negative views were preponderant from interviews in all HSE Areas.

Figure 14: Applicant views on the requirement for a family welfare conference



184. Where the interviewee had a negative view of the role of family welfare conferences in special care, the primary reasons were:

- 13 felt that all options were likely to have been exhausted prior to making the application for special care.
- 12 felt that the requirement for a family welfare conference slowed down the process and took up valuable time.
- Ten stated that they believed family welfare conferences to be useful in other contexts but not for special care.
- Four felt that family welfare conferences might have a more useful role in supporting discharge from special care.
- Four noted that families were often so fractured that a family welfare conference would be impossible.
- Seven noted that their experience of family welfare conferences in such circumstances could be negative or even destructive for the child (e.g. parents making false promises, lack of interest from the extended family, distress for the child, reinforcement of conflict within the family).

185. Interviews with Family Welfare Conference Co-ordinators from the Dublin region and the South suggested that they shared a perception that Social Workers had often made a decision that special care was required before contacting the service, that Social Workers believed the requirement for an FWC caused delays, and that Social Workers often saw the requirement for a family welfare conference as undermining their professionalism. The Co-ordinators also noted that, where there had been a family welfare conference in the past, the families invariably would not want another one. For many applications, the Co-ordinators themselves perceived that the Social Work Department had exhausted all options. Social Workers' knowledge of the intended role for the family welfare conference, as a means of taking one last pause to find any possible alternatives to prevent the child being deprived of

his or her liberty, was felt to be patchy. The Family Welfare Co-ordinators also said that Social Workers often tried to steer the Co-ordinators towards certain decisions and did not fully appreciate the independence of the Service.

186. The Family Welfare Conference Co-ordinators interviewed also stated that often the Social Worker might not obtain signatures from parents or from their line manager. Given that it is a requirement of the HSE to consult at senior level about the resources that might be made available to support the family in the plan that might arise, this is clearly happening inconsistently.

187. Where the family welfare conference was felt to be useful, the primary reasons expressed by interviewees from Social Work Departments were:

- Six said that it enabled all alternatives to be explored to exhaust all options.
- Five said it was useful for all the family to hear all concerns and air their views.
- Four said it enabled concerns to be shared by the Social Work Department with other professionals or, through having an independent chair, to demonstrate to the family themselves that the department was not alone in its concerns.

188. The Family Welfare Conference Co-ordinators generally concurred with the above views on where FWCs had proven useful.

Families views of the process

189. The focus of the research was on the application process for the cohort of applications rather than the role of the family welfare conference *per se* so we did not interview individual families. The views reported in this section, therefore, are those of families as perceived by the Family Welfare Conference Co-ordinators.

190. The FWC Co-ordinators believed that family members were not perceiving the benefits of the process, with low attendance from family members and fear/uncertainty about what an FWC entails. They said that families often were under the misapprehension that a special care bed would be immediately available. The Co-ordinators also said that they did not know whether they were making an effective contribution to the decision-making process themselves because they did not know what happened next to those families, and found this frustrating. The Co-ordinators felt that information packs (paper or using more modern media such as DVDs) need to be developed to provide greater knowledge to families on what special care is, to enable those families to fully contribute to the process. If this is to be pursued, it needs to involve families in the design of any materials.

Support from the Children Acts Advisory Board (CAAB) and National Special Care Admissions and Discharge Committee (NSCADC)

191. The third and fourth components of the Model process consider decision-making by both the CAAB and the NSCADC. These are considered together here.

Emergency Placements

192. Five applications were regarded as 'emergency' by the applying Social Work Department, with apparently little consultation with the CAAB or the NSCADC. For several of these, it was not immediately apparent from the Application Form that the application was regarded as an emergency by the applicant.

193. Most of the applications in the cohort will have felt like a 'crisis' to the Social Workers and, indeed, the children and their parents/carers; but most of those who were admitted to special care actually did so in a planned manner (see section of this report on speed of the process).

194. There are currently no illustrative criteria to define the types of circumstances that define an application as being an 'emergency'. Such criteria might reflect the urgency of the situation: for example, very high likelihood of immediate harm (to self or others) or very high risk of leaving the jurisdiction. There is a need to provide guidance on the process that should be followed for emergency applications, specifying local and national management and gatekeeping arrangements. This should include who decides what is a true 'emergency', and expectations with regards to the involvement (if any) of:

- The NSCADC.
- The CAAB.
- Liaison with An Garda Síochána.
- The Courts.
- FWC Services.

195. The internal procedures for the NSCADC and the CAAB, that are relevant, also need to be formalised, in order to facilitate a speedy response.

196. In addition, there is a need to define what happens after the emergency period has elapsed. If, for example, an emergency admission results for a short-period only (e.g. a week), what should happen next?

Placement abroad

197. During the research, a question was asked by Social Workers about what should happen where their Local Health Office wishes to place a child, who might require special care, in a placement outside Ireland. This raises two issues:

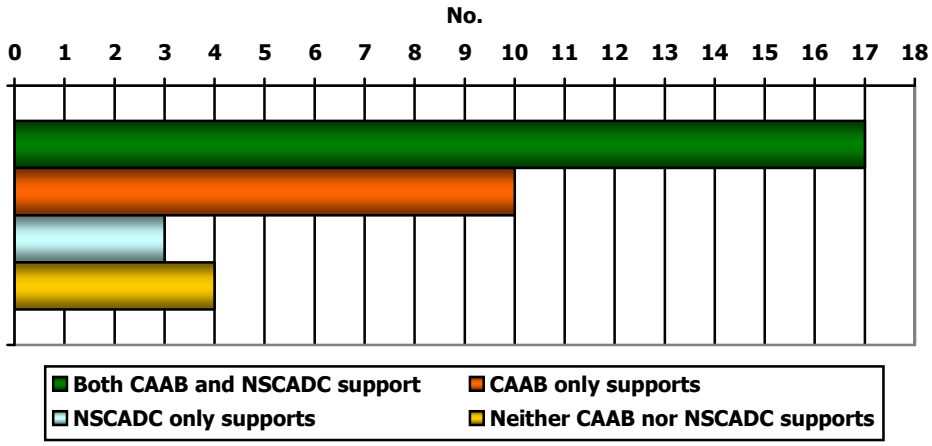
- A HSE national policy on placement of children abroad, who might require special care, is needed. In these circumstances should the criteria for special care be applied?
- The HSE needs to monitor the number of children who *might* fit the Criteria for special care and who are placed abroad.

Views of CAAB and NSCADC

198. 17 applications were supported by both the CAAB and the NSCADC, and four applications were not supported by neither the CAAB nor the NSCADC, a total of 21 applications (62%) where both bodies were in agreement. Of the 17 applications supported by both, two of the cases were subsequently withdrawn as the child's situation stabilised and the other 15 were all admitted to special care. All three cases that were supported by the NSCADC only were admitted to

special care. Out of the 10 cases that were supported by the CAAB only one was admitted to special care.

Figure 15: Support from CAAB and NSCADC for the application



199. Note also that in only three applications did the NCSADC make a decision prior to receiving the view of the CAAB. For two of those applications, the CAAB was just outside its target of five working days for coming to a view (one of these occasions was during a week with a public holiday) and for the third it was technically within its operational target although the elapsed time was eight calendar days (again it was a week with a public holiday). In general, therefore, the CAAB's operational target of five working days enables it to provide the NSCADC with its view prior to the NSCADC's fortnightly meetings.

Applications not supported by both CAAB and NSCADC

200. Of the four applications that both bodies rejected, the NSCADC and the CAAB did not feel that alternative options had been sufficiently explored. Only one of these cases was subject to an appeal, both to the CAAB and the NSCADC, and this appeal was not successful.

Applications not supported by CAAB but supported by NSCADC

201. Three applications were not supported by the CAAB but were supported by NSCADC.

- In all of these applications, the CAAB did not feel that all placement options had been explored nor that a case had been made that a less secure environment would not work.
- In two of the applications, the evidence provided by the applicant contained gaps and therefore was not as robust as it might have been.
- In two of the applications, the Social Work Department themselves did not initially believe that they had exhausted all options.
- In all of the above applications, there were concerns about a known individual to the child.

202. We have previously stated that Social Workers were usually less strong in specifying the extent to which other placement options have been tried or considered and that this is an area to which Social Workers should pay particular attention when making their application.

Applications supported by CAAB but not supported by NSCADC

203. Ten applications were supported by the CAAB and not supported by NSCADC:

- In four applications, there had been two previous placements in special care. This is not currently part of the criteria for special care (hence would not be considered by the CAAB) but is a valid issue for consideration by the NSCADC.
- In five applications, there were ongoing criminal proceedings. Judge MacMenamin's summer 2007 rulings should clarify this situation: again, amendments to the criteria for special care might be made.
- In four applications, the length of time that the child had been detained in a Children Detention School was taken into account by the NSCADC but was not part of the criteria being considered by the CAAB. Again, it seems a valid reason for divergence in opinion.

204. Thus, although there were ten applications that the CAAB supported and the NSCADC did not, there were generally explanations for the difference of views.

Appeals

205. Where an application does not progress, it is the responsibility of the applying Social Work Department to make alternative arrangements. For a number of such cases, the applicant decided to 'appeal'.

206. The CAAB has a formal procedure internally for handling appeals; the NSCADC hears 'appeals' at its next meeting, without having an explicit appeals process.

207. Nevertheless, 13 applications were subject to an 'appeal': ten appeals were made to the NSCADC, and five to the CAAB. The NSCADC changed its view on two applications, and the CAAB changed its view on two applications. These were four different applications and as a result of the change in view on appeal, the CAAB and the NSCADC were then in agreement on three of these applications.

208. For two children, the Social Work Department made a reapplication, complete with all the required supporting reports. One of these contained substantially more detail (this was the application then supported by the CAAB, although the CAAB had changed its decision earlier based on a letter containing the same additional information); the other merely updated the previous Application Form and social history to show how behaviour was escalating. For both of these applications, the additional information provided was similar to additional information that was provided in other appeal situations in the form of a letter: the distinction between what constitutes a 'reapplication' or an 'appeal' is therefore not clear.

209. Comments on appeals emerged from 11 interviews (seven of which applications were not admitted, two of which applications were the subject of successful appeals). These comments suggested that at the moment there is not a defined appeals process. What may be required, therefore, is guidance on:

- Grounds for an 'appeal'.
- How to appeal.
- To whom to appeal (should it be the same body or a different body?).
- How often the Social Work Department can appeal.

- Opportunities to consult prior to the appeal.
- Opportunity to present an appeal in person, if felt desirable.
- When to re-apply rather than appeal.
- The role of updates/additional information where a case deteriorates significantly.

210. Although letters are sent by both the CAAB and the NSCADC notifying the applicant of their views, eight applicants commented on the lack of detail in the feedback that they received when an application was refused, both from the NSCADC and the CAAB. Ultimately, it is the Social Work Department's responsibility to follow this up and a clearer appeals process may assist with this issue.

Role clarity

211. Eight interviewees said that the process left them confused about the relative roles of the NSCADC and the CAAB within the application process. In all of these applications, the views of the NSCADC and the CAAB diverged (some of which then converged after appeal). Some of the applicants were further frustrated because they felt that their "professional opinion" was not given enough weight.

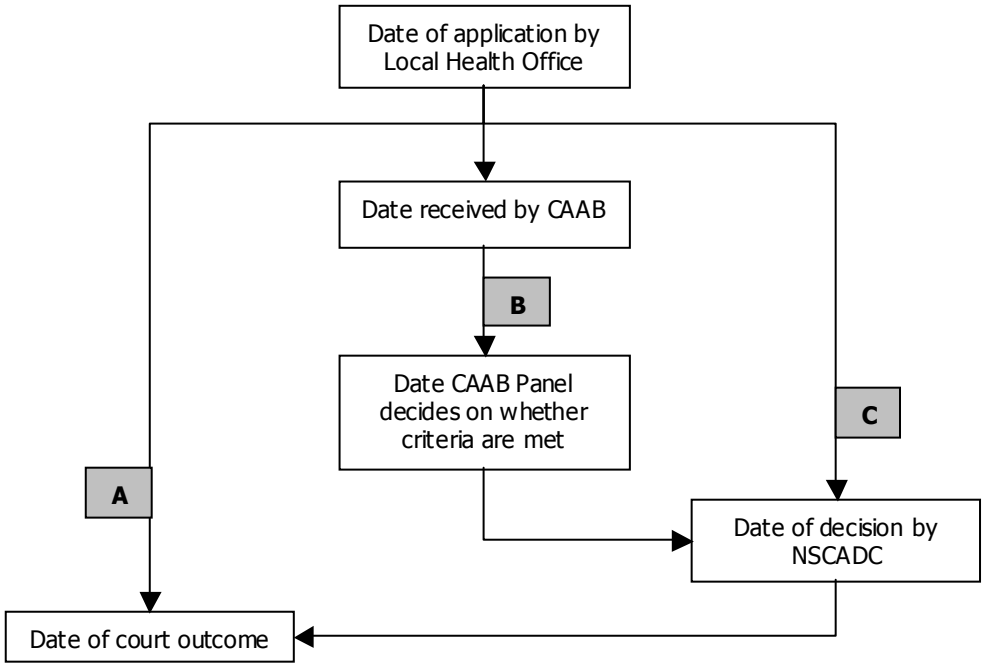
212. This issue partly links to the requirement to define what the appeals process is, but there is also a requirement for guidance to Social Workers on the relative roles of the two bodies. In addition, some interviewees commented that they did not know the composition of the NSCADC or the CAAB panels: this would be useful information to provide in guidance or newsletters.

213. It also suggests that the two bodies need to come together on an ongoing basis to share understanding of differences of views for the different applications: as exemplified above, there was usually a solid explanation for the difference.

Speed of Process

214. The fifth stage of the Model process looks at the length of time waiting for a place. This is an opportune moment to consider the overall speed of the process, from the date of application onwards. Figure 16 schematically represents the processes involved in making an application for special care. The letters A-C represent key stages in the process that can be tracked for speed.

Figure 16: Speed through the process



Stage	"Average" Number of Calendar days
A: Date of application by LHO to date of court outcome	31 calendar days (*see para 216)*
B: Date received by CAAB to date CAAB gives its view	5 calendar days *(see para 218)*
C: Date of application by LHO to date of decision by NSCADC	20 calendar days *(see para 221)*

Date of application x date of court outcome (calendar days)

215. Of the 19 applications admitted to special care, five were admitted within 28 calendar days of the date of application, and a further eight were admitted within 56 calendar days of the date of application ("A" in Figure 16).

216. For the 13 admissions that took less than 56 calendar days, the average time period was 31 calendar days. Again, this serves to demonstrate that most admissions to special care were on a planned basis. There is a discussion issue here, however, about whether this timeframe is felt to be acceptable.

217. Six admissions took longer than 56 calendar days from date of application to date of court outcome. Reasons for delays included:

- Applications not supported, but then supported on appeal.
- Long periods when the child was missing.
- Hearings before the High Court.
- Emergency placements taking away the place planned for the child.
- Placement mix (it seems, only one application was delayed for this reason)

Date received by CAAB x date of CAAB panel (working days)

218. The CAAB has a timescale of five working days to convene a panel when an application has been received ("B" in Figure 16). 29 of the 34 applications were convened within this timeframe; five applications were between five and ten working days; and one was more than 20 working days. In *calendar* days, the average for all 34 applications was 5 calendar days.

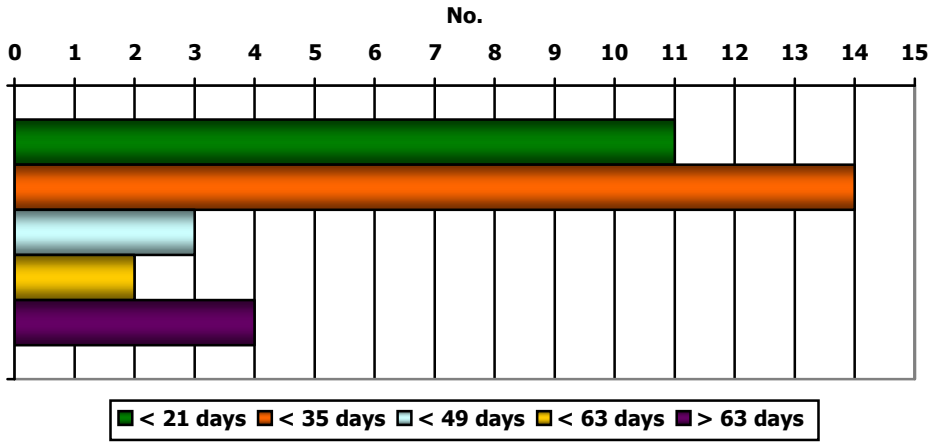
219. Of the five applications convened within 10 working days, three were in weeks with a public holiday (implying that it may have been more difficult to arrange promptly with pool members on holidays), and two were held after an emergency admission had already occurred. For the one application held beyond 20 working days, the CAAB initially responded by asking the applicant to send a more up-to-date social history, care placement history and care plan and this was the reason for delay.

220. Nine interviewees specifically stated that the CAAB's response was quick and no-one expressed any dissatisfaction with the speed of response.

Date of application x date of decision by NSCADC (calendar days)

221. For this item ("C" in the Figure 16), the decision we are using is the first decision of the NSCADC (i.e. not the date of any subsequent appeal). The NCSADC aims to convene every two weeks to consider applications: if papers have been received just before the deadline, they may not be circulated in time for consideration at the next meeting of the Committee; where there is a holiday period (such as Easter), the aim is for the NCSADC to convene every three weeks. However, the NCSADC can also conduct teleconferences in emergency situations. Figure 17 therefore uses three calendar weeks as the first break-point, then rises in fortnightly blocks thereafter. Around a third of the applications received a decision within three weeks of the application, and further 40% within 35 calendar days. For these 25 applications (74% of all applications), the average length of time between date of application and date of decision by the NSCADC was 20 calendar days.

Figure 17: Date of application x Date of decision by NSCADC



222. Of the nine applications where a decision by the NSCADC was taken 35 or more calendar days after the date of application, three of these have already been discussed in the section on the overall length of time from application to court outcome. Of the other six, reasons for delay included:

- Incomplete paperwork to support the application.
- Awaiting outcome of other processes (e.g. parallel applications for a family welfare conference or reports being produced by allied professionals such as psychologists). In one case, prior to Judge MacMenamin's rulings, the NSCADC awaited the outcome of criminal proceedings before a District Court.
- Requests for further information on the onward placement.

223. There were few comments by interviewees on the speed of response by the NSCADC: only five interviewees felt it to be slow. Similarly only four commented on the length of time taken while waiting for a place (although several did feel that they had to chase the NSCADC for a decision).

224. 8 interviewees felt that, overall, the process was fast enough, and only a couple expressed doubts about the speed of the process in all circumstances. Five, however, questioned whether the speed of the process would be responsive enough in an 'emergency' situation.

Court Grants Order and Child is Admitted to Special Care

225. These are the last two components of the Model process. No application that went to Court failed to gain admission to special care, and all but one of these applications was supported by the NSCADC.

Applicants Views on the Application Form and Information Pack

226. 22 interviewees felt that the revised Application Form and information packs were improved (six) or acceptable (16). Of these, eight said that they found the Application Form to be long and difficult but said that they understood why the information was needed. Six specifically said that the embedding of the criteria into the form was useful: this view was shared by members of the CAAB's pool of reviewers. One social work interviewee felt that the child had to be fitted into the boxes too much.

227. Seven interviewees had problems with the Application Form, finding it very difficult. There was no pattern to this by HSE Area. Concerns were primarily about risks of duplicating information contained within social histories or care plans.

228. Specific comments on difficulties with the form generally related to the care placement flowchart, which was felt to be cumbersome, or not knowing how much to put in each section. There was also some perceived duplication when building a case against the criteria (e.g. absconding commonly placed against both the *Real and substantial risks to self* and *Impaired socialisation/impulse control* criteria) and it is to be hoped that the way the criteria have been analysed within this report might provide some help in the future.

Is the Revised Process Better?

229. Ten applicants felt that the revised process was better (70% of these applications were admitted). Most commonly cited reasons were:

- The fact that there is a national process with just one HSE admissions committee rather than three separate admissions committees for the three units.
- Not just the units themselves involved in the decision.
- Fortnightly meetings of the NSCADC.
- Improvements to the Application Form.

- The fact that six copies of the Application Form and a psychiatric report are no longer required.

230. Three applicants had mixed views about whether the revised process was better, liking the new national approach but feeling that the process was slower.

231. Seven applicants felt that the revised process was worse. Two felt they were given insufficient reason for the application not being supported. One said they preferred the more informal localised approach that had previously existed. One felt that the length of time involved was excessive (this was one of the longest applications between date of application and date of admission). One seemed to have significant issues with the processes in place in their Local Health Office.

232. Three of the above also cited a perceived growth in legal costs as an issue as a result of the going to the High Court rather than local District Courts. Feedback from representatives of the NSCADC suggests that their perception is that the change should reduce legal costs, by removing the historical pattern of senior and junior counsels in each Health Board and providing a single point of contact for the HSE. The precise impact of the revised arrangements on HSE budgets, at local and national level, would benefit from further exploration.

233. 11 interviewees had no experience of the previous application processes or no views.

234. However, there was a distinct regional pattern to these views. No applicant from the HSE South felt that the revised processes were an improvement, and six of the seven applicants who felt that the revised processes were worse were from the South. As we have stated in the section on *HSE personnel involved in the decision to apply for special care,* it appears that Social Workers in the South were more likely than in the two Dublin Areas to try to obtain all the necessary signatures from senior management, and that this in itself is a major factor in negative views of the revised process from those workers.

CONCLUSIONS AND RECOMMENDATIONS

235. Conclusions and recommendations are divided to reflect issues relating to:

- Management of practice.
- Processes.
- Monitoring.

Management of Practice

236. As in previous research, there were gender variations in terms of a higher likelihood of females being both the subject of applications and the subject of admissions. There were other gender variations too:

- One of the criteria for special care relates to whether the behaviour of the child poses a "real and substantial risk to his/her health, safety, development or welfare unless placed in a Special Care Unit." Such risks

can be summarised as *Risks posed to self* and *Risks posed by others:* both of these had a much stronger likelihood of resulting in an admission for females than for males.

- Of these same factors, 80% of applications for females had factors related to *sexual risks*, compared to only 29% of the applications for males.
- Under the criteria for special care relating to "a history of impaired socialisation and impaired impulse control", the report considers the extent to which *Risk-taking behaviour* was cited in the application as a reason for seeking admission to special care. Where such behaviour was present, it had a much higher likelihood of resulting in an admission to special care for females than for males.
- Successful applications for females were much more likely to be linked to those who had had a previous experience of special care or for whom consideration of high support had been demonstrated.
- Females with high support as their planned onward placement were four times more likely to be the subject of a successful application than males with high support as their onward placement.
- 50% of the males were assessed as having a low/mild/borderline disability whereas this was only true for 25% of the females.
- The information provided on the Application Form by Social Workers suggested that 50% of the females agreed with, or reluctantly agreed with, the application for special care, compared to only 14% of the males.

237. There are potential practice issues here in terms of whether risk-taking behaviour is more likely to be tolerated in males than in females, particularly behaviours relating to sexual behaviours and risks. Is the behaviour of the females more risky than for the males or is the same behaviour in a female considered to be more risky?

RECOMMENDATION 1: The Health Service Executive (HSE) should consider the development of guidance on Risk Management Strategies to address risk assessment and risk management, with particular emphasis on gender issues and expectations of what resources might be employed locally prior to making an application for special care.

RECOMMENDATION 2: Within practice, social work professionals need to be mindful of whether they respond differently, or in the same manner, to the same risky behaviour displayed by females and males, particularly in relation to sexual risks.

238. For some of the applications, the child was missing at the time of the application. If a child is missing from home rather than from care, this situation provides an additional complication.

RECOMMENDATION 3: The HSE should draw up practice guidelines on options for responding where there are significant concerns about a child who is not in care, who appears to meet the criteria for special care, but is missing.

239. For seven applications, the child was felt to be at risk from a known individual (usually an older boyfriend). 71% of such applications resulted in an admission to special care. In such circumstances it should be imperative to focus on the risks posed by the adult.

RECOMMENDATION 4: Protocols for agencies working together where a child being considered for special care is deemed to be at risk from a known adult need to be re-examined to identify any policy, practice and legislative implications.

240. For seven applications, there were concerns that the child was endangering other children by inciting them to criminal or anti-social behaviour. 71% of these applications led to an admission to special care. It should be questioned whether special care is the optimum method of separating children in these circumstances.

RECOMMENDATION 5: Where there are concerns about the risks the child poses to other children through incitement to criminal, anti-social and/or negative behaviour, there should be a substantive body of evidence to demonstrate that all efforts have been taken to reduce this risk before special care is considered as an option.

241. Every application identified absconding as a risk factor. Absconding is specifically mentioned in this criterion for special care relating to *Impaired socialisation/impulse control*. In addition, in *Health Service Executive v. DK, a minor* Judge MacMenamin noted that an established pattern of absconding is not sufficient to justify deprivation of liberty without evidence about the underlying reasons for the absconding.

RECOMMENDATION 6: Specific guidance on 'absconding' is required to emphasise that absconding alone is insufficient reason for an application for special care.

242. The majority of applications stated that a less secure structured environment would not be appropriate because of the level of containment required (31 applications). However, only 17 (50%) referred to any specific interventions or outcomes that they wished the placement to achieve. More of the applications (20) made reference to the fact that the child had not been engaging with support services than made reference to interventions that they wished for the child while in special care. In addition, some of the applicants stated that they felt that three months was too short a time period to achieve much more than containment, and some were unsure about the different models of care being utilised in the three SCUs. The short-term nature of special care emphasises the need for a long-term vision of the interventions and supports that the child may require: some such needs may only be identified during the placement. This in turn emphasises the importance of the discharge plan and of the SCUs and Social Workers working closely together to identify next steps. It is not within the remit of this research, however, to comment on the effectiveness of discharge plans from special care over the medium-term. Nevertheless, improved information on the models of care operational in the three SCUs would aid Social Workers in considering the purposefulness of their application.

RECOMMENDATION 7: Information on the models of care provided under special care should be made available to Social Workers.

243. Nine children were remanded to a Children Detention School at the time of the application to special care (although this was not always clear on the application form) and 13 applications had ongoing criminal proceedings before the District Court.

244. Prior to 2007, the HSE could apply to the High Court for a child to be detained in a Children Detention School for 'welfare reasons'. Since January 2007, this has not been possible: children can only be remanded (by District Courts) to a Children Detention School where there are criminal charges against them. However, more often than not, the Social Workers stated in interview that they regarded the motive for remand to a Children Detention School as being for welfare reasons, in several instances pending the application to special care.

245. In June 2007, while this research was underway, in *Health Service Executive v. S (S) (A Minor), (2007, paragraph 19)*[26], Judge MacMenamin made a number of significant statements in his judgement. He stated that "detention [in a Children Detention School] would be inappropriate for a young person in the absence of a criminal conviction or sentence". He also expressed concern about cases being before courts for both civil and criminal proceedings simultaneously and stressed that the latter must have priority and prevail. Many applications were not supported by the NSCADC on the basis of the ongoing criminal proceedings and the above ruling by Judge MacMenamin should help to clarify matters in the future.

RECOMMENDATION 8: Guidance on applications for special care should be amended to take into account what *Health Service Executive v. S (S) (A Minor) 2007* says in relation to cases being before courts with both civil and criminal jurisdictions simultaneously.

246. External influence on the Social Work Department, pressing for an application for special care, was present for 10 of the applications: this might come from District Courts, parents, An Garda Síochána or Guardians *ad Litem.* For six of these, the Social Work Department was in full agreement with the need for special care; in four applications, the Social Work Department initially felt that other options could still be tried but came to believe that special care was appropriate. Seven of these applications resulted in an admission to special care: the CAAB supported all the applications where the Social Work Department was in full agreement, and none of the applications where the Social Work Department was initially unconvinced.

247. Most applications were submitted with social histories and care plans that were less than a month old. Educational and psychological reports were more likely to be more than three months old.

RECOMMENDATION 9: The HSE and the CAAB need to agree what defines an "up-to-date" report for each of the report types required, and to provide guidance on what actions should be taken where an "up-to-date" report is unavailable or cannot be obtained. The Application Form should be amended to ask for explanations where attached reports do not meet this requirement.

248. The likelihood of an application to special care being successful appears to be increased if Alternative Care Managers, Residential Managers and the General

[26] *Health Service Executive (Southern Area) v. S (S) (A Minor)* represented by his Guardian Ad Litem and Next Friend ML, and MS, SC and The Special Residential Services Board (Notice Parties) (2007) IEHC 189, unreported MacMenamin J.

Manager have been involved in the process. The former two groups were more likely to have been directly involved in the process whereas the latter were more likely to have provided 'informed approval' of the application. It is important to involve more directly local budget holders in decisions about special care in order to optimise the chances of finding alternative solutions.

249. Additionally, almost half of the applications from the HSE South seemed to have involved some confusion about roles and responsibilities locally. However, only applications from the South and the West appear to have actively sought and obtained signatures from senior management in support of the application. It is important that, where a child is potentially to be deprived of their liberty, there is a clear and defensible audit trail of decision-making within the LHO.

RECOMMENDATION 10: The HSE should refresh the understanding of internal staff as to their relative roles and responsibilities in progressing a special care application.

RECOMMENDATION 11: The HSE and the CAAB should make clear their expectations of evidence from the applying Local Health Office that key senior personnel were aware of, and supportive of, the decision to apply for special care.

250. The application form requires the applying LHO to state what the views of parents/carers and the child were on the application for special care. Parents/carers were reported by Social Workers to be generally supportive of the application for special care, although only 10 of the applications were signed by the parents/carers. However, applicants said that only 12 (35%) of the children expressed any support for the application, albeit reluctantly. Five children were unaware of the referral through fears on the part of the Social Work Department that the child's behaviour would deteriorate if they knew about the application (in particular, the risk of increased absconding or increased self-harm); 13 children knew that the application was happening but were not informed of its progress, for similar reasons. There may be children's rights issues in progressing an application that aims to deprive a child of their liberty without their knowledge. Concerns about the child's safety are understandable but this may be dubious ground.

RECOMMENDATION 12: The HSE should consider the children's rights implications of progressing an application for special care without the knowledge of the child.

251. It is a requirement of the revised procedure for either a family welfare conference to be held, or, if it cannot be held, a letter provided by the local Family Welfare Conference Service confirming this, prior to an application for special care being made. Six applications failed to comply with this requirement at all, while 11 applications made a parallel application to the Family Welfare Conference Service at the same time as their application for special care.

RECOMMENDATION 13: The HSE needs to further emphasise the requirement for compliance with the family welfare conference process in future training and briefing sessions.

252. The views of both the NSCADC and the CAAB have an important role in the revised application process. The report considers the views expressed by both bodies on the applications to special care.

253. For 21 (62%) of the applications, the CAAB and the NSCADC came to the same conclusion about the application, supporting 17 of these and not supporting four.

254. Three applications were supported by the NSCADC but not by the CAAB. In all of these, the CAAB did not feel that all placement options had been explored nor that a case had been made that a less secure environment would not work.

255. Ten applications were supported by the CAAB but not by the NSCADC:

- In four applications, there had been two previous placements in special care. This is not currently part of the criteria for special care (hence would not be considered by the CAAB) but is a valid issue for consideration by the NSCADC (see Recommendations 16 and 17).
- In five applications, there were ongoing criminal proceedings. Judge MacMenamin's summer 2007 rulings should clarify this situation: again, amendments to the criteria for special care might be made (see Recommendation 8).
- In four applications, the length of time that the child had been detained in a Children Detention School was taken into account by the NSCADC but was not part of the criteria being considered by the CAAB. Again, it seems a valid reason for divergence in opinion (see Recommendation 21).

256. For most of the applications, therefore, there were generally logical explanations for the divergence of opinion and we have made recommendations relating to these circumstances that might promote convergence in the future. Nevertheless, where the views of the NSCADC and the CAAB were divergent, the applicants were often confused about the role of the two bodies within the process. In Recommendation 30, we recommend that the HSE and the CAAB should meet on an ongoing basis to discuss issues arising from the application process: this should include a discussion of those cases where there was a divergence of opinion.

RECOMMENDATION 14: Revised guidance should more clearly state the relative roles and powers of the HSE and the CAAB in the application process for special care.

257. Despite the child being 'in crisis', most admissions to special care take place in a planned manner. Where an application progresses relatively smoothly, the average length of time between date of application and date of admission was 31 days. This was the situation for 13 of the 19 successful applications. The HSE and the CAAB need to consider whether this is an acceptable average time. The CAAB generally achieved its target turnaround time of five working days for responding to an application. The NSCADC generally (excluding exceptional applications) average 21 calendar days for their first decision from date of application. In Recommendation 30, we recommend that the HSE and the CAAB should meet together on an ongoing basis to discuss issues arising from the application process. This should include monitoring of the time taken between date of application and date of admission to special care.

258. In addition, there appears to be an unwritten procedure for 'emergency' applications, while those applications defined as an emergency by Social Workers are not necessarily seen the same way by the NSCADC and the CAAB. In order to provide an effective and timely response to emergencies, with robust gatekeeping at local and national level, guidance should be provided on what should happen in an emergency situation.

RECOMMENDATION 15: Guidance should be drawn up for applications that are an 'emergency', including local and national management and gatekeeping arrangements.

Processes

259. Nine of the applications were for children who had been admitted to a Special Care Unit on a previous occasion. All but one of these applications was supported by the CAAB on the basis of the criteria as they are currently written, but none of those with two previous placements in an SCU were supported by the NSCADC. It is appropriate that the purpose of a further admission to special care should be documented and scrutinised as part of the decision making process.

RECOMMENDATION 16: The Application Form should be amended so that, where there have been previous admissions to special care, a case has to be made by the applicant with regards to the additional benefits of a further admission.

RECOMMENDATION 17: Consideration should be given as to whether the criteria for special care and/or supporting guidance should be amended to reflect a higher threshold for applications to special care where there have been two or more previous admissions to special care.

260. Applications that were not supported were most likely to fail because the application had not convincingly proven that all other placement options had been tried or considered.

RECOMMENDATION 18: The Application Form should be amended to more explicitly guide applicants in stating what placement options have been tried, what have been considered, and reasons for such options to not be appropriate. Social work practitioners should pay particular attention to the criterion relating to other placement options in constructing evidence in support of their application.

261. Only 19 of the applications had an agreed, secured onward placement. Where an onward placement to high support or mainstream residential care had been secured, 73% of applications were successful. Where high support or mainstream residential care was identified as a placement option but *not* secured, only 38% of applications were successful. In addition, research has shown that it is better for the child to have a clear idea of where they will be after a placement such as special care has ended.

RECOMMENDATION 19: The Application Form should be amended to more explicitly capture information on whether the planned onward placement has been secured or not. Social Workers should pay particular attention to securing an onward placement, even though that placement may change in the light of the child's response to special care.

262. Although the Application Form asks for details of the child's Social Worker and the Social Work Team Leader, it does not ask how long the Social Worker has been the child's Social Worker. This is important in order to prevent drift in the case, particularly with regards to implementing an effective discharge plan.

RECOMMENDATION 20: The Application Form should be amended to ask how long the Social Worker has been the child's allocated Social Worker.

263. Recommendation 21 addresses changes to the Application Form that would be complementary to Recommendation 8.

RECOMMENDATION 21: The Application Form should be amended so that, where a child is remanded to a Children Detention School, details are recorded on the date of detention, the charges, and details of the Court.

264. Currently in the *Hospital Admissions* section of the Application Form, Social Workers complete information on all such hospital admissions rather than limiting this to those admissions that have some relationship to the reasons being given to support the application for a special care placement.

RECOMMENDATION 22: The *Hospital Admissions* section of the Application Form should be amended so that it guides applicants to only provide that information which is relevant to the reasons being given to support a placement in special care.

265. Recommendation 23 addresses changes to the Application Form that would be complementary to Recommendation 13.

RECOMMENDATION 23: The Application Form should be amended to include, where a family welfare conference has not happened, both the date of the referral to the FWC Service, and a prompt to attach a letter from the FWC Service stating the reasons if a family welfare conference was not convened.

266. The family welfare conference paperwork does not currently record specifically whether the child was in attendance.

RECOMMENDATION 24: Paperwork for the family welfare conference should be amended to record specifically whether the child was in attendance.

267. 13 applications were subject to an 'appeal': 10 appeals were made to the NSCADC, and five to the CAAB. The NSCADC changed its view on two applications, and the CAAB changed its view on two applications (these were four different applications), leading to a convergence of views on three of these applications. Applicants whose application was not supported also often wished

for more detail on the reasons than they are currently receiving. There is a need for a more robustly defined appeals process, addressing:

- Grounds for an 'appeal'.
- How to appeal.
- To whom to appeal (should it be the same body or a different body?).
- How often the Social Work Department can appeal.
- Opportunities to consult prior to the appeal.
- Opportunity to present an appeal in person, if felt desirable.
- When to re-apply rather than appeal.
- The role of updates/additional information where a case deteriorates significantly.

RECOMMENDATION 25: The HSE and the CAAB should respectively define and publish "appeals procedures" for applications for special care.

268. Although the majority view from interviewees was that the Application Form and the revised process were acceptable, there were concerns about the length of the Application Form. Even if the interviewee regarded it as "long but all needed", any streamlining of the information being asked for would help. The inclusion of the criteria on the form was generally seen as positive. SIS will separately make recommendations with regards to the form.

269. With regards to the overall process, many interviewees found the unified national process an improvement on previous processes. However, there was a distinct regional pattern to these views. No applicant from the HSE South felt that the revised processes were an improvement, and six of the seven applicants who felt that the revised processes were worse were from the South.

Monitoring

270. Within the research period, 15 Local Health Offices made an application for special care and 17 did not. There were no applications from the areas of either the former Mid-Western Health Board or the former South Eastern Health Board, both of which are relatively well provided for in terms of local High Support Units.

RECOMMENDATION 26: The pattern of applications for special care by Local Health Offices should be monitored on an ongoing basis.

271. 71% of applications were for children whose nationality and ethnicity was *White Irish*, and 75% of these applications were successful in gaining admission to special care. This compares to a 22% success rate for other nationalities/ethnicities (*Irish Travellers*, *Mixed Irish/English*, and *English*). No procedural bias for or against any nationality/ethnicity was detected, however. In addition, there were no applications for children from any new immigrant communities. However, applications should be monitored according to nationality and ethnicity on an ongoing basis.

RECOMMENDATION 27: The profile of applications and the success rates of those applications should be monitored against nationality/ethnicity on an ongoing basis.

272. There is a substantial body of research that suggests that the actual experience of children on discharge differs from the discharge plan, with variability in the effectiveness of both the onward placement itself and in post-placement experiences.

RECOMMENDATION 28: Further research should be conducted, using a cohort of cases, on the medium-term outcomes for children who have experienced a special care placement.

273. SIS outline a 'model' application process within the report. The premise is, that if a case follows all the correct procedures and meets all the requirements, it would follow this 'model'. However, only three applications actually went through the process in such a model manner. Learning points and practice issues derive from those applications where this model process does not occur and many of the recommendations made within this report aim to address these issues. This suggests a need to repeat the review process again in the future, in order to determine whether there is increased conformity to a 'model' process as a result of any changes made in response to this report.

274. In addition, the environment for this research itself changed during the research period (e.g. the High Court judgements made in the summer of 2007) and will continue to evolve in the future in the light of changes to services and legislation. This suggests a need for the HSE and the CAAB to meet on an ongoing basis (with a frequency to be determined by both parties) in order to make adjustments to the application process in the light of both changes to the operating environment and lessons that might arise from the applications themselves.

RECOMMENDATION 29: The HSE and CAAB should periodically repeat the exercise to review special care applications, as per this current research.

RECOMMENDATION 30: The HSE and CAAB should meet on an ongoing basis to discuss issues arising from the application process.

275. The speed of convening family welfare conferences was generally within documented standards for Family Welfare Conference Services. However, Social Workers often had a negative view of the role of family welfare conferences in the special care application process, believing that usually by this stage all options within the extended family would have been exhausted and that the requirement for a family welfare conference slowed the process down. Many Social Workers who were not convinced of the value of a family welfare conference within the special care process found value in family welfare conferences in other contexts. The Family Welfare Conference Co-ordinators shared some of the views of the Social Workers. There is clearly a continued exercise required to emphasise the role of family welfare conferences as a means of taking one last attempt to prevent an admission to special care. There should also be an ongoing review of whether family welfare conferences are achieving their intended preventive aim within the process.

RECOMMENDATION 31: The HSE should monitor on an ongoing basis the outcomes of applications for which a family welfare conference was held as part of the decision making process for special care, with particular emphasis on identifying the number of cases where an application for special care did not follow (within 3 months) and the outcome of applications where a family welfare conference was held in terms of numbers of applications admitted.

276. During the research, a question was asked by Social Workers about what should happen where their Local Health Office wishes to place a child, who might require special care, in a placement outside Ireland. This raises two issues:

- A HSE national policy on placement of children abroad, who might require special care, is needed. In these circumstances should the criteria for special care be applied?
- The HSE needs to monitor the number of children who *might* fit the Criteria for special care and who are placed abroad.

RECOMMENDATION 32: The HSE should monitor the numbers of children placed abroad who *might* fit the Criteria for special care and develop a national policy regarding such placements. This should incorporate the function of the CAAB in giving its view.

GLOSSARY

Absconding or being absent from a placement has been defined by the Irish Social Services Inspectorate into two categories. The type of absconding relevant to special care applications would come under the category of *absent at risk***.** This is where a child is absent in circumstances that cause concern to their safety based on their vulnerability, previous patterns of behaviour, and other levels of risk.

The **CAAB** see Children Acts Advisory Board.

Care Order is granted by the District Court on application by the HSE with respect to a child, where the court is satisfied that: the child has been or is being assaulted, ill-treated, neglected or sexually abused, or the child's health, development or welfare has been or is being avoidably impaired or neglected or the child's health, development or welfare is likely to be avoidably impaired or neglected. See Child Care Act, 1991.

Care Plan is a statutory requirement stipulated by the Child Care Regulations (Placement of Children in Residential Care) 1995, Section 23 (1). It is an agreed written plan, drawn up in consultation with the child, his or her family and all those involved with his or her care, for the current and future care of the child that is designed to meet his or her needs. It establishes short, medium and long-term goals for the child and identifies the services required to attain these.

Care Staff refer to staff caring for children and young people in residential units, and includes those involved in the care of children in residential units, e.g. teachers.

Case Management Team: In a Special Care Unit the case management team usually includes: Social Worker; social work manager; centre manager; keyworker; teacher; parent; other professionals directly involved with the child (e.g. youth worker, psychologist etc.)

Child/Children in legal terms a child is someone under the age of eighteen. Many older children prefer the term 'young person': however, in accordance with Irish legislation the term "child" or "children" is used throughout this report.

Children Act, 2001 sets out responsibilities for the care, support, protection and control of juvenile offenders and further amends and extends the Child Care Act, 1991 and specifies the provision for the detention of offending and non-offending children.

The **Children Acts Advisory Board (CAAB)** was established in July 2007 under s.227 (1) of the Children Act, 2001 (as inserted by s.20 of the Child Care (Amendment) Act, 2007). For details of the main functions and responsibilities of the Board, please go to www.caab.ie

Child and Adolescent Mental Health Services (CAMHS) offer a range of therapeutic approaches to children, such as family therapy, play therapy, cognitive behaviour therapy and psychopharmacology.

Child Care Act, 1991 is the legislation that sets out the responsibilities of the Health Service Executive for the care, safety, welfare and protection of children.

Children Detention School is a secure residential unit set up to care for juvenile offenders. Children are referred to the schools on the order of the courts.

Committal is where a child or young person can be committed to a children detention school for a defined period under the Children Act, 2001 (as amended by Criminal Justice Act, 2006), following a conviction in a Children Court or higher court.

Criteria for the Appropriate Use of Special Care Units was reviewed and agreed by the Special Residential Services Boards (now the Children Acts Advisory Board since 23.07.07) and the Health Services Executive in November 2006. The Criteria sought to protect at risk children and young people, while ensuring that their liberty was restricted only as a measure of last resort, for the shortest possible time**.** The Criteria is available to download at www.caab.ie

Extern is a not for profit organisation which works directly with children, adults and communities affected by social exclusion throughout Ireland. www.extern.org

Family Welfare Conference (FWC) was introduced by the Children Act, 2001 and made it a requirement to convene an FWC prior to an application being made for special care. The purpose of the FWC is to bring together the child, parents, relatives and professionals in an attempt to come up with a family plan to prevent the seeking of a Special Care Order.

Foster Care means children in care of the HSE who are placed with approved foster carers in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995,* and the *Child Care (Placement of Children with Relatives) Regulations, 1995.*

Guardian *ad Litem* is a person appointed by a court in accordance with s.26 of the Child Care Act, 1991. The main function of a Guardian *Ad Litem* is to:

a) Promote the child's rights and needs in relevant proceedings within the court system
b) Ensure the child has a voice in matters that affect them in accordance with their rights under Article 12 of the United Nations Convention of the Rights of a Child
c) Ensure the child's interests are the primary consideration when decisions are being made about them.

Health Services Executive (HSE) is responsible for providing health and personal social services for everyone living in the Republic of Ireland. As outlined in the Health Act, 2004, the objective of the HSE is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

High Support in the Community refers to high support as a methodology and provided in the community by, for example, Extern or a Youth Advocate Programme (YAP).

High Support Units are residential units set up as a response to the needs of a minority of highly troubled children and managed by the HSE. Children placed in high

support need intensive support away from home and cannot be supported in mainstream residential care settings. High support units are part of the welfare system.

HSU see High Support Units.

'In Care' means children who have been received into the care of the HSE, either by agreement with the parent(s) or guardian(s) or by court order.

Interim Special Care Order means an order made by a court in respect of a child in accordance with s.23C of the Child Care Act, 1991, as inserted by s.16 of the Children Act, 2001. A court will grant this order when there is reasonable cause to believe that there is a real and substantial risk to the health, safety and development or welfare of a child and that it is in the best interests of that child to place and detain a child in a special care unit. An Interim Special Care Order differs from a Special Care Order in that it can only be for a maximum period of 28 days as it is used for cases where there is an immediate threat to a child's health, safety and welfare. See Special Care Order.

Legal representative is a solicitor appointed by a court to represent a child in accordance with s.25 of the Child Care Act, 1991.

Local Health Office (LHO) is the administrative unit of management for the provision of primary, community and continuing care services to a designated area. There are 32 LHOs.

Managers refer to members of staff with line management and/or policy and practice supervisory responsibilities.

The **National Special Care Admission and Discharge Committee (NSCADC)** is comprised of an independent Chair person, the centre manager of each Special Care Unit, and the Chairperson of the previous admissions committee of each SCU.

NSCADC see National Special Care Admission and Discharge Committee.

Parents/Carers includes a surviving parent and, in case the child who has been adopted under the Adoption Acts 1952 to 1998, or, where the child has been adopted outside the State, whose adoption is recognized by virtue of the law for the time being in force in the State, means the adopter or adopters or the surviving adopter. This also includes extended family such as a brother, sister, uncle or aunt or a spouse of the brother, sister, uncle or aunt or a grandparent or step-parent, and foster carer.

Principal Social Worker is a senior manager in the social work structure, responsible for the overall operational and strategic management of a Social Work Department.

Remand Placement is the remand of a child or young person to one of the children detention schools under the Children Act, 1908, pending finalisation of a criminal charge.

Residential Placement refers to mainstream open children residential centres. These can be run by the HSE, voluntary or private sectors.

Respite Care is short-term care, provided to a child in order to support the child, his or her parent(s) or foster carers, by providing a break for the child and his or her primary caregivers.

Review of Admission Criteria and Processes for Special Care (2005) is available to download at www.caab.ie

Review Panels are convened by the CAAB and comprise of a number of professionals from the child care sector and related disciplines. The Review Panels seek to ensure that the criteria procedures have been followed correctly for the application. They base their advice on the appropriateness of an application by applying the *Criteria for the Appropriate Use of Special Care Units.* The sole purpose of the Review Panel is to advise/assist the CAAB. The Chief Executive or his/her nominees will base the 'view' of the CAAB on the feedback provided by (i) the Review Panel and (ii) the case application.

Risk Assessment is a process of assessing risk. The factors typically considered are: Nature of Risk, Likelihood of Risk Occurring, Likely Impact and Protective factors. A Risk Assessment can be a written document, detailing the assessment and supporting evidence. It can also be a process, where risk is assessed in a situation with the information available at the time.

Risk Taking Behaviour means in this report, within the context of the Criterion on *Impaired socialisation/impulse control*, risks associated with:

- Children who cannot judge, are impressionable, or seek out unsafe/risky situations.
- Children who have poor insights into the risks of their current behaviour.
- Children who are vulnerable to predatory individuals.

SCUs see Special Care Units.

SIS is Social Information Systems Ltd, authors of this report.

Social Worker is a front line worker who works with individuals, families, groups, organisations and communities. Social Work is the profession committed to the enhancement of the quality of life, to the pursuit of social justice and to the development of the full potential of each individual, group and community in society.

Social Work Team Leader is a line manager position with responsibility for a team and/or a specific project within the Social Work Department.

Shared Care is where a child transitions between two placements e.g. residential care and home, HSU and home.

Special Care Information and Application Pack was developed and produced by the HSE in collaboration with CAAB (then the Special Residential Services Board) outlining the policy, procedures and revised application forms. This was sent to all Local Health Offices.

Special Care Order refers to an order detaining a child in a special care unit. The court may make such an order where the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development and welfare and

the child requires special care or protection. This order is for a minimum period of 3 months, less than 6 months. See Part IVA Child Care Act, 1991 as inserted by S16 of Children Act, 2001.

Special Care Units are facilities where children who are in need of special care or protection because of a real and substantial risk to their health, safety, development and welfare are detained. They are placed with the explicit objective of providing a stabilising period of short-term care which will enable a child to return to less secure care as soon as possible.

The **Special Residential Services Board (SRSB)** was established in November 2003 on a statutory basis. The functions were set out in s.227 (1) of the Children Act, 2001, as amended by the Criminal Justice Act, 2006. The SRSB was replaced by the Children Acts Advisory Board in July 2007.

SRSB. See Special Residential Services Board.

Young Person – see child

Youth Advocate Programme (YAP) is a not for profit organisation which focuses its efforts exclusively on community-based services provided in family homes and neighbourhood settings in America and has supported international developments including five programmes in Ireland. www.yapinc.org

Youth Homeless are children who are sleeping on the streets or in other places not intended for night-time accommodation or not providing safe protection from the elements or those whose usual night-time residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking other characteristics of a home and/or intended only for a short stay. This includes children who look for accommodation from out of hours services and those in insecure accommodation with relatives or friends regarded as inappropriate, that is to say where the child is placed at risk or where he or she is not in a position to remain.

References

Children Act, 2001.
Child Care Act, 1991.
Child Care (Placement of Children in Foster Care) Regulations, 1995.
Child Care (Placement of Children in Residential Care) Regulations, 1995.
Child Care (Placement of Children with Relatives) Regulations, 1995.
Child Care (Special Care) Regulations 2004.
HSE/SRSB (2006) Criteria for Appropriate Use of Special Care Units.
Department of Health and Children (2016), National Standards for Foster Care, Dublin: DoH&C.
Department of Health and Children (2001), Youth Homelessness Strategy, Dublin: DoH&C.
Social Services Inspectorate (2005), Irish Social Services Inspectorate Practice Guidelines on: Responding to Unauthorised Absences, Dublin: SSI.
Social Information Systems (2003), Definition and Usage of High Support, Dublin: SRSB.
Special Residential Services Board Annual Report 2006

APPENDICES

Appendix 1: Criteria for Admission to Special Care

1. The young person is 11 – 17 at admission[27].
2. The behaviour of the young person is such that it poses a real and substantial risk to his/her health, safety, development or welfare unless placed in a Special Care Unit, and/or on "an objective basis" is likely to endanger the safety of others.
3. The young person will present with a history of impaired socialisation and impaired impulse control, and may also have an established history of absconding which places them at serious risk.
4. If placed in any other form of care, the young person is likely to cause self injury or injury to other persons.
5. Consideration has been given to placement history and the elimination of ***all other*** non-special care options, ***based on the child's needs***.
6. It is clear that a less secure structured environment would not meet the young person's needs at this particular time.
   a) As a general rule, the criteria must be met in determining the appropriateness of placement in a Special Care Unit.
   b) Any exceptions must meet the overriding majority of criteria.
   c) All applications will be reviewed by an Admissions and Discharge Committee of the Health Service Executive.
7. Applications for placement in Special Care Units should be based on a comprehensive needs assessment including the following:

   a) A comprehensive and up to date social history.

   b) A detailed care placement history outlining all social services and other interventions.

   c) A Care Plan that supports the aims and objectives of this placement based on the identified ongoing needs of the young person.

   d) A discharge plan, identifying the subsequent less secure placement or alternative, and identifying agency personnel with responsibility for actioning the plan.

   e) Up-to-date psychological and educational reports which comment upon the grounds for seeking admission to a Special Care Unit.

[27] *It is the view of the Health Service Executive and the Special Residential Services Board that given the intense nature of special care placement, it is generally preferred that the lower age limit be 12 years of age, but there may be exceptional circumstances where a younger child might be considered for a Special Care intervention.*

f) Where there are concerns regarding a young person's mental health, a psychiatric report may be appropriate. Should a young person decline to participate in such a referral, the psychiatrist may report, having reviewed the young person's file.

8. The Health Service Executive should coordinate the sharing of these intensive facilities within and across regional areas. While it is preferable that the young person resides in a specific regional area to facilitate family and community contact and reintegration, given the secure nature of these units and the care obligation, the number of units should be strictly limited.

Where it is not possible to place a young person in a regional area more local to the family, the Care Plan must specify arrangements for family and community contact and integration.

Appendix 2: Special Care – Relevant Sections of the Children Act, 2001 (as amended)

Special care order.	**23B.—**(1) A court may, on the application of the Health Service Executive with respect to a child and having taken into account the views of the Children Acts Advisory Board referred to in section 23A(2)(*b*), make a special care order in respect of the child if it is satisfied that— (*a*) the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare, and (*b*) the child requires special care or protection which he or she is unlikely to receive unless the court makes such an order. (2) A special care order shall commit the child to the care of the Health Service Executive for so long as the order remains in force and shall authorise it to provide appropriate care, education and treatment for the child and, for that purpose, to place and detain the child in a special care unit provided by or on behalf of the Health Service Executive pursuant to section 23K. (3) Where a child is detained in a special care unit pursuant to a special care order, the Health Service Executive may take such steps as are reasonably necessary to prevent the child from— (*a*) causing injury to himself or herself or to other persons in the unit, or (*b*) absconding from the unit. (4) (*a*) Subject to subsections (5) and (6), a special care order shall remain in force for a period to be specified in the order, being a period which is not less than 3 months or more than 6 months. (*b*) The court may, on the application of the Health Service Executive, extend the period of validity of a special care order if and so often as the court is satisfied that the grounds for making the order continue to exist with respect to the child concerned. (5) If, while a special care order is in force in respect of a child, it appears to the Health Service Executive that the circumstances which led to the making of the order no longer exist with respect to the child, it shall, as soon as practicable, apply to the court which made the order to have the order discharged. (6) A special care order shall cease to have effect when the person in respect of whom it was made ceases to be a child. (7) Where a special care order is in force, the Health Service Executive may— (*a*) as part of its programme for the care, education and treatment of the child, place the child on a temporary basis in such other accommodation as it is empowered to provide for children in its care under section 36, or (*b*) arrange for the temporary release of the child from the unit on health,

	education or compassionate grounds, and any such placement or arrangement shall be subject to its control and supervision. (8) Subject to this section, subsections (3), (4), (6), (7) and (8) of section 18 shall apply in relation to a special care order as they apply in relation to a care order, with any necessary modifications.
Interim special care order.	**23C.—**(1) Where a judge of the Children Court is satisfied on the application of the Health Service Executive — (*a*) that the Executive is complying with the requirements of section 23A(2) in relation to the making of an application for a special care order in respect of a child or is deemed under section 23A(4) and (5) to have complied with those requirements. (*b*) that there is reasonable cause to believe that— (i) the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare, and (ii) it is necessary in the interests of the child, pending determination of the application for a special care order, that he or she be placed and detained in a special care unit provided under section 23K, the judge may make an interim special care order in respect of the child. (2) An interim special care order shall require that the child named in the order be placed and detained in a special care unit— *(a)* for a period not exceeding twenty-eight days, or (*b*) where the Health Service Executive and the parent having custody of the child or a person acting *in loco parentis* consent, for a period exceeding twenty-eight days, and the judge concerned may by order extend any such period, on the application of any of the persons specified in paragraph (*b*) and, where the period of the extension exceeds twenty-eight days, with the consent of those persons, if he or she is satisfied that the grounds for making the interim special care order continue to exist with respect to the child. (3) An application for an interim special care order or for an extension of a period mentioned in subsection (2) shall be made on notice to a parent having custody of the child or a person acting *in loco parentis* or, where appropriate, to the Health Service Executive, except where, having regard to the welfare of the child, the judge otherwise directs. (4) Subsections (3) to (7) of section 13 shall apply in relation to an interim special care order as they apply in relation to an emergency care order, with any necessary modifications.
Notification by Health Service	**23E.—**(1) Where a child is placed in a special care unit pursuant to an interim special care order, the Health Service Executive shall as soon as possible inform or cause to be informed a parent having custody of the child or a

Executive.	person acting *in loco parentis* of the placement unless the parent or person is missing and cannot be found. (2) For the purposes of this section, a person shall be deemed to have been informed of the placing of a child in a special care unit if the person is given or shown a copy of the interim special care order or if the person was present at the sitting of the court at which the order was made.
Variation or discharge of special care orders.	**23F.—**(1) Without prejudice to section 23B (5), the court may, of its own motion or on the application of any person, vary or discharge a special care order. (2) In discharging a special care order, the court may, of its own motion or on the application of the Health Service Executive either— (*a*) make a supervision order in respect of the child, or (*b*) if the court is of opinion that— (i) the child requires care and protection which he or she is unlikely to receive unless he or she remains in the care of the Health Service Executive, or (ii) the delivery or return of the child to a parent or any other person would not be in the best interests of the child, make a care order in respect of the child.
Appeals.	**23G.—**Section 21 shall apply to an appeal from an interim special care order or a special care order as it applies to an appeal from an order under Part IV.
Powers of court in case of invalidity of order.	**23H.—**Section 23 shall apply to a special care order as it applies to a care order, with the modification that the court may, as an alternative to making a special care order, make a care order in respect of the child.
Application of Part V.	**23I.—**Part V shall apply to proceedings relating to an application for an interim special care order or a special care order, with any necessary modifications.
Application of Part VI.	**23J.—**Section 37, 42, 45 and 47 shall apply to a child who is committed to the care of the Health Service Executive pursuant to an interim special care order or a special care order.
Provision of special care units by the Health Service Executive.	**23K** (1) For the purposes of sections 23B and 23C, the Health Service Executive may, with the Minister's approval, provide special care units and maintain special care units whether provided by the Executive or provided by a health board before the establishment day of the Executive. (1A) The Health Service Executive may, subject to its available resources and any general directions issued by the Minister, make arrangements with a voluntary body or other person for the provision and operation of a special care unit by that body or person on behalf of the Executive. (1B) Section 38(2) to (9) of the Health Act 2004 shall apply with the necessary modifications in respect of an arrangement under this section with a voluntary body or other person for the provision and operation of a special care unit and the body or person making such arrangement with the Health Service Executive is for the purpose of Part 9 of that Act a service provider as defined in section 2 of that Act.

(2) The Minister shall not approve of the provision of a special care unit unless—

(*a*) having caused the unit to be inspected by a person authorised in that behalf by the Minister, and

(*b*) having considered a report in writing of the inspection,

he or she is satisfied that the requirements of regulations under this section will be complied with by the Health Service Executive, voluntary body or other person, as the case may be, in relation to the unit.

(3) The duration of an approval of a special care unit by the Minister shall be 3 years from the date of approval, and thereafter the Minister may renew the approval for a further period, or further periods, of the like duration.

(4) The Minister, on approving of a special care unit, shall cause a certificate to that effect to be issued to the Health Service Executive and the certificate shall without further proof, unless the contrary is shown, be admissible in any proceedings as evidence that the unit has been approved of by the Minister for the purposes of sections 23B and 23C.

(4A) A certificate issued by the Minister to a health board before the amendment of this section by the Health Act 2004 shall be deemed to have been issued to the Health Service Executive.

(5) The Minister may cancel such a certificate if he or she is of opinion that the special care unit concerned is no longer suitable for use as such a unit or is no longer required for that purpose.

(6) The Minister shall make regulations with respect to the operation of special care units provided by or on behalf of the Health Service Executive under this section and for securing the welfare of children detained therein.

(7) Without prejudice to the generality of subsection (6), regulations under this section may prescribe requirements as to—

(*a*) the maintenance, care and welfare of children while being detained in special care units,

(*b*) the staffing of those units,

(*c*) the physical standards in those units, including the provision of adequate and suitable accommodation and facilities,

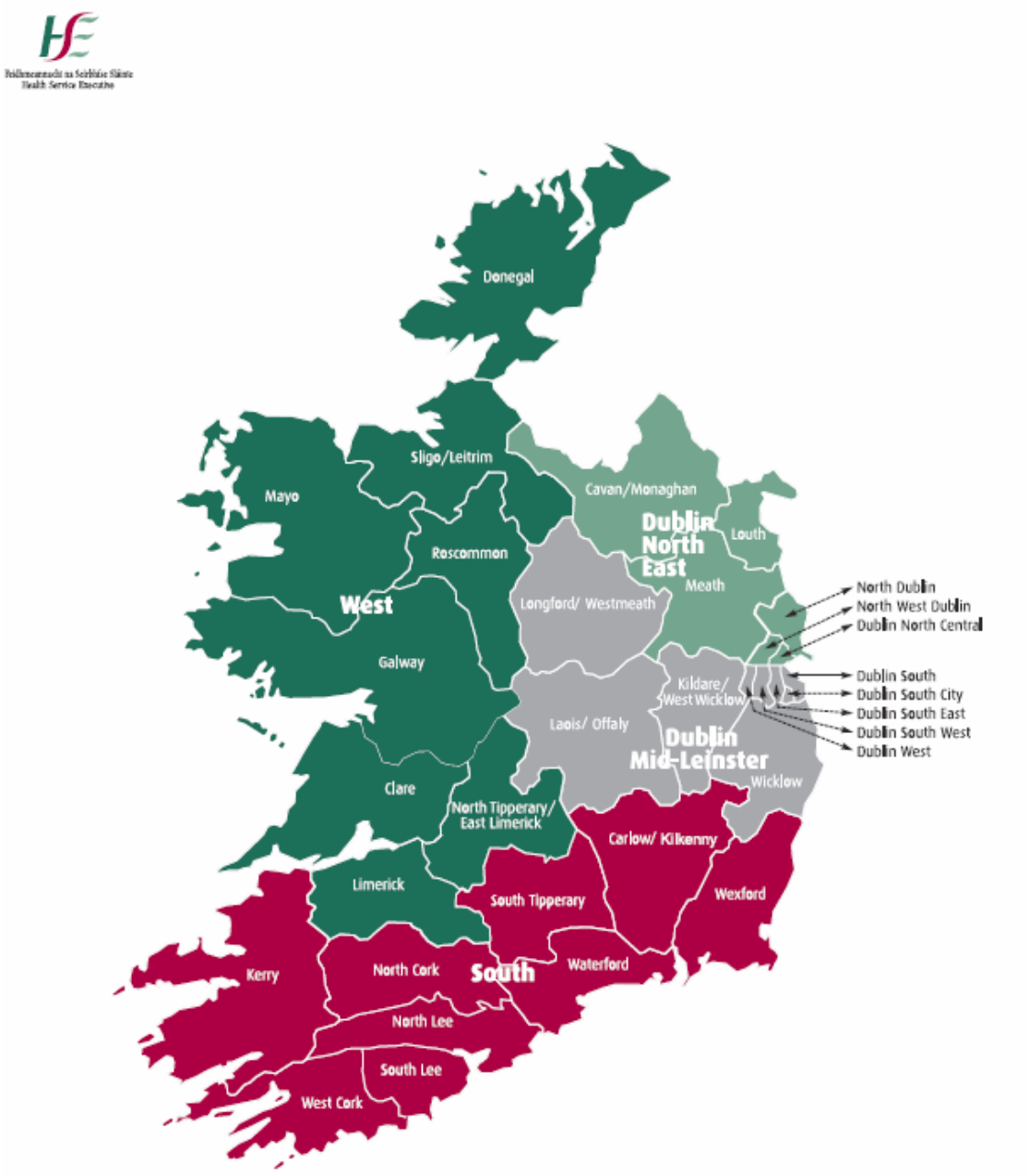
(*d*) the periodical review of the cases of children in those units and the matters to be considered in such reviews,

(*e*) the records to be kept in those units and the examination and copying of any such records or of extracts there from by persons authorised in that behalf by the Minister, and

(*f*) the periodical inspection of those units by persons authorised in that

	behalf by— (i) in case the units were provided in accordance with an arrangement referred to in subsection (1A), the Health Service Executive, and"**.** (ii) in any other case, the Minister n accordance with section 69. (8) Section 10(1) and (2) shall apply with any necessary modifications in relation to a voluntary body or other person with whom the Health Service Executive enters into an arrangement referred to in subsection (1A). (9) Nothing in this section shall empower the Health Service Executive to delegate to a voluntary body or any other person the power to apply for an order under section 23B or 23C. (10) Where a child is detained in a special care unit provided under subsection (1A), the provisions of section 23B(3) shall apply in relation to the voluntary body or other person providing or operating the unit. (11) Nothing in this section shall authorise the placing of a child in a special care unit otherwise than in accordance with an interim special care order or a special care order.
Recovery of absconding child.	**23L.—**Section 46 shall apply to the recovery of a child who absconds from a special care unit.
Amendment of section 4.	**23M.—**References in section 4 to Parts III, IV and VI shall be construed as including references to this Part.
Restriction.	**23N.—**A child on being found guilty of an offence may not be ordered to be placed or detained in a special care unit.

Appendix 3: Map of Health Service Executive Areas and Local Health Offices



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