SOMEONE TO CARE

THE MENTAL HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE WITH EXPERIENCE OF THE CARE AND YOUTH JUSTICE SYSTEMS

CHILDREN'S
MENTAL
HEALTH
COALITION

Children's
FOR IRELAND AND
Research
NORTHERN IRELAND
Network

SOMEONE TO CARE
THE MENTAL HEALTH NEEDS OF
CHILDREN AND YOUNG PEOPLE WITH
EXPERIENCE OF THE CARE AND YOUTH
JUSTICE SYSTEMS

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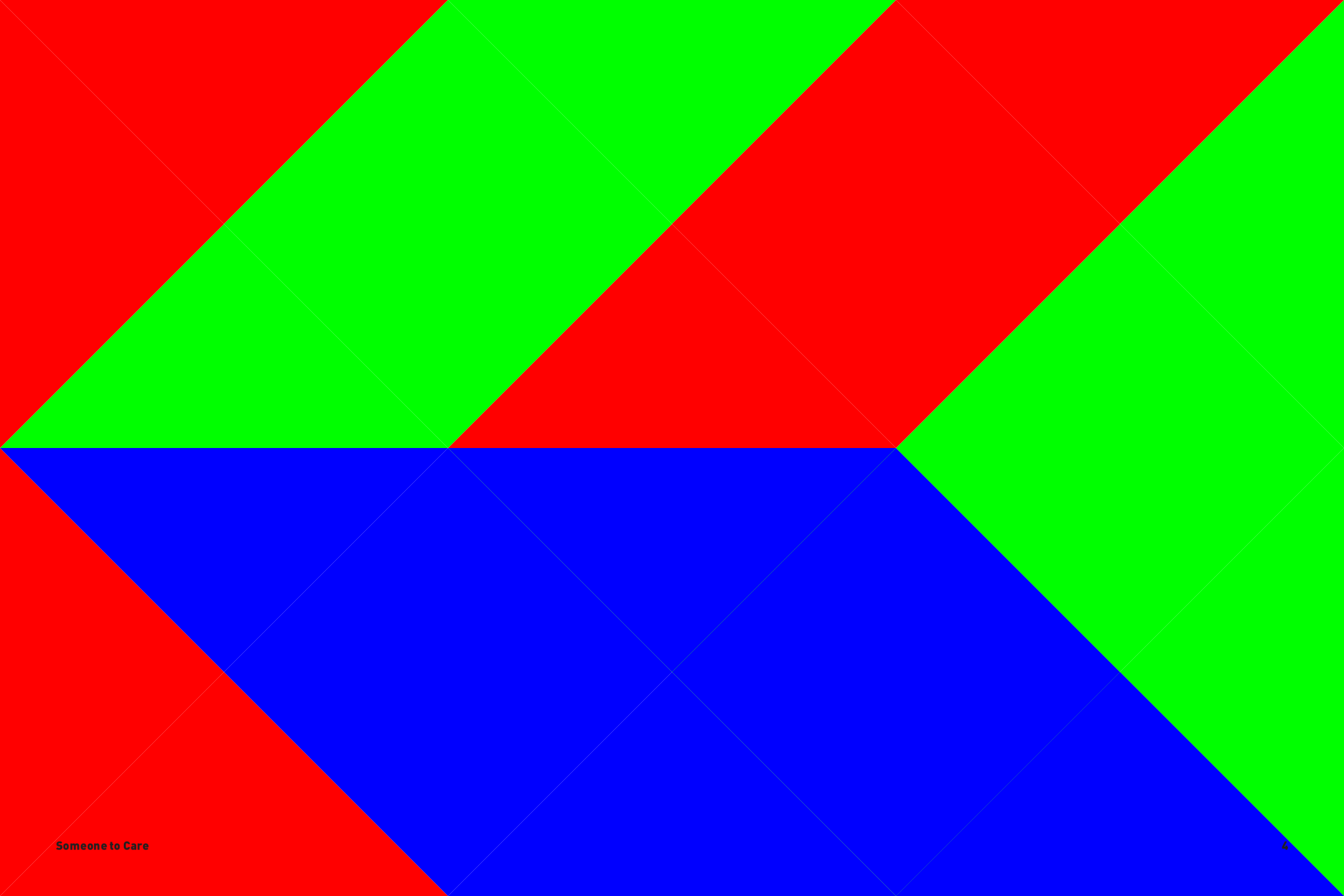
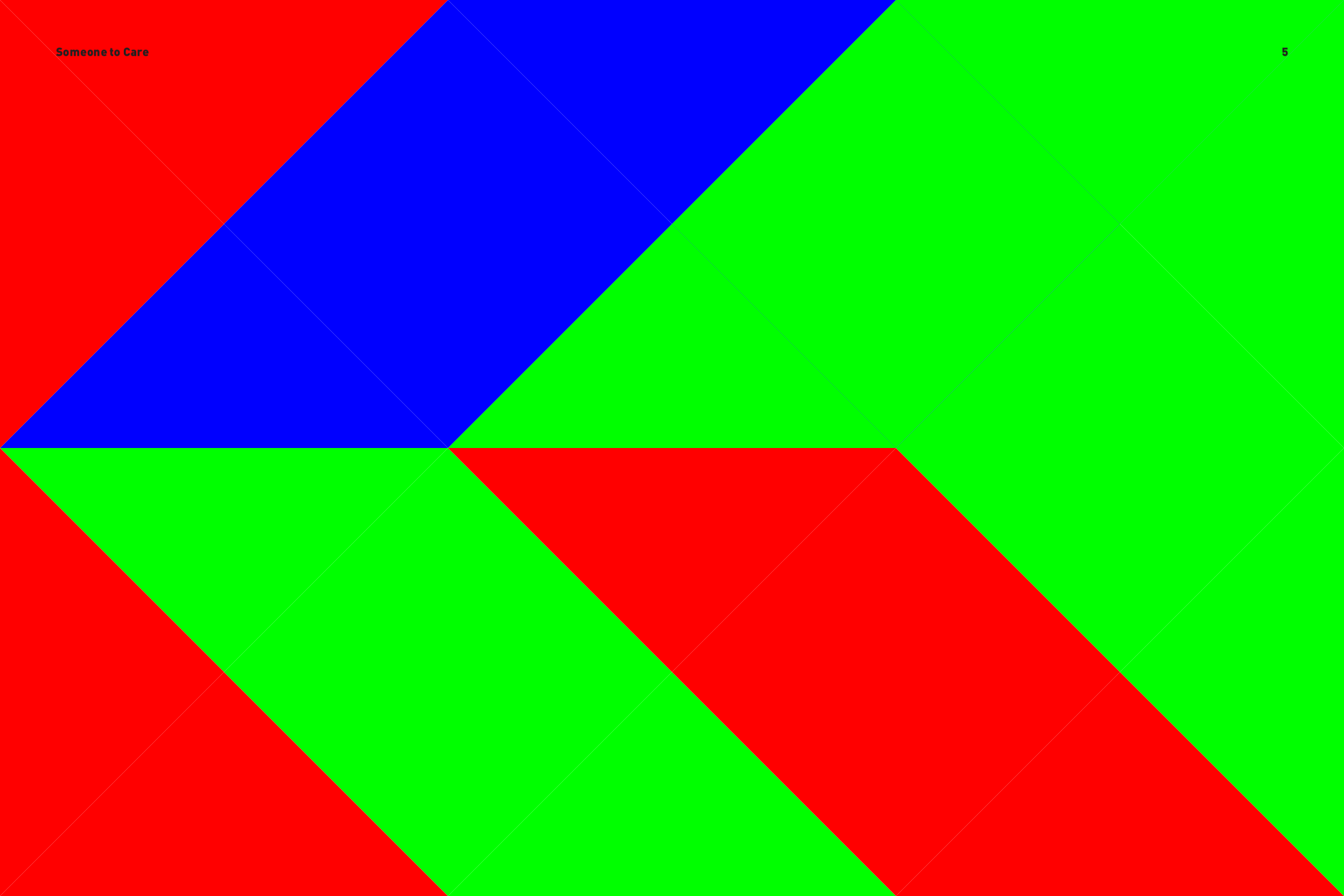




PREFACE

In recent years, a number of shocking reports have documented Ireland's failures towards children in its care. In response to these, some positive developments are currently underway which aim to improve services for these children. For example, the Child and Family Agency has been established, as has the Assessment, Consultation and Therapy Service, a service designed to meet the mental health needs of children in detention, special care and high support units.

However, the steps required to meet the mental health and emotional well-being needs of young people in the care and youth justice system extend further than current policy and service plans. In the 2009 manifesto of the Children's Mental Health Coalition, these mental health and well-being needs were identified as priorities. Early in 2012, Coalition member organisations with experience in the care and youth justice systems were convened to explore the effectiveness of existing services; this report was then commissioned, to examine ways in which the needs of these children could best be met.

Powerful testimonies from young adults who have been through the care system provide the central backdrop to this report. Their voices articulate where the problems lie. They also movingly reveal, through their dignified delivery, the imperative that we find better ways of supporting their mental health and building protective factors to support their resilience, self-worth and self-efficacy. In addition to consulting with young adults, the report sought the views of professionals from different disciplines, who work in the care, youth justice, legal, mental health and education systems, about their views of the mental health needs of these young people and how these systems need to respond to those needs.

The Children's Mental Health Coalition adopts a human rights based approach to its work. Human rights provide useful guidance to States regarding minimum standards of care for children in alternative care, in the youth justice system and those experiencing mental health problems. The right of the child to be heard is crucial among the rights of children under international human rights law. The importance of listening to children and young people is clear from the experiences of the young adults who contributed to this report. We must ensure that the voice of vulnerable children

is really listened to, and is given due consideration and weight in relation to decisions that affect them.

To do this, a critical first step is to challenge stigma and prejudice. In 2011 Amnesty International Ireland undertook nationally representative polling in Ireland. A total of 50% agreed that "wider society is prejudiced against children in the care of the State today"; children who commit crime, Traveller children and children seeking asylum in Ireland were considered low priorities for government attention. The potential for social exclusion and poorer outcomes increases when the experience of a mental health problem is added to the mix.

This report is persuasive in making the case that young people experiencing mental health problems must be diverted from the youth justice system towards community services that address their needs. Indeed, it questions why any child should end up in the criminal justice system at all. Recognition is needed that children may require support to address trauma, neglect or abuse they may have experienced. This could lead to the provision of supports to prevent escalation of mental health problems at later stages in the child's development. This requires us to take a broad, holistic view of mental health, and develop mental health services that provide support for the whole family. Such an approach must also put greater emphasis on the need to support families who through circumstance, are at greater risk. A shared understanding of mental health that goes beyond medical diagnostic labels and addresses the psychological well-being of children and young people is also a crucial step to ensuring effective inter-agency working and equitable access to services.

Of course, support does not always mean a multitude of services. One of the strongest messages from the young people in this report, reinforced by the professionals consulted, is the need for stability and continuity in care. Stability is often missing from their lives and yet the overwhelming message is that if they could develop a single trusting relationship, the impact would be enormous.

This report marks what the Coalition hopes will be the beginning of a process. It clearly identifies the need for a coherent and comprehensive national

strategy addressing the mental health needs of young people in care and in the youth justice system. The mental health needs of these children and young people should, crucially, be central to any new policy and service developments which are currently underway in the reform of children's services.

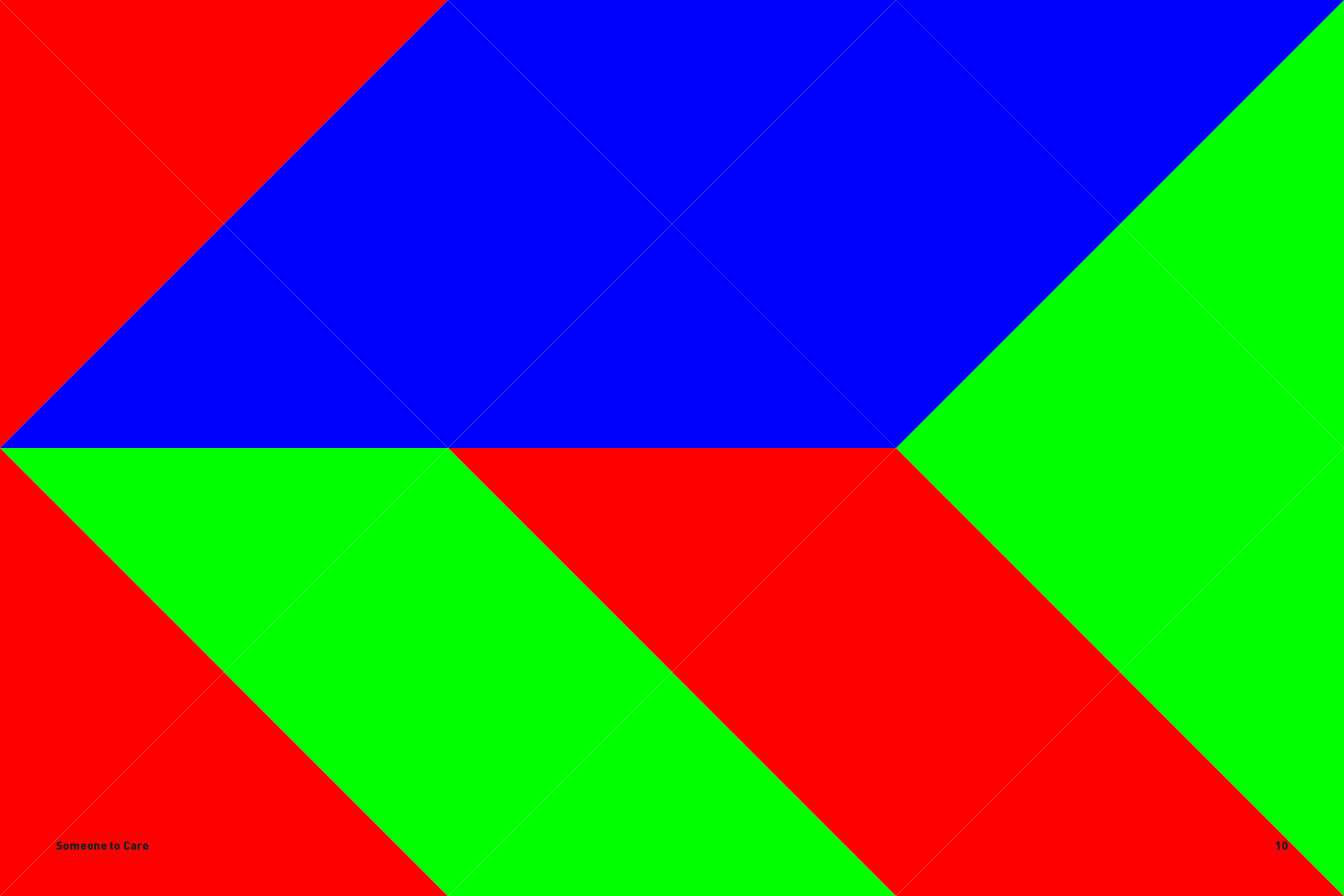
At the heart of this process must be the young people themselves. As experts by experience, they must be involved in the planning, development and delivery of the system. Amnesty International Ireland's 2011 polling revealed a high level of confidence in children's ability to make decisions for themselves and in their trustworthiness. Nearly all respondents (86%) agreed it was important children have their opinions taken into account in significant decisions that affect them, while 67% agreed that children are trustworthy when voicing their opinions on decisions that will affect them. We must start listening.

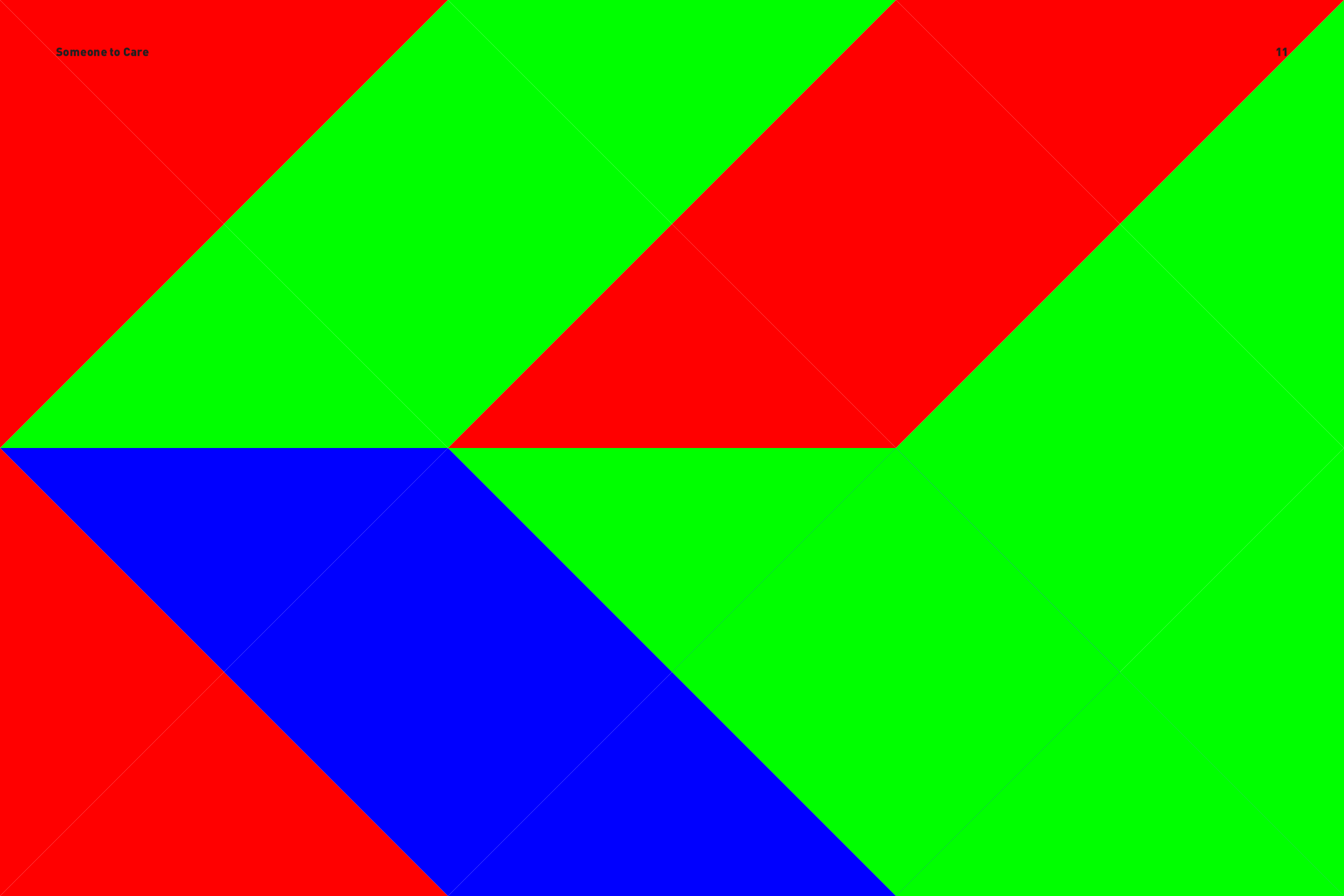
This report notes that the professionals consulted described a 'traumatised and traumatising system'. However, it is important to acknowledge new developments that are emerging in the system. We would also like to pay tribute to the many passionate, caring and dedicated professionals who work with children and young people in the care and youth justice system and in mental health services.

This report hears from eight young adults who have been through the care system and yet show remarkable resilience. They are taking steps to move forward in their lives and have a valuable contribution to make. If we can put in place the right mental health supports for children in the care and youth justice system, we will be building better futures not just for them, but for society as a whole. We will have worked to use our new understanding of their needs to build a transformed future. The lives of our children, all of our children, will ultimately be the better for that.

Orla Barry, Chair
Children's Mental Health Coalition

Colm O'Gorman, Former Chair
Children's Mental Health Coalition





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EXECUTIVE SUMMARY

BACKGROUND AND AIMS OF THE STUDY

—

Significant proportions of children and young people who engage with the alternative care and youth justice systems experience mental health difficulties. Developing timely, effective and comprehensive responses for these young people's needs is challenging, but Ireland has human rights obligations under international instruments to do so. The main aim of this study is to explore the experiences and mental health needs of children and young people from the perspectives of those who have experienced these systems, and to explore professionals' views of the barriers to meeting those needs. In addition we sought to review the international and legal, human rights and policy contexts for the provision of mental health services to young people in the care and youth justice systems; to analyse the economic context; to document learning from international literature on best practice in service provision in these fields; and to make recommendations for future developments.

METHOD

—

In-depth interviews were held with eight young adults with experience of the alternative care system; focus groups and interviews were conducted with professionals, and written submissions invited. Many ethical and safety considerations were built into the study design to ensure that a high quality and sensitive approach was used. The interviewers were highly qualified and ethical approval was obtained from University College Dublin. Young adults were accessed through support services where they had access to professional support if required. In addition, desk-based analysis was conducted of the human rights, legislative, economic and practice contexts to situate the findings from the consultations.

FINDINGS

—

The interviews with young adults identified key issues in relation to their experiences in State care. These were: engagement, trust, relationships; a sense of family, home and belonging; multiple placements, multiple relationships; that one significant relationship; family contact; education; stigma; and turning 18 and leaving care are highlighted. Themes in relation to outcomes were: we were the lucky ones; deserving support; and

thoughts on continuing relationships and facing the future. Young adults identified three key themes specifying what is needed to improve services for young people in the State care system: the need to be understood, the need for better services and the need for child-centred care.

The professionals we consulted saw the system itself as contributing to the trauma experienced by children and young people in State care and in the youth justice system. They noted the very complex mental health needs of children and young people that were affected by a range of developmental, family, social and socio-economic factors, and mental health professionals experienced challenges in assessing and responding to those needs. All observed stigma regarding mental health; stigma in society in general, within State care systems, among non-mental health professionals who are reluctant to consider mental health needs, and among children and young people themselves, for whom help-seeking for mental health challenges was seen as a stigmatising experience.

In terms of providing for mental health needs, professionals argued there is an absence of child-centred care, with organisations focused on their own outputs rather than the child's needs. In terms of assessment and interventions, professionals noted substantial deficiencies, poor resource allocation, many inequities and a focus on crisis management rather than early intervention. Inter-agency working; disciplines reconciling different interpretations of the treatment required and the support needs of children and young people in State care and after-care; and allied professions to be trained in recognising mental health needs, were all identified as core needs. All participants highlighted the need for greater placement and therapeutic stability in order to allow relationships to develop. Finally, all professionals had broad definitions of mental health: it is not just the absence of illness, but a state of well-being and the ability to cope with life's challenges. This was reflected in their views of the range of supports needed to address the complex mental health needs of children and young people in State care and after-care.

There was considerable dissatisfaction expressed at the dominance of the medical model in service structure and delivery.

The human rights, legal and policy analysis identified United Nations and human rights instruments that are particularly relevant to children in the care of the state or who engage with the youth justice system. These include the United Nations Convention on the Rights of the Child (CRC) and the European Convention on Human Rights (ECHR), among others, which recognise children's rights to the highest attainable standard of health, and which establish the right that the best interests of the child or young person be the primary consideration in all actions concerning them. Further international human rights, principles and guidelines applying specifically to mental health, alternative care, and young people in conflict with the law, are summarised. The absence of provisions in Irish law to ensure that children's voices are recognised is noted.

The legal analysis summarises Irish legislation pertaining to the mental health of children and young people, and legislation for the care and youth justice systems. In addition, Irish policies and national standards that apply to children in care and after-care, including children who are homeless and separated children, and young people in contact with the youth justice system, are outlined. The chapter also summarises the findings of recent HIQA reports of inspections of foster care; residential care; special care; and children detention schools, as well as reports by the Inspector of Prisons of St Patrick's Institution. A set of recommendations is made at the conclusion of this analysis for specific aspects of legal and policy reform required to address the complex inter-relationships between children's mental health, their care experiences and their offending behaviours. In the youth justice system, reforms should address diversion; sentencing; community and hospital orders; children in detention schools; and St Patrick's Institution. In the care system, reforms are recommended for guardians ad litem; regulations and standards; seclusion and restraint; special care; and after-care services.

A review of Irish and international literature identified key issues concerning mental health and psychological well-being in the care and youth justice systems. These include the need for comprehensive assessment of need. As almost all children in the care and youth justice system have been exposed to adversity that is likely to affect their development and well-being, it is

probable they have vulnerabilities that are not self-evident. Some examples of assessment models and instruments were identified. Features contributing to good care were explored; including the vital need for placement and therapeutic stability and the need for services to take account of the effects that the children's trauma can have on professionals and on the system itself. The critical necessity of inter-agency co-operation was noted; this is repeatedly cited as a means to ensure better service provision. It is important to note that systemic issues preventing good inter-agency and multi-disciplinary planning and service provision have been identified repeatedly in the literature in Ireland and worldwide. Therefore, piecemeal changes are unlikely to achieve the goal of supporting the psychological well-being of children and young people for whom the State is responsible: systemic change is required.

The annual cost to the State of providing homes for children in care is €233.2 million. The cost of detention is at least €61.3 million, although figures for 16- and 17-year-olds at St Patrick's Institution were unavailable. The cost of providing mental health services is €11.1 million. Taken together these estimates give a total annual cost of almost €300 million. This equates to an annual cost per child in care or detention of about €63,000. It is only by measuring the outcomes from different types of provision that value-for-money assessments can be made. What is clear from the figures presented is that any measure that avoids the escalation of a care or youth justice case is likely to save money. Furthermore, a case could be made for diverting additional spending to activities that could prevent such escalation.

CONCLUSIONS

This study set out to explore the experiences and mental health needs and human rights of young people in the care and youth justice systems. It is clear from this study that these mental health needs are highly complex and require flexible, creative responses. The young adults with experience of State care noted their need to be understood and to have someone to care. Professionals' experiences of the systems as traumatised and traumatising highlights the need for a well selected, well resourced, supported and adequately trained workforce who can provide stability and meaningful relationships for these

young people. Legal and policy changes are required, to respect children's human rights, and to address the complex relationships between their mental health, their care needs and their offending behaviours. The relationship between stability and long-term outcomes for these young people is clearly supported by international research. The need for effective inter-agency collaboration has also been identified in the literature and was a key concern for professionals in this study. In addition, gaps in community-based services in particular, but throughout the various levels of service provision, clearly impact on the State's ability to provide an equitable service to those in need. Finally, the study highlighted the need for a shared understanding of mental health, one that goes beyond medical diagnostic labels and addresses the psychological well-being of young people, affirming their human rights as respected members of our community.

RECOMMENDATIONS

1 Listen to the voice of the child: Involve young people in planning service developments, education and consultation

2 Issue a national policy statement and national strategy to address the mental health needs of children and young people in the care of the State

3 Establish a common assessment framework and ongoing monitoring of children's and young people's mental health needs

4 Provide stability for children and young people in the care and in youth justice systems

5 Provide adequate, equitable access to services

6 Establish mandatory protocols for inter-agency work

7 Develop training programmes in identifying and understanding psychological well-being issues as an integral part of professional development for all professionals

8 Provide legislative protection for children leaving care and detention, and homeless children

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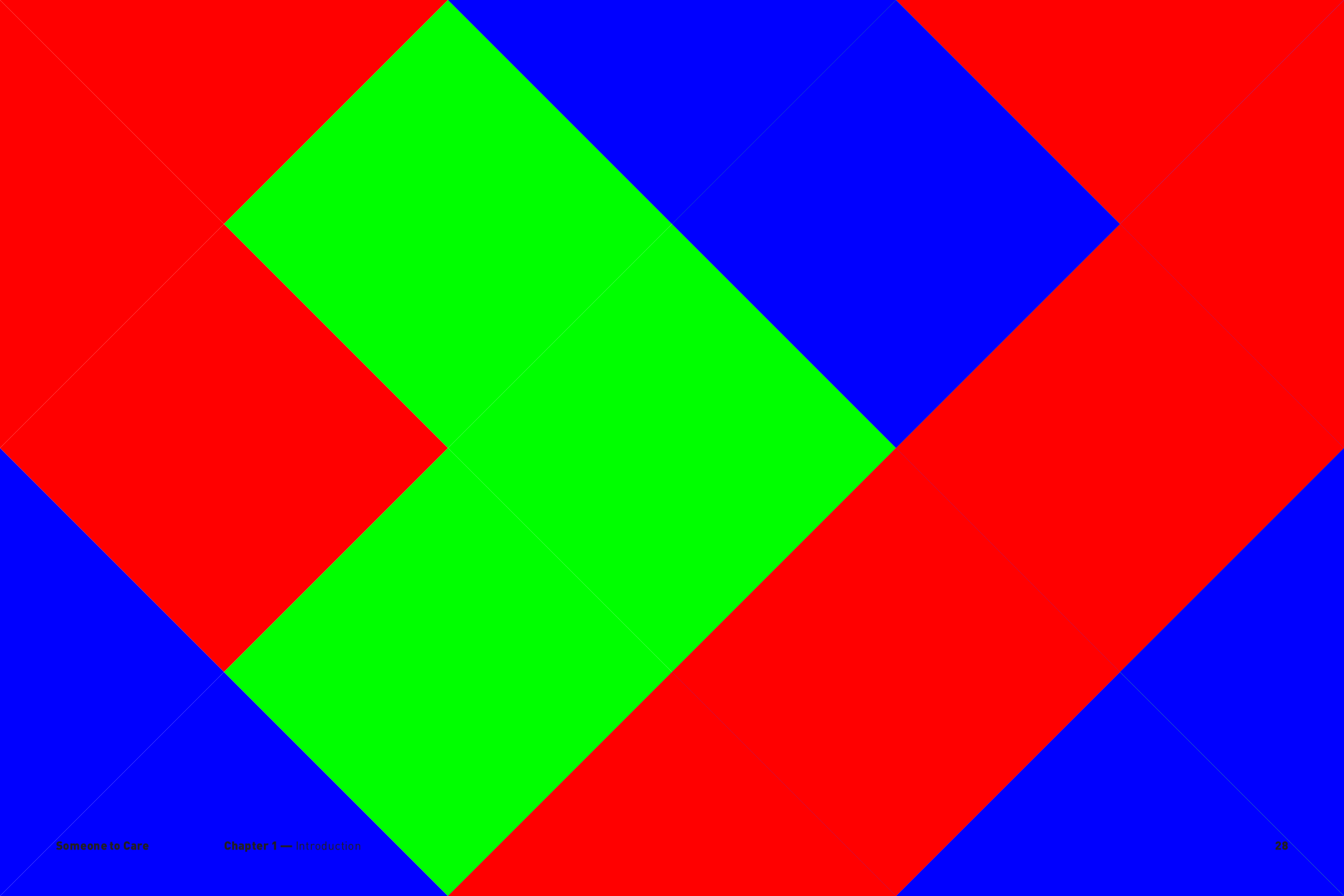


INTRODUCTION

The mental health of young people in Ireland has become a critical concern for Irish society in recent years. **The My World Survey: National study of youth mental health** (Dooley & Fitzgerald, 2012) and **Teenage Mental Health: What helps and what hurts** (McEvoy, 2009) present a consistent picture of pressure on young people's psychological well-being, with regard to self-image, school and exam pressure, bullying and isolation, and difficult relationships with family and peers. According to the My World Survey (Dooley & Fitzgerald, 2012), mental health difficulties peak in the late teens and early 20s, a period of transition for many young people, and mental health problems such as depression and anxiety affect approximately 14% of young people in Ireland. However, protective factors such as positive relationships, support in school, and facilities for young people all help them cope with the pressures of life. In particular, being able to talk about problems and having 'one good adult' in a young person's life were identified as important.

In light of this, the mental health of the most vulnerable children and young people in society is an area of particular concern. The numbers of children entering state care in Ireland has been increasing steadily in recent years, from 5,247 in 2006 to 5,965 in 2010 (an increase of 13.7%; Brierley, 2012) and to 6,332 in 2012 (a further increase of 6.2%) (HSE, 2012a). The mental health needs of children in care or in secure accommodation settings are consistently documented as being significant, with high rates of mental health problems; social, family, and educational problems; aggression, substance misuse and self-harm (Chitsabesan et al., 2006; Ford, Vostanis, Meltzer & Goodman, 2007). These difficulties are often very complex with significant multiple needs (co-morbidity), requiring highly specialised treatment (Tarren-Sweeney, 2008). For young people in contact with the youth justice system, research indicates that approximately 70% warrant at least one mental health diagnosis (Shufelt & Cocozza, 2006) and approximately 20 to 25% have serious emotional issues (Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher & Santos, 2002). Buckley and O'Sullivan (2006) note that despite improvements in recent years in how the State responds to the needs of children and young people in the youth justice system we have yet to implement a child welfare model in such responses. The **National Youth Justice Strategy 2008-2010** (Department of Justice, Equality and Law Reform, 2008) acknowledged that depression and stress are key issues among child offenders and that counselling and mental health services were considered helpful in reducing the risk of offending. The overlap between young people in the care system and the youth justice system is evident in recent figures, which indicate that 42% (n=37/88) of young people above the age of criminal responsibility who were being considered for care, had some form of contact with juvenile justice services (Brierley, 2012). Research consistently shows that about 55% of young people in the youth justice system have two or more mental health diagnoses and about 60% who had a mental health diagnosis also had a substance use problem (Shufelt & Cocozza, 2006).

This study aims to explore the mental health needs of children and young people in the care and youth justice systems in Ireland and to identify what

needs to be done to best meet these needs. In doing so, we consulted with young adults and professionals with experience of those systems; reviewed international literature; and analysed economic, legal, and human rights aspects of care and youth justice. As a starting point, however, it was important to establish what is meant by 'mental health'. This chapter therefore begins by defining mental health. It then discusses how mental health difficulties may arise, referring to international frameworks that may be useful in understanding the origins and service implications of mental health difficulties. The findings of recent consultations with young people in Ireland are also reviewed here, underscoring the need to hear what young people have to say about their experiences and how professionals and society might best respond to meeting their needs. Lastly, this chapter describes the method for the present study and provides an outline of the report.

WHAT IS 'MENTAL HEALTH'?

There is considerable debate internationally about the definition of mental health. A range of terms is used, underpinned by varying mental health models (NHS Health, Scotland, 2010). The World Health Organisation (WHO) has adopted a broad definition of mental health for children and young people, focusing on optimal well-being:

> **Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the level reached and the competence achieved in psychological and social functioning. WHO, 2005, p. 7**

The WHO also states that mental health in children and young people "includes a sense of identity and self-worth; sound family and peer relationships; an ability to be productive and to learn; and a capacity to use developmental challenges and cultural resources to maximise development" (2005, p. 7). This focus on positive functioning and broader psychological well-being reflects an increasing discourse on positive mental health, a concept that extends beyond the absence of mental health problems (Barry, 2009). The implication of this broader concept of mental or psychological well-being is that mental health is relevant to everyone, not just those with diagnosed psychiatric disorders, and that services to support mental health need to go beyond diagnosis-specific interventions. Barry argues that there is a need for supportive environments, reduced stigmatisation and discrimination, and support for the social and emotional well-being of service users and their families.

In Scotland, policy incorporates the consistent use of mental health definitions across NHS Health Scotland (2010). Mental health problems and mental well-being are identified as two separate constructs, both of which exist on a continuum (see Figure 1). This model recognises that a person can have a diagnosed mental health problem yet experience psychological well-being; and that individuals can have poor psychological well-being without having a diagnosable mental health problem.

When considering the issue of mental health it is important not to pathologise individuals who experience difficulties. The Mental Health

Commission in Ireland published a discussion paper in 2005, **A Vision for a Recovery Model in Irish Mental Health Services**, that emphasises the expectation of recovery from mental ill health and promotes the following principles for individuals: living well; participating fully in the community; autonomy; self-management and responsibility; hope; personal growth; person-centred services; resilience and empowerment (Mental Health Commission, 2005). This recovery model provides a holistic view of mental illness that focuses on the person, not just their symptoms. It recognises that help for people experiencing mental health difficulties may involve a range of mental health disciplines but also involves the use of peer supports, formal and informal, and local community resources.

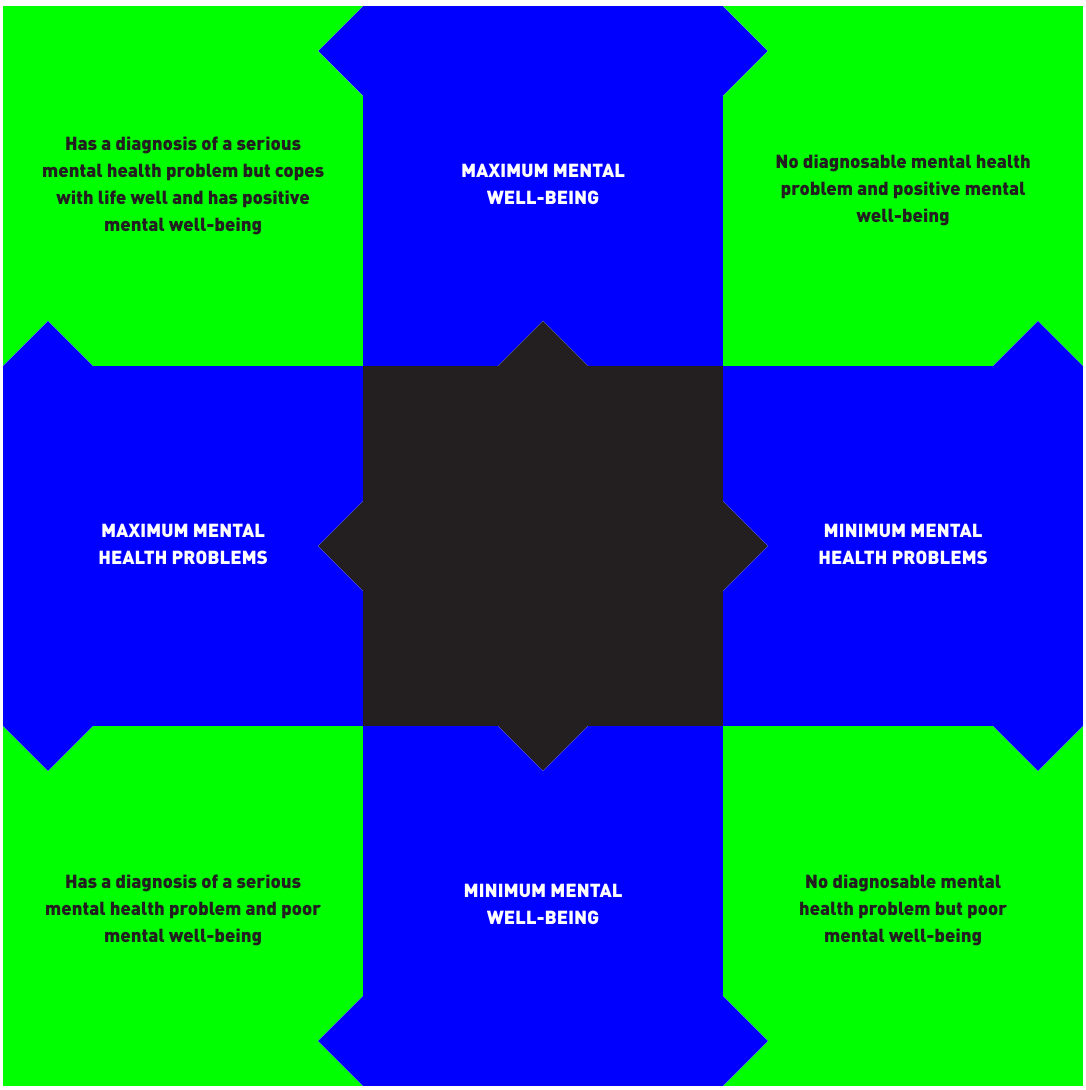
The National Educational Psychological Service (NEPS) in Ireland also takes a holistic view of mental health difficulties, noting that "relationships with self, others and community may be affected and the difficulties may interfere with the pupils' own personal and educational development or that of others. The contexts within which difficulties occur must always be considered, and may include the classroom, school, family, community and cultural settings." (NEPS, nd, p. 4) However, it is notable that NEPS does not use the term mental health, referring instead to behavioural, emotional and/or social difficulties. It defines these as "difficulties which a young person is experiencing which act as a barrier to their personal, social, cognitive and emotional development. These difficulties may be communicated through internalising and/or externalising behaviours." (NEPS, nd, p. 4) The Special Education Support Service, which operates under the remit of the Department of Education and Skills, uses the term "emotional disturbance and/or behavioural problems" to categorise such difficulties, and notes that these are the main special educational needs that teachers encounter (Department of Education and Skills, 2012). Emotional disturbances can however be considered to be mental health difficulties, and behavioural difficulties in children are frequently an expression of an underlying mental health problem. Such differences in terminology may have consequences for how the difficulties that children experience in school are interpreted and addressed by education, care and justice agencies.

In this report, we use the term 'mental health' to refer to psychological well-being and use these terms inter-changeably throughout. The terminology 'mental health problems' or 'mental health difficulties' is intended to reflect a continuum of difficulties. These range from sub-clinical difficulties to those that meet the diagnostic criteria for psychiatric disorders.

MENTAL HEALTH NEEDS OF CHILDREN IN THE CARE AND YOUTH JUSTICE SYSTEMS

The most recent annual Child and Adolescent Mental Health Services (CAMHS) report (HSE, 2012b), indicated that 20% (1,684) of 8,479 cases of children who attended community CAMHS teams in November 2011 were in contact with social services, while a further 8.76% (743) had a history of contact with social services. This suggests that overall, nearly one in three children attending CAMHS may have some history of social service contact. Of the 1,684 children who were in contact with social services and also

FIGURE 1
MODEL OF MENTAL WELL-BEING AND MENTAL HEALTH PROBLEMS (SOURCE: ADAPTED FROM TUDOR, 1996, IN NHS HEALTH SCOTLAND, 2010)


Has a diagnosis of a serious mental health problem but copes with life well and has positive mental well-being
MAXIMUM MENTAL WELL-BEING
No diagnosable mental health problem and positive mental well-being
MAXIMUM MENTAL HEALTH PROBLEMS
MINIMUM MENTAL HEALTH PROBLEMS
Has a diagnosis of a serious mental health problem and poor mental well-being
MINIMUM MENTAL WELL-BEING
No diagnosable mental health problem but poor mental well-being

attending CAMHS, 72.7% (1,223) had contact only with social services; 6.7% (113) were in relative foster care; 13.2% (223) were in non-relative foster care; and 4.8% (80) were in residential care.

The high proportions of children involved in child protection or care systems experiencing mental health difficulties is a consistent pattern reported in international research as well as in Ireland. In the UK, Ford et al. (2007) found that 79.8% of boys aged 11 to 15 who were in care had emotional or behavioural problems, compared with 12.8% of their peers. For girls of the same age, the figures were 77.9%, compared with 9.6% respectively. Additionally, there is evidence that care and secure care settings are often populated by the same children; in the UK, children who have been in care account for 41% of those in young offending institutions (Green, 2005). Children in residential care have more mental health problems than those in family-type foster care, while those in kinship care have fewer problems again (Tarren-Sweeney, 2008). Among young offenders, estimates of the prevalence of mental health needs have varied from 31% of males in the UK (Chitsabesan et al., 2006) to 70% in America (Cauffman, 2004). These needs often co-exist with learning difficulties and other vulnerabilities, such as substance dependence, which exacerbate offending behaviour (Chitsabesan et al., 2006; Hagell, 2002). Mental health problems also persist upon leaving care and detention, although the nature of the problems has been shown to change over time. In a study of children before and after admission to secure accommodation in the UK, Kroll et al. (2002) found that education, substance misuse, self-care, and diet needs were well met but that psychological needs and aggressive behaviours persisted.

A small number of studies in Ireland show similar patterns of mental health needs in children in the care and youth justice systems. McNicholas, O'Connor, Bandyopadhyay, Doyle, O'Donovan and Belton (2011) reported on the mental health needs of 174 children in care with an average age of 10.8 years. More than a quarter were CAMHS clients, although one in six did not have a social worker and one in three did not have a General Practitioner (GP), so the possibility remained that mental health needs had not been properly assessed. More than half of the children in foster care and almost 90% of those in residential care had behavioural problems (McNicholas et al., 2011). One in five children had a family member with a mental health problem and a similar number had a family member who had a drug- or alcohol-related illness. Overall, long-term care with frequent placement changes was significantly associated with poorer outcomes and increased mental health needs.

Among 59 girls in a detention school, Smyth (2006) found histories of aggression and anger problems, self-harm and suicide attempts, depression, and substance misuse. Hayes and O'Reilly (2007) compared the mental health needs of a group of children in detention to those of a group attending community-based adolescent mental health services, and to a control group. In the detention group, 82.8% met diagnostic criteria for at least one psychological problem, while the figure for the community-based group was 60%. In the detention group, 67.9% were found to have 'conduct disorder' compared with 5% in the community-based group. A large proportion of the detention group had a family member with a

criminal conviction (97%) and a family member who had served a jail sentence (90%). Furthermore, those in detention had experienced school problems, including being sent to the principal's office (97%), truancy (83%), suspension (97%) and receiving additional help with reading (50%); all significantly higher rates than the community and control groups.

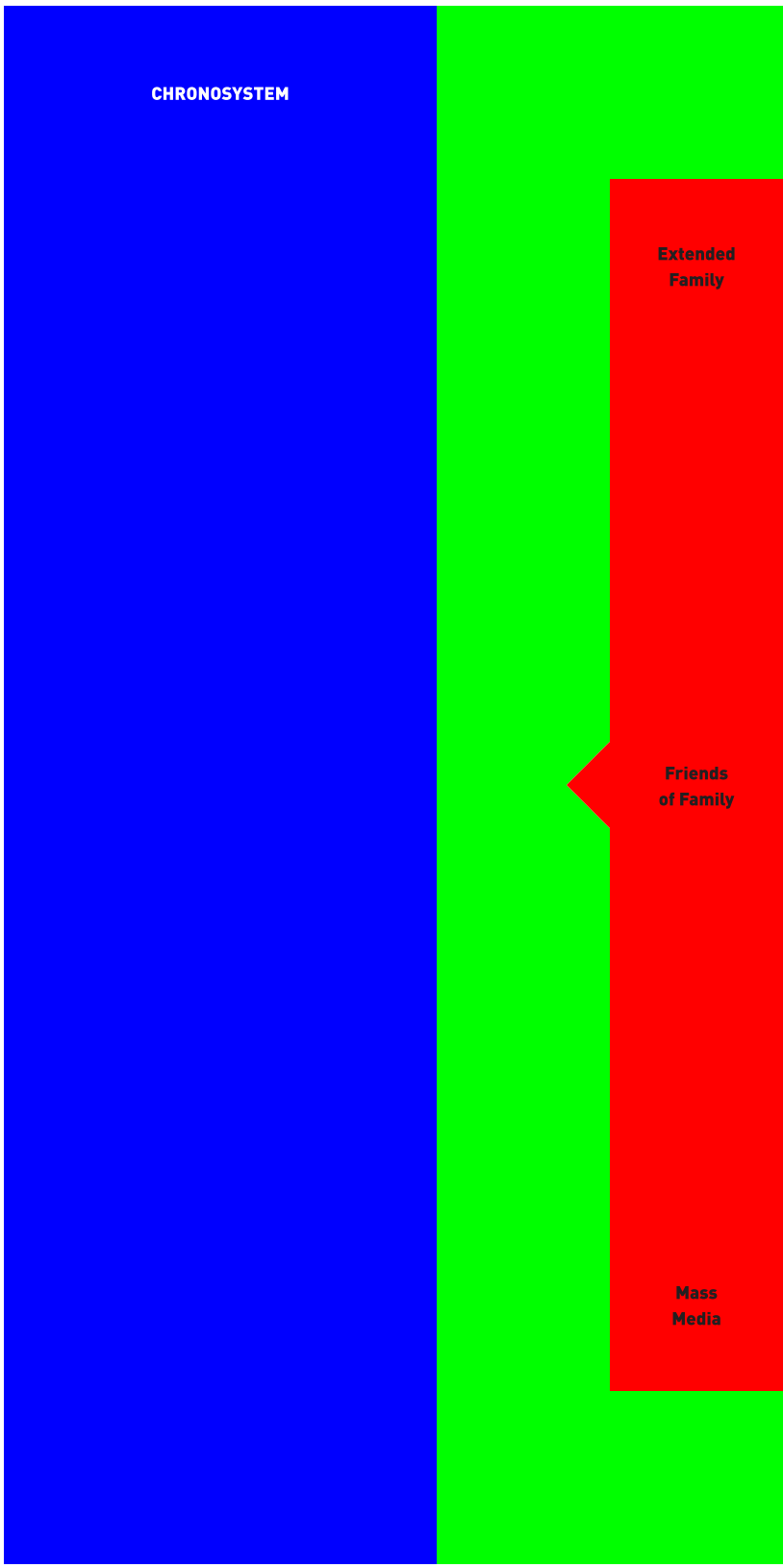
ORIGINS OF MENTAL HEALTH DIFFICULTIES

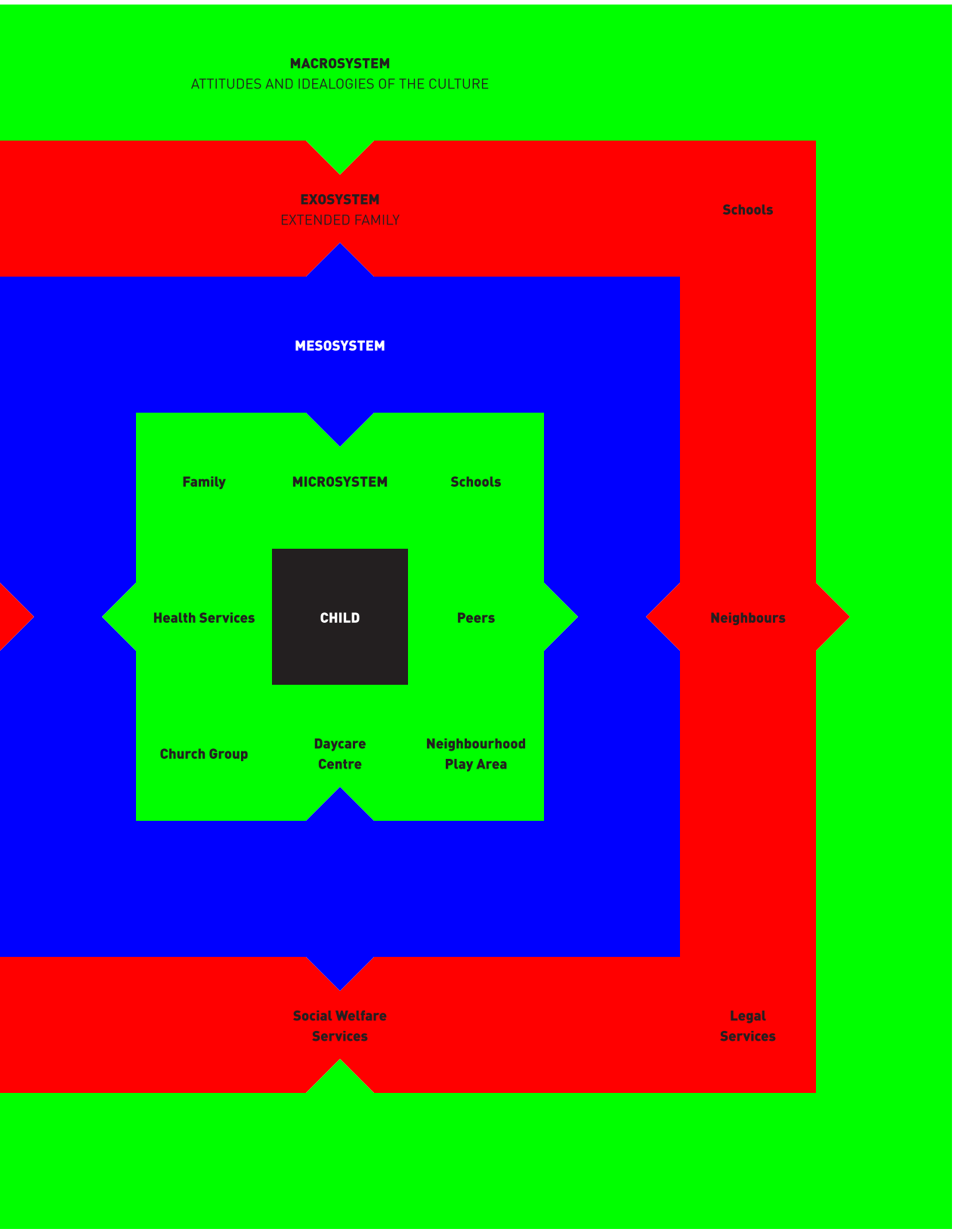
The level of mental health difficulties found in children and young people in the care or the youth justice system is attributed by researchers to a range of factors, including the child or young person's own experiences and aspects of services that fail to meet their needs. Certain biological and social experience relating to their family of origin may predispose the child to later life difficulties: e.g. pre-natal impairments associated with maternal substance use; disadvantaged backgrounds; disorganisation and high level of need within families; parental mental illness, alcohol and drug use; domestic violence and abuse; and interpersonal trauma involving the primary care giving relationship, leading to disturbed attachment relationships (DeJong, 2010; Golding, 2010; McAuley & Davies, 2009). To understand the origin of children's mental health needs and identify the means to address them, a conceptual model of child development is helpful. Bronfenbrenner's bio-ecological systems theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006) builds on a social constructionist understanding of development. A holistic model, it accommodates the role not just of children themselves, but also of their family, community, wider society, and even the historical period in which the child lives (Walton, 2001).

Central to the model is the child (see Figure 2), whose development is not viewed in isolation, but in the context of relationships and environmental and social settings. These include family and familial relationships that provide the child's earliest constructions of meaning: the interaction and developing attachment with the parent leads the child to internalise expectations, patterns of behaviour and constructs about themselves. The extended family, friends, teachers, school and immediate community provide further relationships and development contexts, interacting with the child and with each other, and all may influence the child's psychological well-being. The next layer of influence is the social and institutional context in which development takes place: formal structures like State services and informal settings like a wider neighbourhood. The final layer of influence consists of culture, customs, norms and politics. All these layers of influence on a child's experience and development are also influenced by the historical period in which people live. Currently, in Ireland, this is one of high indebtedness and unemployment, and reductions in social services.

Applying this bio-ecological model of development to mental health, therefore, means that psychological well-being is developed not only within the child but in their relationships with others; in the settings in which they live, learn and play; and that social, political, economic and cultural factors also have an influence. Therefore, the task of promoting mental health must be undertaken in all these settings, not just at the level of the individual or their family (Barry, 2008).

FIGURE 2
BRONFENBRENNER'S BIO-ECOLOGICAL MODEL OF CHILD DEVELOPMENT (ADAPTED FROM BRONFENBRENNER AND MORRIS, 2006)




MACROSYSTEM
ATTITUDES AND IDEALOGIES OF THE CULTURE
EXOSYSTEM
EXTENDED FAMILY
Schools
MESOSYSTEM
Family
MICROSYSTEM
Schools
Health Services
CHILD
Peers
Neighbours
Church Group
Daycare Centre
Neighbourhood Play Area
Social Welfare Services
Legal Services

The importance and urgency of addressing the high levels of mental health need among children in care or contact with the youth justice system can be highlighted by the fact that, in the decade 2000 – 2010, the deaths occurred of 196 children and young people in care or known to child protection services in Ireland (children and young people were in care within the meaning of the Child Care Act, 1991 at the time of their death; in receipt of aftercare within the meaning of Section 45 of the Child Care Act, 1991 at the time of their death; or known to the child protection services within the meaning of the Health Information & Quality Authority (HIQA) guidance to the HSE of 20 January, 2010 at the time of their death). In a recent report examining these deaths, specific failures in mental health services were identified by the Independent Child Death Review Group (ICDRG; Shannon & Gibbons, 2012).

It is of particular note that the ICDRG Report found that mental health services were either not involved in the cases of children who died, or their involvement was not known to child protection services "because of reluctance to share appropriate information or expertise" (p. 409). The report stated that families experiencing such difficulties are often referred to as "dysfunctional" (p. 409), where it may have simply been that a family member, parent or child required targeted mental health service supports or services. The ICDRG highlighted that certain behaviours are strong indicators that the child may be at risk or vulnerable and in need of mental health assessment: these include alcohol, drug and solvent abuse and fire setting. According to the report, escalating patterns of 'at risk' behaviour and poor impulse control should be viewed as indicating that the child is in need of urgent mental health intervention. The authors recommended that when a child is referred to the HSE, a comprehensive assessment of the child's needs must be carried out, including a review of the child's physical, psychological and mental health, in order to ensure a plan is in place to tackle and resolve any problems.

Since 2010 the National Review Panel (NRP) has investigated deaths and serious incidents in relation to children, and the issues identified by the ICDRG recur in NRP reports (HSE, 2010a, 2010b; NRP, 2011a). These are: delays or failures in assessment, and poor inter-agency communication and lack of service co-ordination. For example, a two-year delay before a psychological assessment was undertaken for Young Person B meant that care was based on incomplete information (HSE, 2010b). Child O, who had a mild intellectual disability, discipline problems on transition to second-level education, and was involved in minor criminal activity and drug use (NRP, 2011b), was referred to CAMHS, failed to attend, and died before another appointment could be arranged. The NRP investigation of that case noted that despite a high standard of inter-agency working, there were tensions between professionals as to the best approach to take. The NRP (2012) also reviewed the case of Adam who, after a history of bereavement, poor school attendance, and alcohol use, was referred to CAMHS. The initial assessment concluded that Adam did not have a major mental health disorder; he was referred back to social workers. They were expected to conduct their own assessment, but did not receive this correspondence until after Adam's death. Cases such as these underline the gravity of the potential consequences where services do not assess or support young people's mental health needs, or where they do not adequately communicate with one another.

CONSULTATIONS WITH YOUNG PEOPLE IN CARE AND THE YOUTH JUSTICE SYSTEM

To provide high quality mental health services and supports for children and young people in the care and youth justice systems it is essential to incorporate the views of young people themselves of how such services can best assist them. There has, however, been very little research consulting young people. Here, we highlight the findings of studies that have involved directly asking young people for their views.

Davies and Wright (2008) reviewed 12 international qualitative studies of looked-after children exploring their views of mental health services. The issues highlighted were the importance of individual contacts; positive personal attributes in carers, like being kind or approachable; the sense of something being done; and respect for confidentiality. In terms of therapeutic approaches, Davies and Wright (2008) noted that while talking could be valuable for some, for many children it could be challenging and a source of discomfort. Across age groups, children noted the value of non-verbal interactions like drawing and playing in enabling them to engage in therapy.

McEvoy and Smith (2011) undertook consultation with 211 children in the care and youth justice systems in Ireland, not specifically about their mental health but on the issues most affecting their lives, their assessment of the services and supports available to them and recommendations for how things might be done differently. Participants were aged eight to 17 years and lived in a range of settings: 28% lived in foster care; 23% in residential centres; 20% were in detention schools or in St Patrick's Institution, a detention centre; 16% were separated children seeking asylum; 8% were children who had recently left care; and 5% were in other categories including children with disabilities. The main issues children identified were the complexity and importance of relationships with their birth family; the need for assessment, vetting and training of foster carers; the disruption caused by multiple placements; and the value of having one person or agency who can support a child throughout their care experience. In addition, children in detention schools and St Patrick's Institution identified some specific issues in the consultation. These included the lack of freedom, privacy and services, and the importance of alcohol and drugs to them. In addition, a lack of respect from staff was a considerable concern; participants from St Patrick's Institution wished to be treated like human beings. They also wanted to be able to bring their views to management and someone to talk to who did not work in the detention setting. However, mental health was not in the specific remit of this consultation and there are few references to mental health issues in the report.

The Ombudsman for Children's Office (OCO) undertook consultation with children who had been in St Patrick's Institution (OCO, 2011), a detention centre, and with children and young people in Ireland who are homeless (OCO, 2012). According to the OCO (2011), the mental health of young people at St Patrick's Institution may be adversely affected by the conditions of detention, including the practice of 23-hour confinement. The report recommended "ready and timely access to appropriate professional

support as regards identifying and treating any mental health problems they may be experiencing" (OCO, 2011, p. 38). Ironically, participants suggested that disclosing serious mental illness or suicidal ideation would lead to 23-hour confinement (OCO, 2011). The OCO (2012) also consulted with children and young people who are homeless about their experiences of mental health issues. According to the participants in the consultation, the problem of placement instability, ultimately resulting in homelessness, compounded existing vulnerability to mental health problems. They gave examples of care staff in emergency units providing valuable support for children and young people's mental health.

A study carried out by the non-governmental organisation Empowering People in Care Ireland (EPIC; Daly, 2012a, 2012b) involved a survey of 45 young adults and in-depth interviews/focus groups with eight young adults who had experience of the care system in Ireland. The circumstances of those interviewed varied, as did the number of care placements (ranging from two to 23) and the length of time spent in care (between two and 17 years). The study found that 39% of care leavers had mental health needs. Social support was identified by young adults as the greatest need of care leavers; several spoke about receiving help from family, friends and former carers. Five of the eight young adults interviewed did not feel ready to leave care at 18 and felt under pressure to become an adult almost overnight. Being able to make a more gradual transition from care through the availability of more step-down supported accommodation was identified as a way this could be positively addressed in future.

In 2011 the HSE commissioned an audit to review the capacity for alternative care services in Ireland (Brierley, 2012). The study consisted of an audit of professionals to establish the capacity of services for young people at a specific time point in 2011. Some feedback was obtained from 14 young people through a short survey and one small focus group; of these 14 young people, nine felt it was easy to get the information, advice or support they felt they needed on mental health issues. A key concern emerging from the data gathered from professionals, however, is the proportion of children who were referred to mental health services for intervention but did not engage. In psychology and alcohol substance misuse services, and in CAMHS, the numbers of children who did not engage where the service was made available exceeded the numbers of children actually seen in these services.

A UK organisation, Young Minds, committed to improving the emotional well-being and mental health of children and young people, worked with 50 young people from residential homes, secure settings and foster placements and ran a variety of creative workshops focusing on the areas of placements, education and support services (Young Minds, 2012). The authors observed that young people who have experienced considerable trauma may feel that it is safer not to trust adults and may reject the therapist for much longer than other young people. Creative ways of developing trust and building relationships may be necessary in order for the therapeutic process to begin.

Difficulties engaging young people with services has also been a concern in services in Ireland. For example, addressing this concern is one of the

key principles underpinning the establishment of the new Assessment, Consultation and Therapy Service (ACTS) designed for special care settings, i.e. that services will be made available on-site, to facilitate young people's engagement (personal communication, Director of ACTS, 2013).

Overall, therefore, there are consistently high levels of mental health needs seen in children and young people in the care and youth justice systems. Reports of deaths and serious incidents underscore gaps in service provision and communication between services about these children and young people. Where services are provided, young people's frequent failure to engage suggests that it is important to ask what kind of service can be effective and engaging for children and young people with complex histories and needs. However, young people's views have only been sought occasionally in research.

Taken together, these issues underscore the need to consult directly with young people about their experiences of mental health and to identify, from young people's and professionals' perspectives, how best the services available can respond to young people in meeting their needs.

THIS STUDY

This research study was designed against the backdrop of positive service developments in Ireland for children and young people in the care and youth justice systems, including the establishment of the Child and Family Agency and the ACTS (see chapter four).

The aim of the study is to explore the experiences and mental health needs of young people in the care and youth justice systems, from the perspectives of young adults who have had such experiences, and to explore professionals' views of the barriers to meeting these needs. In addition, the study seeks to review the international and national legislative, human rights and policy contexts for the provision of mental health services to young people in the care and youth justice systems; to analyse the economic context for provision of services to these young people; to document learning from international literature on best practice in service provision in these fields; and to make recommendations for future developments for existing services, such as child protection services, child and adolescent community mental health services, primary care services and services within the youth justice system, in meeting the needs of these children.

Róisín Webb, Coordinator of the Children's Mental Health Coalition, designed, commissioned and managed this research project. The study was conducted by a team of researchers from the Children's Research Network for Ireland and Northern Ireland (CRNINI), coordinated by Dr Brían Merriman.

RESEARCH DESIGN

The terms of reference for the study consisted of four distinct but interlinked components, from which conclusions and recommendations would be drawn:

A **Consulting young adults and needs analysis:** Identify and give voice to the views of young adults who had recent experiences of the care and youth justice systems, through individual interviews and focus groups, and inviting young adults to help to design this consultation. A subgroup of Children's Mental Health Coalition members who provide supports to young adults after care or youth justice experiences would assist with inviting participants.

B **Social policy research and consultation with professionals:** Identify common recommendations regarding the mental health needs of children and young people in the care and youth justice systems; best practice in Ireland and in other jurisdictions; reasons why barriers and impediments to positive change continue to exist; and how better systems could be put in place through a literature review and consultation with a wide range of professionals working with children and young people in these systems.

C **Legal and human right framework:** Set out the obligations of the State under relevant human rights standards that apply to the mental health needs of children and young people, and review the relevant European standards and international human rights obligations. Set out the relevant legal and policy framework and examine whether reform is necessary to ensure the needs of children in the care and youth justice systems are met.

D **Economic analysis:** Examine current spending in meeting the mental health needs of children in the care and youth justice systems, including through private specialised mental health services in Ireland and abroad. Conduct a review of international research of cost effectiveness analysis of investing in the mental health of children in these systems.

ETHICAL APPROVAL

Ethical approval for the study was granted by University College Dublin Human Research Ethics Committee to consult young adults aged over 18. It would have been valuable to consult young people under 18 as well, in order to capture current experiences in the care or youth justice system in addition to the reflections of those who have progressed through the systems. However, this was not possible within the timeframe available for the study.

CONSULTATION WITH YOUNG ADULTS

The study involved in-depth interviews with eight young adults. These interviews provided an opportunity to learn about their experiences and

how services work from the perspective of those who have engaged with them. They were conducted with young adults who had contact with after-care services, with the intention of gaining perspectives on all stages of the state care process.

As part of the design process for young adults' interviews, two young adults with experience of the care system were consulted on the proposed interview questions, as well as on practical matters regarding the organisation of meetings. In the original design, focus groups were proposed in order to maximise the number of participants in the study and to allow for more interaction among participants; one-to-one interviews were offered if participants were not comfortable talking about sensitive topics in a group. All participants expressed a preference for individual interviews.

Interviews with young adults who had been in care were arranged through EPIC and Focus Ireland, both of which are agencies supplying after-care support services to yong adults, are members of the Children's Mental Health Coalition, and were available to offer follow-up support to young adults if necessary. However, this does carry the risk of some bias in the sample as only those young adults known to the partner organisations could be involved. Through several organisations, many attempts were made over several months to recruit young adults who had experience of the youth justice system, without success.

For the consultation, participants were provided with information on the study and given at least one week to consider whether to take part. They signed consent forms at the time of the interview. There were eight participants in the consultation with young adults, seven women and one man; seven were aged 18 to 24 years and one was 27 years old. A small token was given to each young adults in recognition of their contribution to the study.

Finally, we wished to ensure that the experiences of young adults with experience of the youth justice system would also be reflected in this report. Therefore, after-care agencies who engage with these young adults contributed brief descriptions of the experiences of the mental health needs and services of three young adults. This was with their informed, written consent.

CONSULTATION WITH PROFESSIONALS

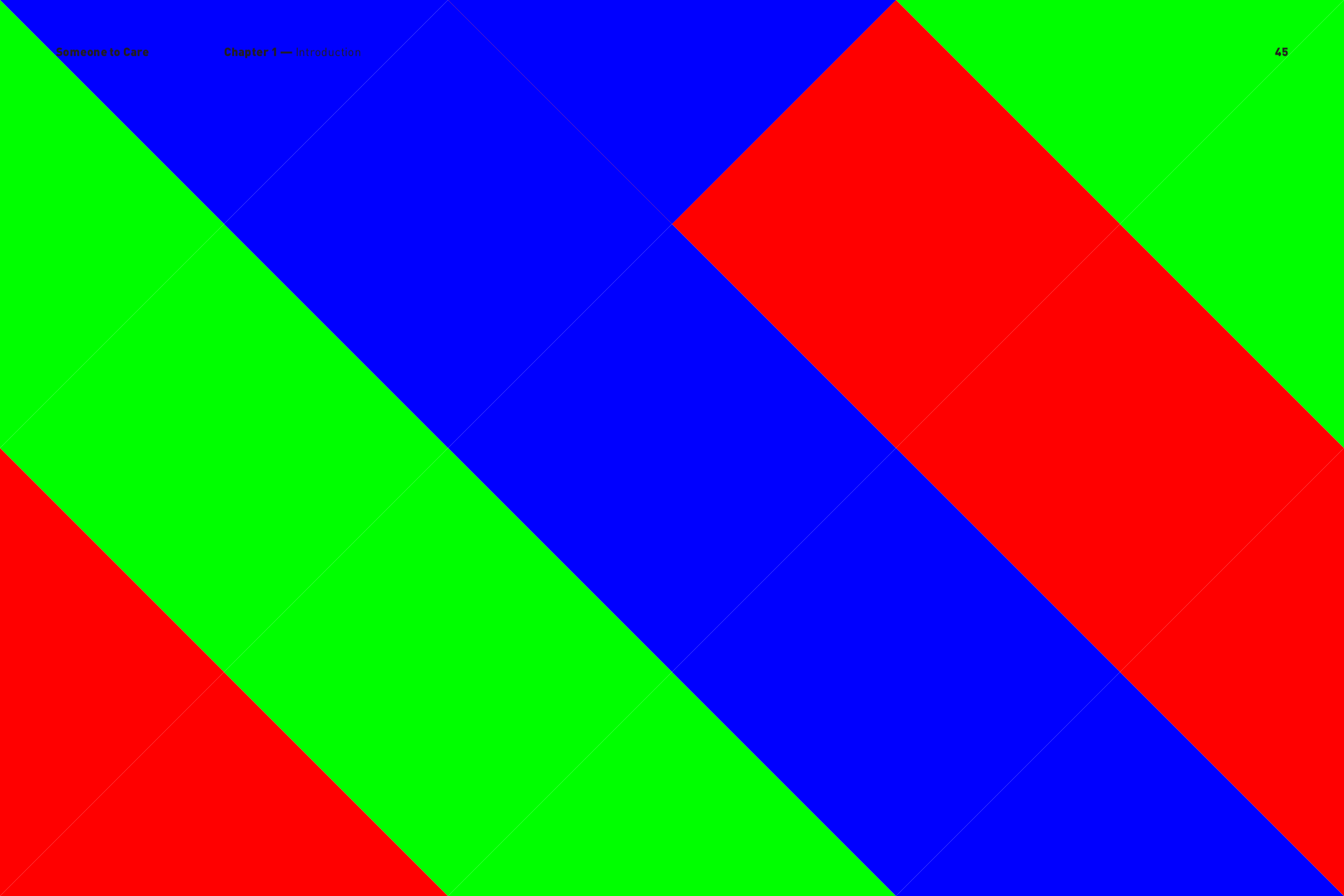
A series of focus groups and interviews with professionals who work in or with the care and/or youth justice systems in Ireland explored their views of existing services, barriers to service provision, and examples of good practice.

For this consultation, 24 professionals from 14 disciplines contributed their perspectives. The goal was to gain the views of professionals from the full range of services who have contact with children and young people in the care and youth justice systems. Purposive sampling was employed to ensure that a good range of professionals with experience and expertise in this field participated in the consultation process. Participation

was invited through a number of routes including through professional bodies, service provider agencies, direct approaches to individuals with expertise and 'snowball sampling'. Consistent efforts were made over several months to ensure representation of the views of various mental health professionals; including psychiatrists, psychologists, CAMHS social workers, occupational therapists and speech therapists, child protection social workers, education officers, youth justice workers (including those working in children detention centres) and lawyers, among others. Information about the study was provided to potential professional participants and participants signed consent forms. The topics of the interviews and focus groups were structured to address (i) definitions of mental health; (ii) barriers to service provision; and (iii) professionals' examples of good practice. Interviews and focus groups also took account of issues raised by participants and therefore varied according to the composition of each group.

REPORT OUTLINE

Part one of this report gives an account of the consultations with young adults who have experienced State care (chapter two) and the professionals working in the mental health, care, youth justice and education systems (chapter three). Brief case studies of three young adults who have engaged with the youth justice system are placed between the earlier chapters of the report. In part two, the report addresses contextual factors that impact on service development in responding to these needs. Chapter four outlines the many services in Ireland providing for children and young people in the care and youth justice systems. In chapter five, the human rights, legal and policy context of the care and youth justice systems are summarised. Chapter six provides an economic analysis of the costs of providing care and services to this vulnerable group. Chapter seven explores the research findings on practice in the field of mental health and related services that respond to the mental health needs of young people in the care and justice system and notes some models of practice that can address those issues. Finally, the report presents conclusions and recommendations.



PART 1
THE CONSULTATIONS

CHAPTER 2
YOUNG ADULTS' PERSPECTIVES

51 INTRODUCTION
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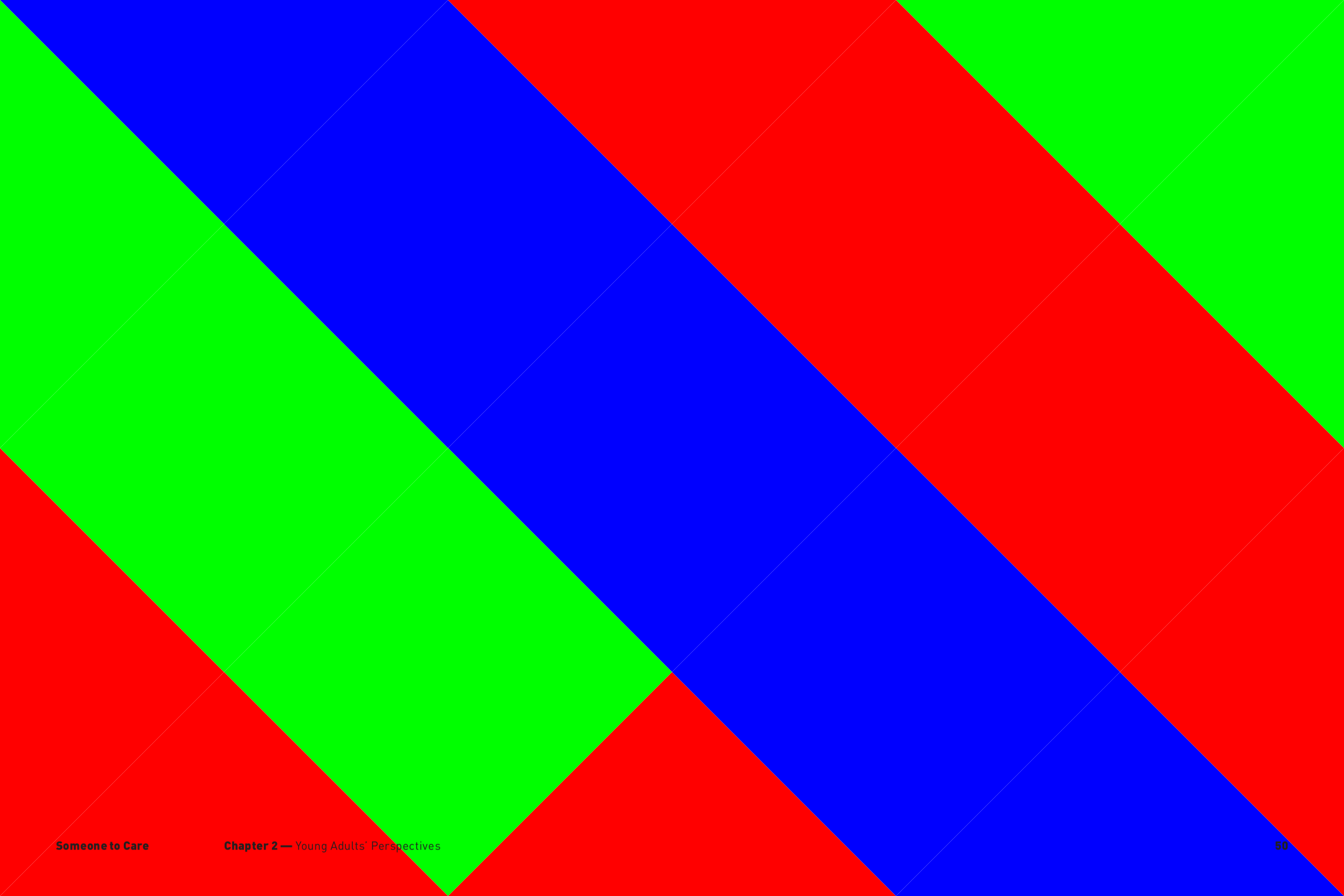

INTRODUCTION

Seven women and one man aged 18 to 24 years, with one 27-year-old, took part in individual interviews about their care experiences as part of this study. They entered care between the ages of one and 15 years, and each experienced between two and 23 care settings: relative foster care, foster care, residential units and secure units. Some had family support workers in the home or extended family care prior to being taken into State care. Some were aware that they were being taken into care; others were not. Some went into care with the understanding that they would shortly be returned home. Due to unforeseen circumstances – in one instance, the death of the child's mother – they remained in care. All participants are still in touch with people who cared for them in their former care settings, either residential care staff or foster parents, or both.

Their stories prior to going into care depict neglect, sexual abuse, parental alcohol and drug problems and parental mental illness. Each had a unique story that represented a history of trauma, some of which occurred before they entered care and some of which appears to have occurred within the care system. Their individual histories, their needs, and their views of the care system and the people within it are captured here.

This chapter begins with descriptions of going into care. Next, it describes the themes drawn from conversations with these young adults about their experience in care. These are engagement, trust and relationships; a sense of family, home and belonging; multiple placements, multiple relationships; that one significant relationship; family contact; education; stigma; and turning 18 and leaving care are highlighted. Themes in relation to outcomes are presented and include we were the lucky ones, deserving support, and thoughts on continuing relationships and facing the future. Finally, the chapter concludes with a summary of young adults' views of what is needed to support the psychological well-being of young people in care.

GOING INTO CARE

For the young adults interviewed, going into care was a difficult experience and they had clear recollections of the event:

> **Well at first it was hard because, the way we were told, it was horrible. 'Cause we were just having dinner one day and my mam came in and says, 'Oh yeah, by the way, you're moving'. And we were like, 'What?' So we were all upset. We were just really like 'What do you mean?'. (YA7)**

The first night in a residential care home was described as, **"nerve-wracking … 'cause I didn't know what to do, and I just stayed in my room. I was just looking up at my wall, and I was crying, and I was like 'Oh my god. This is going to be the rest of my life' " (YA7)**. Another young adult described the experience of being taken from her mother:

> **I remember the day they came to take us. They bribed my brothers with sweets and they were gone. We all went up into a room…**

> and I stood there and I was torn. Because I was a good girl, and I followed the rules and I did what I was told, and the social worker was asking me really nicely to step outside the room and my mother was saying, 'Don't go anywhere'. That's exactly how she … 'Don't leave, don't move, don't move'. She knew if I had left the room, I was gone. And the social worker was like 'Come on, your brothers are up here and you can give us a hand with them'. I was always able to settle the boys … and I left the room and I didn't see my Ma again for [several] months after that. And they'd nowhere to put us, and we went to [hospital] and we were on a ward, me and my two brothers. (YA6)

Following these early traumatic events, the young adults had mixed experiences in care.

EXPERIENCES IN CARE
ENGAGEMENT, TRUST, RELATIONSHIPS

Most of the young adults described difficulties in engaging with staff while in care, accompanied by pressure to open up to strangers, **"[You] have to deal with problems you're not ready to deal with and then being told you have to deal with it or you're not allowed move out of the place" (YA6).** This difficulty was, for many, exacerbated by the multitude of staff they had to interact with in their lives:

> And there's so many people in and out of your life, do you know what I mean, so many people wanting to… I just want to help this young person, and I just want to make their life so much better and all, and they're in it for the wrong reasons, and they don't fully understand. They don't see what's right in front of them. (YA8)

> You can't form kind of any close relationship with anyone, because you're probably not going to see them for another week, you know, and it's like I always kind of felt there was no point in me trying to talk to any of these, because they're all gonna be gone, or I'll be gone, or somebody would be gone. (YA4)

Young adults were very aware of the importance of forming relationships with staff members in residential units and foster care. Words like **'connection', 'close', 'really care', 'who I felt listened to me'** were used to describe positive experiences, or what they need in such relationships. Young adults described staff who did not seem to care, where it was just a job to them, and others with whom they formed close bonds. Having a connection was seen as a clear pre-requisite for being able to talk to staff, **"You could get a staff you don't get along with and the staff doesn't get along with you and they come and ask, and you're just like, "Go get out of my face!', you don't want them near you" (YA1)**. One member of staff was described as **"she's strict when she wants to be, but that's what we liked about her, because she had rules and boundaries" (YA1)**. And a foster father was described as **"just that type of person that you could just open up to. You know, even if he wouldn't want to hear it, he'd still sit there and try listen" (YA2).**

The young adults also described difficulties engaging with counselling relationships. One young adult came under pressure to engage in counselling but was not able to and feels that if someone whom she trusted had encouraged her to engage, that might have helped. Others described a lack of services, **"There could have been a counsellor, I desperately needed one" (YA5)**. One young adult spoke of difficulties engaging due to changes in counsellors, **"I used to go for counselling every week in there and then the counsellor I went to see, she stopped working in there, and I started with another counsellor, and then he stopped working in there as well, so I don't really trust counsellors anymore" (YA6).**

One young adult thought that too much emphasis was placed on formal help rather than allowing the young person to vent their feelings:

> **Cause it's all about, 'We'll define then we'll treat it'. She might not need treatment, she might just need to shout at you for an hour and get it out of her system and then she's fine, you know. I just I think it's very, you need to have your paperwork, and you need to be seen to be doing everything to protect the child, which is fine, so they have to be calling to doctors and they have to be getting all these people involved, and sometimes all you wanna do is just scream for no reason other than you want to scream. (YA4)**

However, when they were able to access the right help, it made a real difference to their ability to trust. **"If it wasn't for [the psychologist] I'd probably have a lot of trust issues still, 'cause what I did with him, it did take a while but I slowly got trust back in, or I learned to trust him over a period, and I'd say that did help me to trust more" (YA3).**

The difficulty engaging when in care appeared to stem from a number of factors: the young person's readiness to form a relationship; inability to talk about very traumatic experiences; changeovers in staff rosters and placement instability. However, the young adults interviewed were clear that they really needed to engage and to form relationships. One strong need featured in these conversations was the need to be understood. **"Just the one value would be, to have someone I felt could understand me, and who knew what I was going through" (YA3)**. Many showed insight when reflecting on how they presented while in care, **"I used to assault care staff, fighting with young people... But then coming to the end then I kinda needed to respect the staff, and show them my respect, 'cause you had to think they are human beings at the end of the day. And it took me a very long time to notice that" (YA1)**.

Another felt that staff attitudes didn't engender trust:

> **I trust nobody. I trust nobody. And these are things that I don't want to own. I don't want to own these feelings. I don't want to, do you know what I mean? ... 'We'll just rear them and get them out, because once they're 18, they're their own problem, and we don't have to deal with them'. I wasn't taught how to... I had to learn how to love myself. And these are things that proper counselling and all could have given to me, do you know what I mean. (YA8)**

At the same time, however, this young adult also felt that her time in care had had positive elements: **"I owe who I am, most of it, the good bits, to my experience in there" (YA8)**. Another also reflected a mixed experience, recognising that being in care was very difficult, but that it would have been even worse had she stayed at home:

> **At the time I would have said 'I hate it'. And now I would have said, 'It's the best thing that ever happened to me'. But that's because I know what could have, or what would have happened. I am certain what would have happened if I hadn't gone into care. So I can say now it's the best thing that ever happened to me. But when I was in care it was horrible. (YA5)**

A SENSE OF FAMILY, HOME AND BELONGING

Striking comments by some young adults referred to their sense of isolation and aloneness. **"Basically you're on your own against the world" (YA1);** and **"I'm still stuck dealing with everything on my own" (YA5)**. In contrast, others described their placement setting as **"home"** and discussed the importance of feeling a sense of belonging there. One young adult described her feeling when visiting her former residential unit: **"It feels like home" (YA2)**. She did not feel this about her subsequent, long-term foster placement. Another described her residential unit very warmly as **"family", "Oh my god, it was so great, it felt like I was in a family. It felt so cool, it was just amazing...It's like they're all my mammies, not even my mammies, my big close sisters. They just make you feel so good" (YA7).**

Two young adults described their foster families as their 'real' family:

> **I think kind of when they were fostering they were looking for to create a family... They were looking for their own children and then we became that... It was very much a family home, and we felt that, you know, even though we didn't have their name and we weren't actually theirs, we felt it I felt it you know I felt the love. (YA4)**

"My foster parents were really the only family I ever had really. So they're my Mam and Dad and they see me as their daughter" (YA5). Not all foster families offered this experience; one young adult described being sent to emergency care while her foster family went on holiday: **"You know I wasn't part of that family unit and I was the outsider to not be included" (YA4)**. Another example of lacking a sense of family and belonging was when biological children were treated differently to foster children in not being allowed to have friends over, or having to take showers at prescribed times.

MULTIPLE PLACEMENTS, MULTIPLE RELATIONSHIPS

The difficult experience of multiple placements affected young people's need for stability to form relationships with staff, make friends, and achieve good educational outcomes:

> The way I was just thrown to meet with people and to build a relationship with them and then going from one relationship to another relationship with someone and then another one, and just kept going on and on and on. And it took me ages to build a relationship with anyone... And actually building up that relationship to actually talk to them and opening up to them and then you're told that you're moving. (YA6)

> It was very unsettling because I wasn't able to attend courses or schools because there was moving all the time, so... It was kinda hard. (YA1)

Even within one setting, young people had difficulty forming relationships with so many carers, **"You could meet 20 different people in one week; who are you meant to form an attachment there like? Who are you meant to go to?" (YA4)**. **"There's no kind of continuity within it or there's no kind of stability" (YA3)**. The lack of continuity in relationships with social workers and other professionals was also challenging:

> I'd ring and I'd be asking for whoever me social worker is and you'd get, 'Oh, no, sorry. She's moved on. Your new social worker is...' whoever it was. Nice to be informed of that, it was nice for the new one to ring me and say, 'Hi, I'm [name] I'll be your new social worker'. (YA2)

One young adult described having many social workers: **"I couldn't tell you how many social workers I've had. There have been that many. I know that a lot of the time I didn't have social workers" (YA5)**. Earlier she had a social worker for seven years and had appreciated that continuity:

> The social worker I had when I was a kid was great. As a kid she would have got stuff for us for Christmas or that kind of thing, she would have come to the communions or whatever. It's not like now, you're a social worker for a year or two. You were a social worker for years then. My parents had the same social worker for years. (YA5)

THAT ONE SIGNIFICANT RELATIONSHIP

All of the young adults described at least one person with whom they formed a bond while in care. Three formed close bonds in their foster families, with a foster father and co-fostered sister and with their foster parents. Many formed close bonds with the professionals or staff they met, including a family support worker: **"She'd be on our side. I love her. I still see her now"**, and a social worker and counsellor **(YA7)**; a course co-ordinator: **"She's probably one of the nicest people you'd ever come across" (YA6)**; a staff member of a care home with whom the young adult went to live with when things fell apart: **"I was really close with her" (YA6)**; a service manager (YA1); a psychologist (YA3); and a social care worker:

> You knew where you stood with her... She was just, she was stability... She was kind of my beacon she was. She'd always know what I was doing, where I was going, and how I was feeling, and

> she was kind of my coping mechanism really, and I owe a lot of my kind of success and how well I've done to, kind of, her and how much stability she provided for me. (YA4)

Others spoke of professionals along the way that made a difference; primary or secondary teachers, guidance counsellors and Home School Liaison Officers. These helped in various ways, for example contacting social workers because of concerns about neglect; noticing scars from a young person cutting herself; listening to a first disclosure of sexual abuse; or visiting after the death of one young person's mother.

As young adults reflected on the time they had spent in care, their thoughts and perspectives were very mixed. One wished she could have had:

> Someone I felt could understand me and who knew what I was going through, but again that's an impossible thing to ask for. 'Cause most children in care the staff don't know what you're going through, 'cause they've never been there, they may have read about it, they may be trained to deal with it, but they don't know what that person is going through. (YA3)

FAMILY CONTACT

Contact with family of origin varied for the young adults interviewed. The degree to which reasons for lack of contact had been explained to them varied as well:

> I didn't see my mam or whatever, but now I know that I couldn't see her because she wasn't able to you know, she wasn't able to you know be there for us or whatever and I understand that now, but as a child you're thinking, 'Well these must all hate me', you know and, 'They're not letting me see my mammy'. (YA4)

Young people's rights to decide about contact with their families was raised by one young adult:

> Because when I wasn't talking to [biological father], that was my choice. He said it was his but it was mine, but they started pushing that I had to have access because there was a law somewhere saying that a child has the right to see an adult, to see the parent. And they pushed that so much. (YA5)

An issue highlighted by two young adults was the absence of information about their experiences and their family histories, **"It's like your mam and dad can tell you everything you done as a child, I don't have that. Who do I ask about my birth, you know? Who do I ask about the first time I rode a bicycle, you know? You don't have that stability, you know, when you live in care" (YA4).** Many young adults, because of being taken into care so young, were unaware of their early family history. One described that her relatives are now deceased so there is no one to ask about her mother and her family. **"If I wanted to know her favourite colour, there's nobody now to ask" (YA5)**. They described attempts to access records that would give them information about themselves. However, this was a difficult

experience, **"At 18, when I was starting to think, 'God, I'd like to know,' and it was only bad things that I was told, or mostly bad things, very little good, there should have been more support there" (YA5)**. The same young adult felt she should have been given more information about her family while she was in care:

> **They can't give information because of confidentiality. And that is a big, big problem. I wouldn't know from one day to the next if my mother... was in hospital or not in hospital. And I know that it's the exact same now for kids in care. Fine, you don't tell a five-year-old, 'Well, mammy's after slitting her wrists,' but at 15 why couldn't it have been said? (YA5)**

EDUCATION

Multiple placements had an impact on some young people's education. One young person, due to challenging behaviour, experienced a number of changes in second-level school. **"The one thing I always stuck with is my education though. No matter what I went through like, even if I was off my face, I'd still go in and do my courses and do what work I needed to do" (YA6)**. One was doing very well in school until they were told they were not returning home as they had expected; they then dropped out of school. Another participant spoke of potential that was never realised because they were returned home. **"I could have been so much more, do you know what I mean... I didn't reach my full potential because of all the issues that I had" (YA8)**. One person spoke of the determination of her care worker to ensure that she stayed in the same school throughout her care experience. This young adult worked to support herself through college. Another has tried various courses and struggled to find the area they want to study in.

STIGMA

Young adults spoke of the stigma they experienced from other young people and from adults, associated with 'being in care', and of not telling others in school that they were fostered. **"Living with the 'Oh you're in care! Have you ever been in jail?' or 'You rob people!' that kind of thing, 'You do drugs, you do drink' " (YA5)**. One took her foster parents' surname to avoid this. **"I had their surname rather than my own. So it just saved... I just hated people knowing and it meant that they didn't have to" (YA5)**. Three young adults mentioned the need to be seen as normal: **"To just live as a normal teenager would" (YA3)**; **"It's not natural to go through what we go through, it's not natural" (YA6).**

TURNING 18 AND LEAVING CARE

The young adults interviewed were all contacted through after-care or support agencies, so all were linked in with services. However, their stories depicted the challenges on turning 18 and leaving care; for many, this is a critical time. Some had left care before their 18th birthday while others remained in supported housing. Two described the experience of turning 18 as distressing. **"It hit me like a ton of bricks. I was crying and all I was, after I left care. I didn't know what to do... I didn't know what to do,**

where to go, who I was" (YA1); "On my 18th birthday I sat out on the stairs by myself, crying by myself... It should have been one of the happiest times of my life. But it wasn't. I remember it was horrible. And I remember not knowing where I was going to go" (YA8). She had been returned to family care when 14, and was "thrown out" of home by her mother at 16. "It was probably the biggest mistake they ever did, should have never sent me home. From there my life proceeded to fall apart. Completely, absolutely completely, the support all dried up" (YA8).

Turning 18 was seen as a frightening and difficult transition. "It's a big bad world when you turn 18, and the children in care don't know what is gonna hit them" (YA1). The expectation that young people would be able to cope on their own at 18 was seen as too much:

> I don't know anybody who at 18 who would say to you I am a fully functioning adult... I mean even the term 'after-care' it implies an end to your care, it's like you're almost like 'Right, get out the door now. We're done with...' Eighteen is kind of, you're going out for the first time, you're starting college, or meeting new circles of people, you're doing things that are very different to what you would normally be doing. It's a different transition but it's just as stressful and as emotional for a young person... If you need care up until you're 18 you're not going to automatically not need care when you're an hour after 18. (YA4)

Young adults' experiences on leaving care were varied. One became pregnant at 18 and managed to get a deposit together for a "shed built onto the back of a house, right, just a brick shed" (YA8). After the baby was born she went to live with her boyfriend and his family until she got her own apartment. Another participant loved having her independence, but struggled with the practicalities of budgeting for rent and shopping. She didn't pay her rent in her first apartment and was "thrown out", "So then I just had to nail it on the head; the rent gets paid first, before the smoking, before anything." The fear of homelessness loomed large for this young adult, "I didn't want to be on the streets. I just think reality kicked in. If I don't have this house now, I'm gonna be on the streets" (YA1). Two young adults described a smooth transition at 18; one stayed with their foster family and another moved into an apartment close to their foster family.

Experiences of support varied. One young adult was moved from her residential unit, against her wishes, into an apartment "I hated them for doing it... It just fucked me up completely. When I moved out I just completely went downhill. That was it. I didn't want anything to do with anyone, I just went mad" (YA6). Another who was in foster care experienced pressure from the HSE to move to an after-care placement, even though she and her foster parents were happy for her to remain. After-care workers were generally seen as a positive support: "That's one person now that I have a lot of time for" (YA1); "If I didn't have that after-care worker I would be in quite a lot of trouble right now probably homeless or whatever" (YA2). One young adult however noted the importance of getting along with this person: "I told them from the beginning I never wanted to work with her. I didn't get on with her. I wasn't able to talk to her" (YA6).

OUTCOMES

Most of the young adults interviewed described themselves as doing well. They have stable living arrangements, some are in relationships, two have recently finished college and are seeking work in the social care sector, while another is trying to get into college to study social work. One attends an adult mental health service; her baby lives with her boyfriend and his family. Although she sees him every day, **"I don't have a say in anything that goes on with him. That's what kinda kills me" (YA2)**. One young adult is doing well except for health issues. Another is back living with her family but tries her best to keep a distance, **"I don't even want to move anymore, I just isolate myself from everyone and just sit in my room all day and don't do nothing" (YA6)**. One young adult enjoys freedom and independence now:

> **I never seen meself having me own place, and having what I have now, me boyfriend, and having everything I have now that I love having. And I love having me own freedom. That I could wake up at six in the morning if I wanted to and just open me front door lock and go out for a walk if that's what I want. It's just the sense of your own independence. (YA1)**

There was a strong sense from these young adults that they believe they did well, that they were lucky compared to other people they knew in care, in terms of their placements, their life choices and their capacities. **"I was lucky. I was lucky to be where I was put" (YA7).**

> **I've been around gear, friends of mine that killed themselves off gear, that cut their arms so bad they got a skin graft. I seen it all, like, in my time in care. That's why I came out better than all them'd come out.... I came out better because I didn't choose to go down that wrong path like a lot of other people in care. (YA1)**

One young adult described a disadvantage of coping well; she had received less support and had to work three jobs through her college years, while her brother who uses substances receives many supports:

> **I feel like, yes, we had a shit childhood, yes, our path was probably a bit laid out a bit for us, but I chose to do what I'm doing now and to go to college, he chose to go down there and do whatever he was doing, so I don't see why people who make the wrong decisions get all the help when the people who try to do the right thing get no support. (YA3)**

Many of the young adults described on-going contact with staff members from their time in care. Such contacts included a young adult calling regularly to the residential unit where she lived, **"I'm always up there like and eh so every so often I'll go up and be like [jokingly], 'I'm not going home. I'm not going. You're gonna have to drive me out' " (YA2)**. Another said a manager from a unit rang her recently, after seeing the young adult had posted on a social media website that she was feeling down. One young adult moved in with her ex-social care worker and her husband as she was going through a difficult time. Another had maintained regular contact through multiple changes with the manager from the first unit she lived

in, and ascribed her successes to this relationship, **"I maintained contact with her through all my placements, I'd kind of meet her once a week, we'd always touch base, she'd always know what I was doing, where I was going, and how I was feeling, and she was kind of my coping mechanism really" (YA4).**

Some of the young adults described good relationships with their biological families now: one has siblings in care and they see each other weekly; one reconnected with their biological father while in care; while another has made contact since leaving care. One young adult described good supportive contact with their biological parents. Two young adults have no connection with their biological siblings or parents.

NOW AND THE FUTURE

Finally, the young adults in the consultation reflected on their experiences and their sense of themselves at the moment. For some, it is very challenging. **"It's so difficult, the loneliness, because I've still got no family. I've got no mother, I've got no father, like, that's not normal" (YA8)**. Others had the sense that they could see the good in life, despite the difficulties they face. **"I'm very good at drawing positives out of negatives" (YA3)**. Others were actively building for the future:

> **I've been staying on the good road, trying to get meself into courses and whatnot. It's just I think the reality of being 18 you're an adult now so you can't really, people are beyond tolerating you acting like a child, 'cause you're an adult... When I was younger I didn't care about my life, and I didn't think I'd live to be 18 to be honest with you. But now I feel looking back, I was lucky I didn't turn out like that because I'm very strong. In the inside like, I'm very strong, but it took me a very long time to cop on to that. To how strong I actually am. (YA1)**

WHAT YOUNG ADULTS SAY IS NEEDED

In the consultations, the young adults described many ways in which the system needs to respond to the mental health and well-being needs of children in care. Some of these are implied by the experiences described above, and participants also reflected directly on this question, and drew on their experiences as well as those of people close to them. The needs they described are grouped into three overarching categories. They are: the need to be understood, the need for better services and the need for child-centred care.

THE NEED TO BE UNDERSTOOD

This need was central and was expressed by all the young adults who participated. They wanted someone in the care system who understood them and who appreciated the challenging circumstances that had brought a young person into care. When asked what professionals could do to help young people more, one respondent noted:

> **They have to give you like a bit more understanding like. The kids are in care for a reason, they're not just in care for the good of**

> their health, they don't want to be there, they'd rather be at home with their families, well some of them wouldn't, but they'd rather be at home with their families, so they have to like, give it a bit of, do you know what I mean, meet them half-way. (YA1)

In order to feel understood, young adults wanted stable relationships in care, and time to get to know people they were expected to confide in. **"I think they should firstly get to know the person before they even try start talking about anything. And they should be a stable person for them to talk to" (YA7)**. Several felt that understanding could only come from people with experience, either of the care system, **"Knowing that someone who's talking to you isn't just talking to you from a book, you know, they actually have that experience" (YA4)**; or of life and emotions, **"More savvy intervention, do you know what I mean, you need people who are clued in to life and reality, do you know what I mean, emotion, feelings... You have to have had some level of hardship in your life to have that level of understanding. I don't think you can teach experience like that" (YA8)**. They said too many people in the care system were theory-focused:

> It's very much, theory to practice, like, 'This is resilience theory in its finest right here', or 'This is attachment theory. That's an ambivalent attachment there if I ever saw one', you know, like, they don't have that kind of insight. (YA4)

THE NEED FOR BETTER SERVICES

All the young adults said that services for children and young people in care and after-care should be improved. Services needed to be made adequate, one simply said:

> Interviewer: What do we need to do to help young people more?
>
> YA5: Proper services [laughs].

Others mentioned specific aspects of services. Several wanted more stable placements in care:

> Being put somewhere, knowing that I would be there until I was at least 18. Being moved around all the time, that has an impact on everyone. To this day I'm just constantly moving and moving and moving. (YA6)

Another felt that children should be sent to foster rather than residential care:

> I just think for young people going in, it shouldn't be residential care, it should be foster care, you know, and it's important to kind of make that attachment early you know, but that foster care needs to improve: more kind of efforts need to be put into the services being improved for foster care. (YA4)

One young adult felt that support would have been more effective when she was younger:

> There's not enough intervention early enough, do you know what I mean. To save yourself, you put on a façade, and people need to see through that, do you know what I mean, that's where it's going wrong, and they think because you're young you don't need it yet, but if I had been helped with my self-esteem … when I was that young, do you know what I mean, when it could have sank in and I could have believed it. (YA8)

Several valued life story work which care staff had done with them, or wished they had had it. "It's nice if you can try and capture a small bit of it, and put it in a book, you know, it's nice for anyone to have them kind of memories" (YA4).

Another reflected on a sibling's struggle to access services for multiple needs:

> There's no one service that deals with a dual diagnosis, so he goes from one place for his mental health and he goes to another place for his drug addiction, and then he goes into rehab and he can't take the drugs he's been given for his schizophrenia because it's a drug-free zone. (YA4)

From this, she concluded that a single co-located service should be created to meet young people's complex needs: "One service that will actually deal with a person with drug addiction and mental health, you know, go into the one building and get the one lot, rather than going from south Dublin over to north Dublin you know" (YA4).

Three participants wanted to see less formal and more communication-friendly mental health approaches and settings. One visualised a centre for young people: "I'd open up a centre, and it would be a mental health centre, but it would not be called that. I would call it… Chat If You Want. That's what I would call it, Chat If You Want. And you could come in, you could have regular appointments, there would be a place where you could have tea" (YA7). The centre would include punch bags, beanbags – "just to chill and relax or do meditation" – and opportunities for younger children to draw, sing and play with toys. Staff would be trained in "what not to do" – they should not pressurise children into disclosures but should allow this to happen over time. Another young adult imagined a similar service with a relaxed atmosphere: "More chilled out… Just that they can feel comfortable and where they feel like they can just express what they want to feel" (YA1). One young adult proposed a helpline specifically designed for children and young people in care: "I would love to see something along the lines of Childline but for kids in care. I would love to see something like that. Specifically for kids in care… where if someone were stranded or if something went wrong there was somebody at the end of a phone where they could get to" (YA5).

After leaving care, participants felt services were still crucial and should be available to all: "It needs to be what they 'will' provide not what they 'may' provide if they decide to" (YA4); and social workers should make after-care plans for all. Participants said all young people leaving care needed help with practical skills such as budgeting. "Like, someone who

would sit down with them and go through their money with them and with knowing what their entitlements were" (YA2), e.g., paying rent, managing household tasks and help with services such as the community welfare officer. At this time in their lives, when they often sought information about themselves and their families, they wanted assistance with this process, which several described as requiring engagement with multiple services and dealing with distressing information. **"I heard some awful things about my mother and awful things that she did then. And at 18, when I was starting to think, 'God, I'd like to know' and it was only bad things that I was told, or mostly bad things, very little good, there should have been more support there" (YA5)**.

THE NEED FOR CHILD-CENTRED CARE

Finally, young adults described the need for child-centred services that were based on their individual needs. To achieve this they wanted children in care to be actively listened to, to be told the truth, and to have someone to advocate for them. One young adult felt that while adults might listen to children, they don't necessarily attend to what is being said, **"Not many kids who're in foster care actually get listened to. Well, they do, but it goes in one ear and out the other. As fast as they're talking, it's gone" (YA2)**. The same participant also wanted frequent inspection of foster homes and separate conversations, to avoid intimidation:

> **And one thing I would say, is do not have foster parents sitting in the same room as a child when they have the inspectors in. Because I had that, and I'm not messing, I felt so tiny when she was in that room. 'Cause I couldn't really open me mouth, 'cause she was looking at me like, 'Mmm, if you say that now, you'll be in trouble after this'. (YA2)**

Linked to the need to hear what children have to say is a need to be honest with a child, even if there was difficult news to break. **"Even if it hurts the child they need to know the truth... Like even if you know you'll upset the child, it is much better to do it early on, instead of them building their hopes up and up" (YA3)**. When people in the care system were honest and gave children a voice, this was appreciated. **"Yeah, 'cause I remember when social workers said to me, 'Your first ten minutes will let you know if you like them or not', and she said, 'You don't have to, you don't have to live with them, just because they want you doesn't mean you have to' and she was very straight as well about the whole thing" (YA4)**.

The interviews also highlighted the need, during and after leaving care, for person-centred approaches. One highlighted the service that EPIC provides, **"EPIC is individual, and it's person-based, it's not kind of 'Aw, she's 18 and she's had this, so she must fit into this category,' you know, it's very individual, you know" (YA4)**. Another noted that services are not matched to a person's level of need, **"When I needed it the most, they weren't there. When I didn't need it they were there throwing at me" (YA6)**. The value of a person-centred approach is highlighted by the range of needs young adults felt they had. One suggested that for some, a light touch was needed: **"A social worker that calls you once a week, just one phone call, just to see how you're doing ... all they might need is just a**

friendly phone call and to know that there is someone there if they do ever need somebody" (YA4); in contrast, another felt the need for long-term individual therapy: **"There needs to be like, serious psychotherapy needs to be done" (YA8)**.

The challenge of interpreting what being 'child-centred' means is illustrated by the view some of the young adults have now, that they needed therapeutic help while in care, even though they were unaware of it, or resisted it at the time. One believes that experienced care or therapeutic staff should have picked up on a need she was unaware of when younger: **"If I had been helped before I knew I needed the help, do you know what I mean" (YA8)**; while another pointed out that she had not wanted counselling then: **"No. No, not at the time I didn't, no. Not at all, not at the time"**, but had a different perspective now: **"Now I think I probably should have. I don't think any kid should go through that without talking to somebody" (YA5)**. However, a third young adult's experience was that being pressurised into therapy had been harmful: **"When you're being forced into it and you're actually really not ready to do it, it just totally... it makes you worse than what you really are" (YA6)**.

Finally – and linking back to the need to be understood, expressed by all the young adults in this study – participants said that young people in care need someone who knows them and can advocate for them. What is needed, one participant said, is:

> **Having that one person. That one person who knows you inside and out, and it's very difficult to do that if you're in care. The people can't get to know you well enough because they're chopping and changing. That's where they're going wrong. (YA8)**

She also explained she would have wanted this 'one' person to have an advocacy role for young people in the system, someone **"To fight for the services. And people weren't fighting for me, do you know what I mean" (YA8)**. When the State cares for young people, therefore, one young adult summed up, it should apply standards which are applied to all other children, **"I just think, yes, they're living in care, and they've come from crap backgrounds, but that doesn't have to define them, I mean treat them like the way you would treat your own child, any other child" (YA4)**.

SUMMARY OF CONSULTATION WITH YOUNG ADULTS

The young adults shared many insights into their experiences in care, including their own and their families' mental health experiences, and they contributed thoughtful reflections on how services should support the mental health needs of children and young people in the system.
A core need they described was to feel understood by at least one person caring for them. Having stable, good quality placements and stable, on-going therapeutic relationships was important to achieve this. Improving foster care with training and inspections was also important. In addition, it was suggested that being cared for by people who had life experience or personal experience of the care system was necessary. Young adults said they needed to have someone in their life who knows them and who can advocate for them.

Overall, the young adults believed that mental health services needed substantial improvement, and that services should be person-centred. They should be flexible enough to respond to levels and times of need, and professionals need to exercise good judgment in deciding when to offer therapeutic support, and when not to. They noted that services should be less formal and more youth-friendly; and a dedicated helpline for children and young people in care was suggested. The right to after-care for all was raised and it was noted that this should include support for the challenging process of accessing information about their histories. Finally, when caring for children and young people, young adults noted that professionals should listen to them, and they should hear what they say.

YOUNG ADULTS WITH EXPERIENCE OF THE YOUTH JUSTICE SYSTEM: CASE STUDY 1

—

Seán (not his real name) who is 20 years of age, was taken into care shortly after birth and remained in care due to difficult, on-going family issues. He experienced several care placements; these were in foster care, high support and a long-term placement in children's residential care. Seán is a highly vulnerable young person who experiences low mood and suicidal ideation, which he associates with his childhood experiences. He worked well with his childhood psychiatrist; she extended her care to support him when he was moving from his long-term children's residential unit, which was a difficult transition. He has presented at local Accident and Emergency services with challenging behaviours. On a few occasions, when Seán was under considerable emotional stress, and when using alcohol, he received charges for public disorder and minor offences, and was placed under the supervision of a Junior Liaison Officer.

When Seán transitioned to adult mental health services, he attended on three occasions, and was seen by a different member of the team on each occasion. Having to explain his situation again each time, he became very distressed and refused to return. At this point, the after-care support agency advocated on his behalf and the consultant agreed to see him personally. The consultant reviewed Seán's medication with him; Seán decided to come off his medication in a planned manner, which he completed successfully. During this process, however, Seán was told that he had been referred to the wrong mental health services catchment area and that he now needed to move to a new mental health team. Once again, when attending his appointments, he was seen by different team members on each occasion. He became frustrated and has not engaged further with adult mental health services, as he found them anonymous, difficult to access and unsupportive. Seán has moved on to more independent accommodation now and relies on his GP for support when he requires it, as he feels that adult mental health services do not meet his needs.

CHAPTER 3
CONSULTATION WITH PROFESSIONALS

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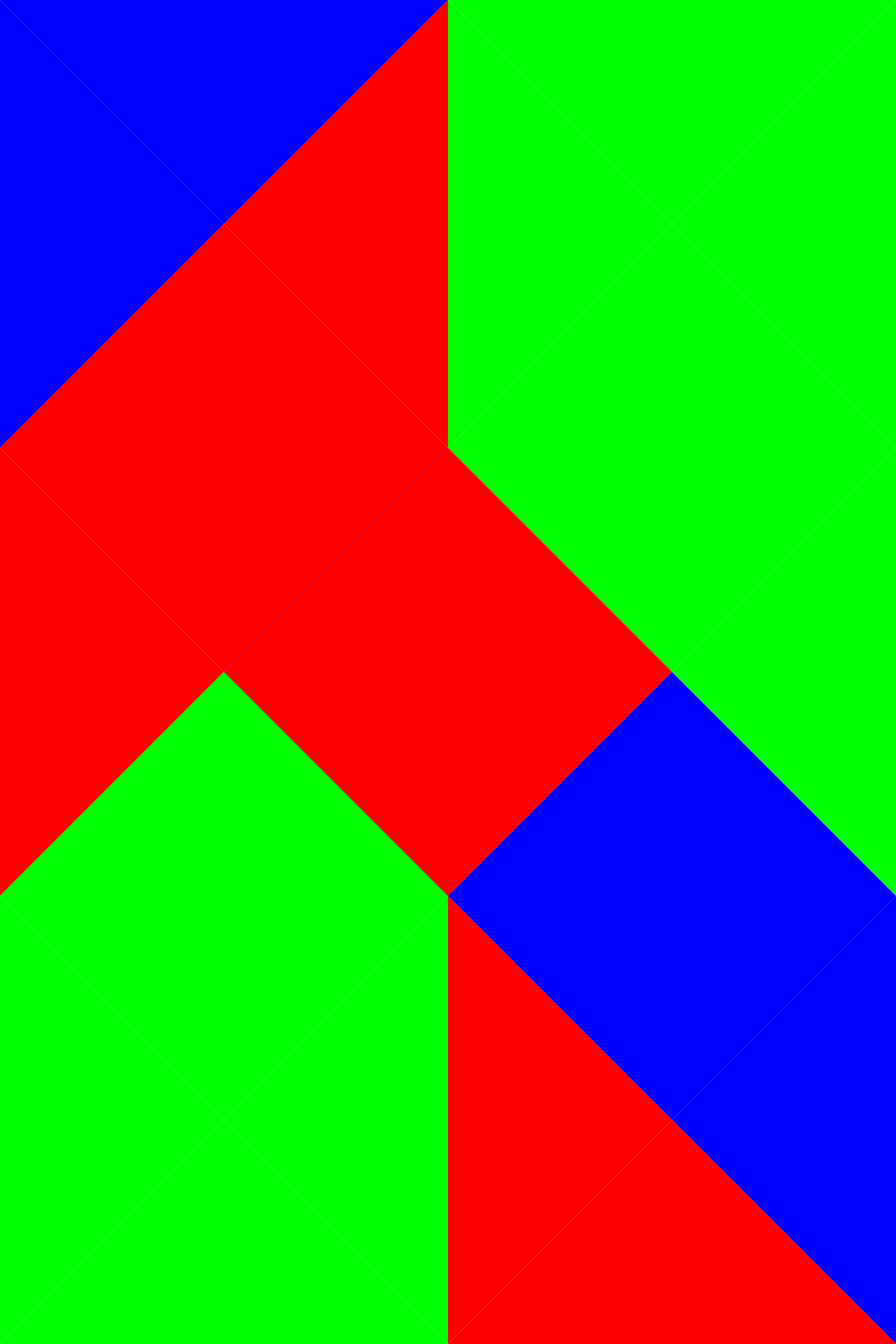

INTRODUCTION

The consultation for this study included 24 professionals from 14 different professions in the care, youth justice, mental health and education systems. This chapter first addresses professionals' views of the mental health needs of children and young people in State care and in the youth justice system in Ireland. Next, it outlines their thoughts on the challenges within the system. Finally, the chapter notes their views of current successful approaches, before summarising what professionals believe the State needs to do to improve the mental well-being of children and young people in its care and youth justice systems.

A TRAUMATISED AND TRAUMATISING SYSTEM

Considering the diversity of professions consulted, it was notable in the consultations that there was considerable consensus among professionals on the need to address mental health needs of these young people as a matter of priority and a collective recognition of the State's failure to provide for these young people. Overall, professionals concurred that children in care and the youth justice system have considerable, very complex mental health needs that are not being met; that levels of poor family functioning are rising; and that children in care, who are already traumatised by early experiences, are being further traumatised by the system itself:

> **The single biggest impact on kids' mental health and trauma, which is – I prefer trauma because that's what they've been through in my experience – is the system itself. (Psychologist)**

According to participants, the system traumatises children particularly by failing to provide appropriate, stable placements and mental health supports for them. These failures escalate the level of need, as does the lack of early active intervention. Together, professionals argue, this increases the financial burden on the State and, rather than meeting the needs of the most vulnerable in society, is contributing to their difficulties.

Professionals also believed that the system itself is disturbed by the nature of the experiences of the children and young people in its care, as well as by their behaviours. These include self-harm and aggressive and sexualised behaviours, which it was noted, are frightening to carers and to the system. Professionals noted that traumatised and vulnerable children project anxiety and risk, yet there is inadequate support and training for staff working with them. Professionals also experienced the system as chaotic and lacking in scrutiny and accountability. The combined result of these various factors is that professionals and the system are "**running around in crisis, trying to prevent tragedy, rather than planning from the beginning" (Psychiatrist)**.

MENTAL HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE

MENTAL HEALTH AND COMPLEX NEEDS

All professionals involved in this consultation viewed mental health as extending beyond the absence of illness. "**Particularly for this group of**

children, we need to be thinking about mental health as a much broader thing… a biopsychosocial developmental model" (Psychologist), a model which needs to encompass behaviours and factors beyond psychiatric diagnoses.

> **Psychiatrists would see them and say there's no illness, and in many cases there is no illness, but you still have the behaviours, which are very risky to young people, to their families, to society and they continue to remain at high risk of either injury through trauma, through violence or whatever, regardless of the fact that there's no illness there, the risk remains. (Psychiatrist)**

They described mental health as encompassing well-being; welfare; safety; the ability to form good relationships; and emotional literacy, which one participant defined as the **"Ability to recognise in others and themselves a variety of emotions" (Diversion project manager)**. Overall, this meant the capacity to cope with life's challenges, **"Being able to deal with what life throws at you" (Psychiatrist)**. Professionals stressed that many children and young people in State care show exceptional resilience, **"There's lots of kids who have shown the most unbelievable amounts of resilience that, you know, a child in the general population would never be able to" (Social worker)**.

Professionals encountered many mental health and developmental difficulties and diagnoses among the children and young people in their care. These included attachment disorders, attention and hyperactivity difficulties (including ADHD), autism, learning disabilities, speech and language disorders, depression, self-harming, drug-induced psychosis, conduct disorders, poor impulse control and anger issues. A particular challenge is that children typically present with multiple, complex needs; a psychiatrist noted the clusters of diagnoses often seen:

> **If you have a young kid in care who has an attachment problem, is probably traumatised, may be substance abusing, is probably dyslexic or might have a learning disability … it would be quite typical. They'd have multiple difficulties, and they're very hyperactive and impulsive. (Psychiatrist)**

Speech and language needs were seen as interlinked with mental health. Professionals see a high incidence of disorders such as dyslexia, communication difficulties related to impoverished vocabularies, and other language disorders, any of which can lead to difficulties in school and social relationships if left untreated.

A high incidence of anger and aggression was also noted: **"I suppose we'd see the very high levels of aggression… And we've gotten to the point where we wouldn't even call it anger issues. What we're talking about is rage" (After-care service manager)**. Some saw anger as masking sadness and distress, while others noted underlying substance use and poor emotional literacy. Substance use was linked to mental health issues such as depression. Professionals noted that some mental health issues were drug-induced, while in other cases, substance users were self-medicating for mental ill health.

Broader mental health needs noted by professionals related to identity, relationships with family and friends, social skills, and self-efficacy and self-esteem. Identity and a sense of belonging were cited frequently, as were relationships with family, foster families and friends:

> Helping the child to have a sense of belonging, to have a sense of containment, to have a sense of care, and a sense of people caring about them... a genuine opportunity to learn more appropriate relationships, how to regulate themselves within those relationships and how to develop attachments. (Psychiatrist)

> They want to be supported in their primary relationships with their peers and with their families. You know, the key to success for young people is ... being able to build relationships with others. (Social worker)

To facilitate relationships, children and young people in care and the youth justice system often require social skills development:

> One of the huge issues for them is, is the lack of social skills to enable them to socialise, to negotiate, to deal with issues, confrontations. They don't have the skills to do that, so their reaction is often to confrontation, to lose their temper, to abuse people, to hit out, strike out at people, from a very young age. (Senior prison official)

In addition, professionals in the youth justice system noted a lack of self-efficacy, the sense that children and young people can affect their own life outcomes:

> That kind of belief that they might be able to alter the course of their lives... There's huge resistance among young people ... to even considering an alternative path... They would say things to me like "Sure everybody gets arrested, everybody gets charged, everybody goes to prison". (Diversion project manager)

Interestingly, professionals identified low self-efficacy as occurring together with low but also high self-esteem.

Finally, transition from care and after-care were noted as particularly vulnerable times: "When young people leave care they face enormous issues. Isolation is often one of them and if you have mental health issues, then that will exacerbate it" (Social worker). After-care workers noted that some young people dreaded turning 18 and struggled with the many adjustments they were required to make. Issues with birth families and questions of identity were added to challenges of new living circumstances or homelessness:

> And the process of leaving care as well can bring up a lot of emotional problems for kids ... It's another rejection for them, and that's when I find a lot of the kids regress again. (After-care worker)

Despite these complex and prevalent mental health needs, there was a perception that professionals are reluctant to engage with them:

> **There is a fear of mental health concerns among professionals in Ireland. There is a fear, and there's a reluctance, and there's a concern that if you actually focus on a mental health concern for a young person, you're opening up a Pandora's box, and it's better left, and that's a cultural shift we'll have to do. (Solicitor)**

STIGMA, LABELLING AND DIAGNOSIS

Professionals described the social stigma that affects children's and young people's understanding of the concept of mental health, and the double stigma of having a mental health diagnosis as well as being in care or detention/diversion: one psychologist noted that children say: **"I'm not coming to you. I'm not mad too"**. The stigma associated with mental health diagnoses was also seen within the care, justice and educational systems. Ironically, at the same time, the systems encourage diagnosis, although this was considered **"labelling"** by some professionals. Professionals expressed their concern about the requirement for a diagnosis from the care, education, Child and Adolescent Mental Health Services (CAMHS) and adult mental health systems in order for children and young people to access services, as this encourages diagnoses to multiply. Finally, one social worker felt that, among children and young people, it is not mental health difficulties themselves that are stigmatised but rather help-seeking: **"Stigma is associated with going for the help even more than the issue itself"**.

As supports from the system were seen to depend on diagnoses, it was interesting to note that professionals identified issues regarding both under-and over-diagnosis of mental health issues. These relate to the complexity of need typically seen with children and young people in their care: six or seven diagnoses were common. These diagnoses label children, yet do not help with understanding them or their needs:

> **I read all these previous assessments that get done, and done, and re-done. And I look at them and I have no idea who this child is, or anything about them. (Psychologist)**

A core concern expressed by most professionals was over-reliance on the medical model. This was seen as contributing to over-diagnosis, for example, where difficult adolescent behaviours were defined as pathological. Conversely, it may cause under-diagnosis, as even if psychiatric diagnostic criteria are not met, the impact of early trauma or deprivation may carry considerable risks to psychological well-being. Therefore most professionals argued that the medical model does not effectively identify the complex needs of these vulnerable children and young people.

FACTORS AFFECTING CHILDREN'S AND YOUNG PEOPLE'S MENTAL HEALTH NEEDS

Professionals identified individual, family, social and cultural factors as contributing to mental health challenges encountered by children in State

care. These included untreated developmental delay, parenting capacity, intergenerational cycles of need and deprivation, and broader social factors. A social worker pointed to untreated developmental delay, **"Quite often… it starts with kind of, some form of developmental delay that quite often has gone unrecognised, untreated for years and years"**, while a psychiatrist noted multiple early vulnerabilities:

> **I would think invariably, kids who end up in the care system are both genetically and environmentally vulnerable. And it's the combination of those two things, and on top of that they're most likely traumatised, and most likely have an attachment problem. So from the beginning they're a dysregulated, distressed population. (Psychiatrist)**

Poor parenting, neglect and abuse were also common in the stories of these children and young people: **"They're the recipients as well of quite a lot of horrific language, violence, negativity, destructive negativity from their parents" (Senior prison official)**. These lead to mental health challenges including attachment disorders. **"The kids are being traipsed in to us with mental health difficulties. How could they not have, given what they're living with at home?" (Psychiatrist)**. Broader social issues also play a part: a culture of male violence, economic deprivation and gross social inequalities were identified as damaging. **"It's about the messages you give people, 'cause if I sit here and I tell you, 'You're a shit, you're a shit, you're a shit', then that will undoubtedly affect you" (School principal); "In terms of their mental well-being … if you … knock a person over and over and over again, they're going to have mental health issues" (Diversion project manager)**.

Finally, professionals noted an intergenerational cycle of need. Particularly in the youth justice system, boys and young men assume that they will go to prison, like their fathers and uncles. In addition, professionals noted the prevalence of multiple generations of chaotic families. Professionals who have worked in the systems for two decades or more expressed their frustration that they are now seeing the children of those they worked with 20 years ago.

CHALLENGES IN THE SYSTEM

SERVICES

Assessment and Intervention: Professionals identified many problems where assessments were delayed and interventions delivered only when needs were acute. There was consensus that earlier intervention was needed at various stages throughout childhood and the early teens. Crucially, assessment and support should take place at entry to care:

> **The entry to care, that's the point where kids should get mental health services, that's the point where they should go to counselling and getting help… but like when they're acting out is the point where all the services are thrown at them. (After-care worker)**

Professionals noted that a lack of communication between agencies and professionals means many children are over- or under-assessed. Finally, they argued for the inclusion of parents in assessment processes where appropriate.

Availability: Waiting times for CAMHS services of a year or longer were noted by all professionals. They also noted many inequalities in service access including geographical and financial barriers whereby services were less available in rural areas, and affluent parents can pay for private assessments and services. There were also quality differences between centres and different care arrangements for children from the same family. Furthermore, sporadic after-care provision creates considerable inequalities. Perhaps the greatest factor in inequalities identified however was age. **"The late teens is the time of greatest need and least services" (Education officer)**. Yet in these years, and despite repeated calls for provision, many CAMHS still do not take new referrals aged 16 or 17 years.

The professionals noted the justice system was being used to fill gaps in HSE and mental health provision. First, this occurs by neglect; mental health needs of children and young people are not addressed, and escalation leads to criminal behaviours; **"the sad reality for many of those children is that they ultimately end up in custody rather than having the necessary services in the community" (Solicitor)**. Second, it was suggested the HSE uses the criminal justice system as a '**respite**' system for itself, when it has no place for a child or young person. Several professionals described their anger at this practice:

> **I had a really bizarre case about two years ago [regarding a child in a residential unit], where you had the social worker get into the witness box to object to bail, rather than the Guard. It was quite incredible. (Solicitor)**

Finally, the lack of suitable foster carers and other placements is a major issue. **"When we place a child in care"**, one social worker explained, **"we're constrained by what we have available. We can have a good sense of what they need, but no suitable placement available. We're constantly being faced with that predicament."**

Good, Stable Placements: All professionals identified appropriate, stable placement as a basic need. However, this was unusual, in their experience:

> **Psychiatrist: "What would make the most difference … would be a commitment to an appropriate stable placement. That's very idealistic, but that is the single most important thing that's indicated for any child in care."**
>
> **Interviewer: "And the system isn't facilitating that at the moment?"**
>
> **Psychiatrist: "It's not at all … there'll be exceptions … down to an exceptional foster parent, or down to an exceptional manager of a residential home."**

They describe children placed inappropriately due to lack of suitable placements; multiple moves; and inappropriately short-lived high

support placements for very challenged children. Furthermore, staffing instabilities were identified as a problem. Due to a high turnover of staff in care settings, the system does not facilitate mental health professionals to stay with a child through multiple placements if these are in different locations. In these conditions, it was noted that it is impossible to create therapeutic stability, and, above all, it is impossible for children and young people to learn to trust.

Staff and foster parents' attitudes to children and young people: One social worker summed up the qualities of a good foster carer as **"Providing a warm, caring, nurturing environment; reflective; have good emotional attunement; awareness of a child's needs; understand the child's behaviours; have the skills to respond to challenging behaviours - while still doing all of that with a lot of love."** However, professionals described negative attitudes to children and young people within the systems, leaving children and young people to believe they are unacceptable and not deserving of respect. Examples given were foster parents treating foster children differently from their own children by going on holiday without them, or staff in youth justice services referring to children and young people as 'scumbags', 'gougers' and 'knackers'.

Across systems, professionals noted that carers and staff struggled to understand and respond constructively to challenging behaviours. Professionals concluded that staff with positive attitudes are needed, and that training is necessary for all staff working with children and young people.

The Education System: School was seen as a protective factor for mental health and well-being. Professionals agreed however that the second-level education system is unsuitable for the more vulnerable and disadvantaged children in society, with a more stable and supportive environment needed, **"Our second level education system needs to totally readjust" (Senior prison official)**. The primary school system was seen as having a child-centred ethos, but the abrupt shift for the child adapting to secondary school, to managing new circumstances, classes, relationships, multiple teachers and stricter rules was seen as particularly challenging for young people. The syllabus-driven system requires a minimum reading age of 11 to 12 years, a school principal noted, which disadvantaged children in the bottom 20%, particularly boys, do not have. As a result, many disadvantaged or vulnerable children do not succeed in transitioning to secondary. The system in Finland was cited, where children continue through to 16 years, **"Because of the challenges, because of the nature of the community... they need, the one, the two teachers, they need to go through to 16, the Finnish model, if you like" (School principal)**.

In about half of cases where children have secondary school attendance problems, education professionals noted that mental health factors are involved, but because these may manifest as difficult behaviour, this is often not recognised by schools. This is further compounded by schools being limited to two National Educational Psychological Service (NEPS) assessments per year with schools often not wanting to 'waste' an educational psychology assessment on a child who, they surmise, may not stay in school. Cutbacks to guidance counsellors were another

major concern. Even without professional counselling qualifications, professionals noted that a guidance counsellor can be someone the child can talk to in the school environment, and that this can be enough to keep a child in school.

INTER-AGENCY WORKING

The complex needs of children and young people in the system were seen to cut across agency boundaries with multiple agencies working with a single child or family, even 10 or more. A lack of co-operation by agencies was noted; this has a negative impact on children and young people in general, and on the quality of assessments conducted.

Inter-agency working, professionals agreed, is key to helping children and young people, **"Common sense suggests we all need to work together" (Senior prison official)**. However, many barriers to inter-agency working were noted. The first referred to mismatched expectations, work approaches and languages, **"We work so differently, we all talk different languages" (Speech and language therapist)**. Each agency has their own set of rules, training, and boundaries and there is a lack of appreciation of the pressures of each other's systems.

A second barrier identified was the considerable differences in models used to understand children's needs and behaviours. This applies particularly to social work and mental health models. Social care staff, one psychiatrist noted, tend to use a behavioural model and are **"Less likely to have perspective of emotional components, or levels of distress"**; a psychologist struggles when social workers **"Ask me to do things [that are] not therapeutically appropriate"**; and social care workers and psychiatrists differ regarding the role of medication in treating ADHD and mood/anxiety issues. Most noticeable was a Catch-22 described by many: social workers want CAMHS to give therapeutic support to a child or young person; CAMHS argue they cannot do so until a secure placement has been achieved; and social work feel that secure placement cannot be achieved until issues have been dealt with therapeutically.

A third challenge to inter-agency working noted was related to resources and intra-agency Key Performance Indicators (KPIs), **"Everyone is gatekeeping" (Psychiatrist)**; **"Everyone is under pressure regarding KPIs" (Social worker)**; **"And so you waste time and energy protecting your own area" (School principal)**. This leads to agencies seeking to divest themselves of children. **"There's always big battles between the agencies. They'll almost kind of want to throw the child at you" (Psychologist)**; **"Agencies dump on one another" (Psychiatrist)**.

Participants noted that personal relationships help best, but that this is not a sustainable model of inter-agency co-operation. There is concern that adding more agencies (e.g. Child and Family Agency; Assessment, Consultation and Therapy Services) will complicate the situation regarding inter-agency communication: **"Another silo with more boundaries" (Psychologist)**.

LACK OF CHILD-CENTRED FOCUS

The care and youth justice systems, professionals agreed, are not child-centred. Children are often not consulted on their cases and newly appointed professionals, like social workers, probation officers, may not meet children in their care, or even inform them of the change. Often, decisions are made by people who have never met the child, on grounds other than the child's best interests. The organisation's needs come first and so complexity of need is not addressed: **"These kids fall between too many stools" (Social worker)**; **"The child disappears from the centre and is replaced by the system" (Senior prison official)**. The focus is on the file, not the child: **"The file has priority" (Senior diversion official)**. The focus should instead be on **"trying to make this one child's life better" (Senior diversion official)**.

Professionals felt very strongly that management and the overall system are not supportive of children's needs. Instead, they describe a focus on bureaucracy, and outputs measured by very restrictive KPIs, which has led to a lack of support for the holistic or longer-term approaches necessary for working with children and young people with complex needs. For example, they described being pressurised to close cases when not appropriate, or having a six-session limit for therapy imposed on them. Furthermore, due to territorial concerns and the strict adherence to KPIs, initiatives to consult with other professionals are discouraged.
A major challenge is the lack of suitable placements, so that professionals are **"scrambling around for places – 'Jesus what place is available for this kid?'" (Psychiatrist)** leading to many unsatisfactory placements: **"shoving somebody in there: 'We may as well' " (Psychiatrist)**.

PROFESSIONALS' EXPERIENCE OF THE SYSTEM

It was particularly notable that across the consultations, all professionals from all fields expressed negative emotions and responses to the system. Advocating for services for children was described as **"a battle" (Social worker)**. Professionals' workloads are increasing, particularly for social workers, **"You're just chasing your tail and getting more and more demands put on you."** Professionals described themselves as **"angry"**, **"frustrated"** and **"beaten down"** by various aspects of the system. They found it **"bewildering"**, and were **"saying the same things over and over again"**, which was **"disheartening"**. In the face of this it is not surprising that some described **"giving up"**.

MEETING THE MENTAL HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE

This final section reports on the factors professionals identified when asked for examples of good practice relevant to the mental health of children and young people in State care and after-care, as well as what the system needs to do in order to meet their complex needs. It was notable that, when giving examples of good practice, many cited exceptional individuals and on-the-ground relationships, rather than systemic factors or practice models. Examples of good practice from professionals' experience in Ireland and elsewhere are given here and several are discussed further in chapter four.

It is important to note that all participants in this consultation conceptualised children's and young people's mental health needs broadly, and agreed that many needs could be met, for example, through a combination of stable placements, having carers or staff who were able to tolerate emotional distress or challenging behaviours, and experiencing positive relationships. Professionals noted that supporting mental health often meant identifying the most pressing need in a child's life at a given time; this might be a therapeutic solution, or it might be for housing, sibling relationships, educational support, or other needs. Indeed, mental health professionals noted that psychological therapies are not appropriate for all vulnerable children and young people, though these can be very effective in the right circumstances.

CARE SYSTEM

In the care system, professionals agreed that quality foster care itself was the preferred intervention available for children, "**I think we do need to bear in mind that the single greatest, most effective intervention for children in care is foster care" (Psychologist)**. However, foster carers required training and supports, including 24-hour back-up, to prevent all-too-frequent placement breakdowns. Private foster care was praised and one social worker suggested the HSE should emulate this system, rather than pay private companies to provide it, **"They have an excellent model of care for their carers. That's what we should aspire to."** Multi-dimensional treatment fostering, an evidence-based model, was described as having had mixed results in Ireland compared to other countries, a reason suggested for this was that the selection may be less rigorous here.

Where children and young people have high levels of challenging behaviours, professionals noted they are harder to place in foster care and that residential homes are resisting taking them. Outsourcing was seen as resulting in good services in some instances, but professionals also cited examples of expensive private profit enterprises with poor outcomes. One professional queried the ethics of the HSE's refusal to place children coming from high support in HSE residential care units, yet placing them in private provision. It was noted that HIQA and HSE inspections have improved some residential units greatly.

The courts minor list was commended, as was the Child Care Act 1991, section 47, through which court directions regarding a child's needs can lead to change, although the HSE is challenging its widespread use. Finally, applying the welfare approach of the Children's Act **"Would solve a lot of problems" (Senior diversion official)**.

YOUTH JUSTICE SYSTEM

Several innovations in the youth justice system were praised by professionals. Garda case management is "**absolutely super" (Detention school manager)** and diversion schemes in several areas of the country are **"fantastic" (Senior prison official)**. Restorative practice has had **"some great results" (Senior diversion official)**; it shifts the focus with young offenders from blame to behaviour change and works with pro-social behaviour, empathy-building and motivational interviewing. Oberstown's

children detention school behaviour management programme and an ADHD treatment approach were also cited as examples of good practice, as were parenting groups for fathers in prison.

INTER-AGENCY APPROACHES

Several professionals commended youngballymun's evidence-based supports for all phases of childhood from pregnancy, agreeing a cohesive model was preferable to 'hit-and-miss' programmes. The Ballymun Network inter-agency model was experienced as positive by one professional, although another suggested it had not been as effective as hoped. It was noted by all professionals that inter-agency working should be mandatory. However they felt that changes were required to support this. These included adjusted KPIs; information-sharing protocols; assessment-sharing for greater understanding and to avoid repeated assessments; and training to help communication and understanding different perspectives. Specialist multi-disciplinary, multi-agency teams dedicated to children in care were seen as necessary to provide adequately for children's needs. Some considered such teams should not be full-time for children in care, to avoid burnout among professionals.

THERAPEUTIC SUPPORTS

It was noted there is relatively little research evidence available for the use of psychological therapies with children with very complex needs; however, this may simply reflect the general lack of research for interventions to support this very complex population. In some cases, individual long-term psychotherapy was seen as very constructive, and professionals were surprised to note that Children's Act Advisory Board (CAAB) therapeutic guidelines for children in care did not explicitly cite this. A challenge professionals noted is that children can be very reluctant to engage with any therapeutic input, particularly in adolescence, **"it's very difficult to get any young person to engage in something that they don't necessarily want" (Solicitor)**.

> **One of the biggest challenges I have with this population, who tend to come across my radar when they're older (they tend to be adolescent), is that you're at a stage where they are often impossible to engage, and that's an enormous, enormous difficulty. (Psychiatrist)**

In this context, professionals noted the importance of assessing and working with children when they are younger:

> **They've gone for 14 or 15 years and nobody has helped them, nobody has understood them, and, it's nearly too late in a way, 'cause when they were four and five and six they would have sat down and done a bit of work with you, but now it's more difficult to do that with them. (Speech and language therapist)**

Professionals in all sectors underscored the need for speech and language therapy for many children in State care. As challenges in these areas affect children's communication, social interaction and school engagement, they

noted that failing to intervene early can lead to considerable educational, behavioural and mental health challenges later. Professionals also cited a range of supports and programmes which, their experience indicates, are very effective for children in the care and youth justice systems, and to which children and young people respond well. These include social skills training; emotional literacy or emotions work; life story work; attachment enhanced parenting and basic mindfulness processes for self-regulation. Finally, professionals noted that the multiple placements experienced by children and young people means it is rare to be able to maintain a relationship over time. This is despite the fact that a core need in any therapeutic relationship is for consistency.

SUITABILITY OF CAMHS

The suitability of CAMHS, as currently structured, for children and young people in State care and after-care was questioned. Professionals working both within and outside CAMHS noted that attendance may pose problems for particularly vulnerable and challenged children and young people for several reasons. First, attending appointments requires involvement from supportive parents or care staff; it is unusual for CAMHS teams to meet children off-site, and professionals indicated that few CAMHS look into the issues behind non-attendance at clinic. This creates problems for vulnerable or deprived children and young people. A second issue is that, for many children and young people, parental mental illness may be the reason they have entered care. Therefore attending a mental health service has very negative connotations for them. For such reasons, a CAMHS psychiatrist suggested that a more community-based service such as Headstrong's Jigsaw model of delivery might serve their needs better.

ACROSS SYSTEMS, A RANGE OF FURTHER NEEDS WAS IDENTIFIED

Further needs identified by professionals were for earlier assessment and intervention; mandatory mental health training for all staff; mental health components in youth justice schemes; and legislation changes.

Earlier assessment and intervention were considered to be essential to prevent escalation of need. Professionals within and outside CAMHS argued that it needs to be flexible and see more children, even if for a one-off consultation, though this would require adjustment of CAMHS KPIs. Professionals also urged that mental health services be provided as soon as an assessment identifies a need. Long waiting times were seen to exacerbate mental health needs; in addition, as stigma can inhibit attendance, a long wait between an identified need or an assessment and appointments can magnify this. Further suggestions were to expand the role of public health nurses, who could be more involved in early identification; and to lower the threshold for bringing children into care, as some children have developed significant difficulties by the time this happens.

The need for mandatory mental health training for all staff working with children and young people in the care system, the youth justice system, and education was highlighted. In particular, professionals suggested

that training in understanding young people's aggressive behaviours was critical. These are often manifestations of underlying mental health factors yet are poorly understood and may be met with aggression or exclusion.

The need for the introduction of mental health components in the youth justice system was also highlighted, in particular the need to include positive mental health dimensions in the work of the Garda Youth Diversion Projects and Juvenile Liaison Officers; links to mental health services; and establishment of a referral pathway to CAMHS or community psychology. As seen in other countries, the use of hospital orders rather than custody was recommended, where a therapeutic setting is designated, rather than a youth justice one. Furthermore, rather than relying on discrete therapeutic treatments, therapeutic environments were recommended, where all staff are trained in the model and in de-escalation techniques.

In terms of legislation, it was noted that there are few mandatory obligations in Ireland and therefore no accountability to address the needs of children with mental health concerns, those with disabilities, or those who are in adult prisons or adult psychiatric units. Further, it was considered that the extent of obligations under Section 3 of the Child Care Act 1991 was unclear, particularly since the Children's Constitutional Referendum in 2012. Concerns were raised about separated children and asylum seekers, with a call from some professionals for immediate mandatory mental health evaluation for a child who presents at any port of entry to the State. This would benefit not just the child but also decision-makers in determining their credibility.

Finally, professionals suggested that legislation allowing for permanency planning would support the stability needs of children in care; and that after-care should be a mandatory right with a supporting statutory footing for after-care services. Ideally, young people receiving mental health supports would remain with the same mental health provider until the age of 21 to support their transition.

SUMMARY OF CONSULTATION WITH PROFESSIONALS

In conclusion, professionals from social work, youth justice, mental health and education all viewed the system itself as contributing to the trauma experienced by children and young people in State care and the youth justice system. They noted the very complex mental health needs of children and young people which were affected by a range of developmental, family, social and socio-economic factors, while mental health professionals experienced challenges in diagnosing needs. All observed stigma regarding mental health. Stigma was seen in society in general; within State care systems; among non-mental health professionals who are reluctant to consider mental health needs; and among children and young people themselves, for whom seeking help for mental health challenges was stigmatised.

In terms of providing for mental health needs, professionals argued that there is an absence of child-centred care, with organisations focused on their own outputs rather than the child's needs. In terms of assessment and interventions, professionals noted substantial deficiencies, poor

resource allocation, many inequities and a focus on crisis management rather than early intervention. Core needs identified were for inter-agency working; for disciplines to find ways to reconcile different interpretations of the treatment and support needs for children and young people in State care and after-care; and for allied professions to be trained in recognising mental health needs. All participants underlined a central need for greater placement and therapeutic stability in order to allow for relationships to develop. Finally, all professionals had broad definitions of mental health: not just the absence of illness, but a state of well-being and the ability to cope with life's challenges. This was reflected in their views of the range of supports needed to address the complex mental health needs of children and young people in State care, after-care and the youth justice system.

YOUNG ADULTS WITH EXPERIENCE OF THE YOUTH JUSTICE SYSTEM: CASE STUDY 2

Michael (not his real name) was diagnosed with receptive language difficulties and also with Oppositional Defiant Disorder. Despite assessments and reports indicating his speech and language and mental health difficulties, Michael has received little intervention or supports from mental health services. He has been cared for in various residential services, as his family is unable to manage his behaviour and the resultant risk he presents in the community. Michael has been charged several times; usually while he was under the influence of substances. He spent six months in St Patrick's Institution. He is now 19 years of age and relies on community-based addiction services for support. His options for moving on are limited and the level of risk he is at in the community remains high. He has no links with mental health supports or services at present.

YOUNG ADULTS WITH EXPERIENCE OF THE YOUTH JUSTICE SYSTEM: CASE STUDY 3

James (not his real name) entered State care at the age of 17 and is now 18-years-old. He presented with very complex emotional needs, and during particularly stressful times he has engaged in self-harm and suicidal ideation. James has been involved in some serious criminal activity and is now becoming involved in the criminal justice system. He attended a psychiatrist in CAMHS during his time in care. He also spent two weeks in an adolescent inpatient unit. His entry to that unit was through an Accident and Emergency referral, a process which took very long and which he experienced as intrusive. He was later discharged to an after-care service. James also self-harmed on several occasions in the after-care residence and had to return to Accident and Emergency, where he waited long periods of time to be assessed by a psychiatrist. As he has now reached the age of 18 he can no longer access the adolescent mental health services which were supporting him. James was upset about this and was very unhappy about the manner in which he was transferred to the adult mental health services. He has currently disengaged from services and is very reluctant to further engage with mental health services.

PART 2
THE CONTEXT

CHAPTER 4
SERVICE DEVELOPMENTS IN IRELAND

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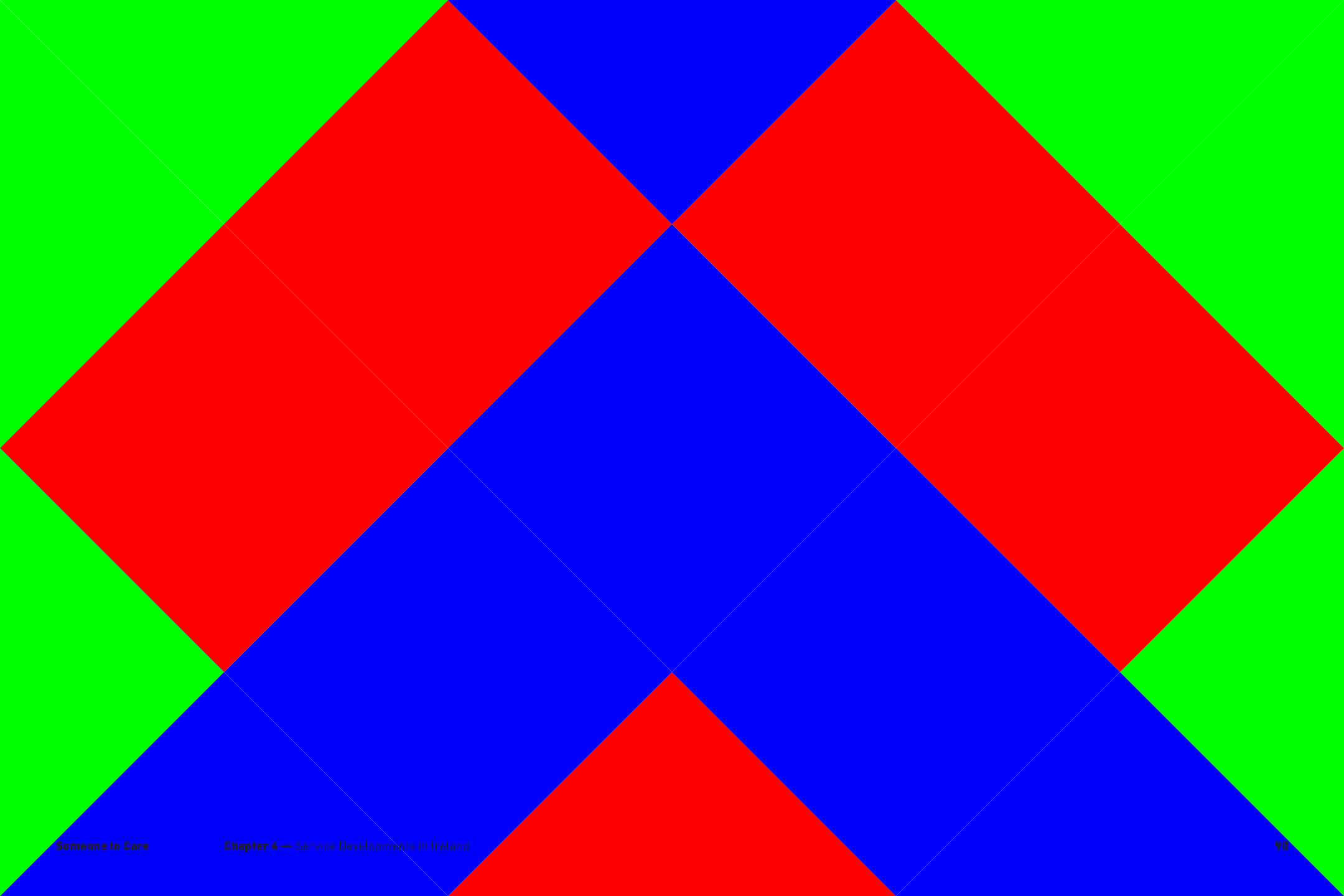

INTRODUCTION

There are currently substantial changes underway in service development within the care and youth justice systems in Ireland, intended to provide a more comprehensive response to the needs of these young people. These include the recent establishment of the Child and Family Agency (CFA); the appointment of a Directorate of Mental Health Services in the HSE; on-going development of Children's Services Committees; the development of primary care centres; and the development of the Assessment, Consultation and Therapy Services (ACTS) designed for high levels of need. This chapter gives an outline of the landscape of services that currently provide mental health services (directly or indirectly) to young people in the care and youth justice systems.

The concept of a continuum of need was noted in chapter one of this report. This is consistent with models of care that encompass a continuum of health and social service interventions for those with mental health difficulties ranging from universal services to levels of increasing need and decreasing demand (Hardiker, Exton & Barker, 1991). According to Hardiker et al., universal (level 1) services may need to be available to all, whereas level 2 services are for children with particular identified educational or social needs that are amenable to short-term interventions and support. At level 3, services are for children and families with more serious problems and often involve several agencies, including specialist mental health services. Level 4 interventions occur where children are in care, in custody or in hospital.

ALTERNATIVE CARE SERVICES

The HSE has responsibility for all State alternative care services. According to the **HSE Performance Monitoring Report December 2012** (HSE, 2012a), a total of 6,332 children were in the care of the HSE and more than 90% had an allocated social worker, ranging from 90% for children in relative foster care to 100% for High Support and Special Care.

Foster care is the preferred alternative care arrangement in Ireland and involves placing a child in the care of approved foster parents. Of children in care, nearly two-thirds (63.1%; 3,993) were in HSE foster care and nearly one-third (28.9%; 1,828) were in foster care with relatives. In addition, there were 334 children (5.3%) in general residential care, 18 (0.3%) in High Support, 23 (0.4%) in Special Care, and 136 (2.1%) in other HSE care placements. Private placements were provided by the HSE for 361 children with higher proportions of residential, High Support, and Special Care, and lower proportions of foster care. There were 1,154 young adults aged 18 to 21 years in receipt of after-care services (Brierley, 2012).

According to Brierley (2012), there were 112 mainstream residential units in Ireland in 2010, 49 statutory and 63 non-statutory. **Residential care** units usually cater for between three and six teenagers. Children under 13 years are placed in such units only in exceptional circumstances, e.g., while awaiting a suitable foster care placement; if two or more siblings need to be placed together, following a series of foster care breakdowns; or where a child's care and behavioural needs are considered to be best catered

for in a residential setting. Staff members work a shift system and young people are allocated a key worker. Children living in the centres attend local schools and take part in local sporting and community activities. Centres are typically located in housing estates, on the outskirts of towns and villages (personal communication, DYCA, 2013). **High Support** is a form of residential care for children with particular emotional and behavioural problems whose needs cannot be met in foster care or mainstream residential care; it offers a higher staff ratio of staff than standard residential care (HSE, 2013).

Special Care is a type of care provided under Section 23C (a) and (b) of the Child Care (Amendment) Act, 2011, for children who are in need of special care or protection by the HSE. These children display extreme emotional and behavioural problems often characterised by violent, aggressive self-harm tendencies. Units are purpose-built closed therapeutic facilities providing short-term care, managed by HSE Children and Family Services. There are currently three Special Care Units in Ireland: Ballydowd Young People's Centre in Dublin, Coovagh House in Limerick and Glean Alainn in Cork (HSE, 2012d). The Special Care system has a statutory basis and is supervised by the High Court. An order for detention in a Special Care unit can last for three or six months, and is only made where the behaviour of the child poses a real and substantial risk to their health, safety, development or welfare and where the child requires special care or protection that he or she is unlikely to receive without such an order. Orders can be renewed where grounds justifying the order continue to exist (Kilkelly, 2008).

The **Review of Capacity for Alternative Care Services** (Brierley, 2012) identified that 172 children had experienced three or more placement moves (excluding respite placements) in the year to 31 March 2011; 2.9% of all children in care (n=172/5,965, the number of children in care in December 2010). Two other jurisdictions collect this information: England and Wales. For England the figure was 10.7% (n=7,000/65,520, Department for Education, 2011, cited in Brierley, 2012) and for Wales it was 10.3% (n=530/5,161, Statistics for Wales, 2011, cited in Brierley, 2012). It has therefore been suggested that placements for children in care in Ireland are substantially more stable than for children in care in England and Wales (Brierley, 2012). However the validity of such comparisons should be considered in light of the fact that the Irish care system is structured substantially differently from England and Wales. The current legislative framework in Ireland favours long-term foster care over adoption, which has the effect of including long-term, stable placements in such calculations. In England and Wales, in contrast, there is far less long-term fostering, as the principle of permanency planning means that adoption is favoured for long-term placements.

Brierley (2012) describes a range of services availed of by young people in care, listing 52 services ranging from social work support, child care leader support, educational support, occupational therapy, psychology, speech and language therapy, youth support, family support and Child and Adolescent Mental Health Services (CAMHS).

YOUTH JUSTICE SERVICES

The **Irish Youth Justice Service** (IYJS), established in 2005, has been under the remit of the Department of Children and Youth Affairs since 2011, with responsibility for developing and implementing youth justice policy; detention of children under 18; and implementing provision of the Children Act, 2001. The Minister for Justice and Equality retains responsibility for youth crime policy, criminal proceedings, diversion and community sanctions.

The **Garda Youth Diversion Programme** (GYD), co-ordinated by the Garda Office for Children and Youth Affairs (GOCYA) aims to prevent re-offending and divert children away from the criminal justice system. The programme was given statutory recognition under part 4 of the Children Act, 2001. Since this legislation was enacted, all children who come into contact with the Gardaí are now referred automatically to the Diversion Programme, although not all children are admitted. In 2011, 12,809 children were referred to An Garda Síochána's **National Juvenile Office** for diversion in relation to 27,384 incidents (GOCYA , 2012). This represents a significant decrease (5,177) of the number of children referred in 2010. Prior to 2010, the numbers referred have been decreasing since 2008 when 21,412 children were referred, and have therefore decreased significantly in the three years up to 2011, the lastest year for which information is available (GOCYA, 2012). The reason for this drop is not explained in the most recent Report of the Committee set up to monitor the Diversion Programme (GOCYA, 2012) and the Report does not make a recommendation that the reason for this drop be explored. It is important that these changing trends are reviewed (Kilkelly, 2011).

The percentage of children deemed unsuitable for diversion dropped from a peak of 3,066 (17%) in 2010 to 1,835 (14%) in 2011. The report states that a child will be considered unsuitable if s/he does not accept responsibility for the behaviour, if it would not be in the interests of society to caution the child and the child is offending persistently. These cases are referred back to local Garda management where a decision is taken, in consultation with the Director of Public Prosecutions where appropriate, in relation to prosecution. Kilkelly notes that much more information is needed to fully understand why young people are rejected from the programme and argues that the significance of approximately one quarter of young people being rejected from the programme each year is worth careful scrutiny and greater transparency (Kilkelly, 2011). There is no information in the reports monitoring the Diversion Programme on the numbers of children referred to the HSE for child protection reasons, or the numbers of children referred on to other services such as mental health services; and there is an absence of formal links between the Garda Youth Diversion Programme and mental health services (personal communication with Director of Garda National Juvenile Office, 2012).

Since 1991, **Garda Youth Diversion Projects** (GYDPs) have also been established by An Garda Síochána. Since 2009, the IYJS and the GOCYA have undertaken a programme of development and reform in partnership with the GYDPs and community-based organisations. The projects are located in 100 communities across Ireland working with more than

5,500 children and young people, mainly young men (IYJS, 2012). The projects are run by youth organisations with Garda involvement. They offer community-based activities for children and young people involved in youth offending, or who are at risk of becoming involved (IYJS, 2012). According to the IYJS, the main aim of the GYDPs is to support Gardaí at local level by impacting on attitudes, behaviours and circumstances which give rise to youth offending. Projects aim to develop skills and divert from behaviour that might lead to conflict with the law and the key focus is on children with a pattern of re-offending behaviour (IYJS, 2012). Programmes offered encourage participation in education or training for employment and engagement by families; address alcohol and substance abuse; or teach young people life skills (IYJS, 2012). Young people are generally referred to Garda Youth Projects by a Juvenile Liaison Officer (JLO) or other members of the Gardaí, but may also be referred by another agency or a family member. In 2010, the IYJS and An Garda Síochána introduced a core assessment tool for use by JLOs and GYD staff to help determine which young people in a locality may benefit from project intervention and the needs they present with (IYJS, 2012). Garda Youth Projects are planned locally, based on the patterns of crime in the area; internal monitoring indicates a "marked decrease" in youth crime (IYJS, 2012, p. 6).

An Garda Síochána set up a pilot project for **Youth Crime Case Management** in 2006 to target young people deemed unsuitable for diversion, particularly repeat offenders. Case management aims to help coordinate appropriate interventions and services to meet their needs, while providing courts with greater clarity regarding the child's situation and circumstances. The Garda Case Manager acts as a single point of contact for information about the child and liaises with all agencies working with children being case managed. This process has now been rolled out nationally (Quinn, 2012). **An Garda Síochána Children and Youth Strategy 2012-2014** (An Garda Síochána, 2012) contains a commitment to utilising and developing this scheme further.

For children remanded or sentenced to detention by the courts, there are three **Children's Detention Schools** in Ireland located on one campus in Lusk, Co Dublin. For girls there is Oberstown Girls' School and for boys up to age 17 there is Oberstown Boys' School and Trinity House. The Minister for Children and Youth Affairs stated on 10 May 2013 (www.dcya.gov.ie) that a Children (Amendment) Bill will be drafted to amalgamate these schools into a National Children Detention Facility, to allow for more efficient use of resources, common policies and better implementation of a child care model of detention.

As stated by the Minister, the Children (Amendment) Bill will also facilitate the necessary legal changes for the transfer of responsibility for all children under 18 years from **St Patrick's Institution** in Dublin to the children detention schools. St Patrick's Institution is a closed, medium security detention facility for remand and sentenced male prisoners to 21 years of age (www.irishprisons.ie). The practice of detaining 16-year-old boys there ended in May 2012 but 17-year-olds will still be remanded and detained until the new National Children Detention Facility is completed. At the time of writing the target for completion is mid-2014. The European Committee on the Prevention of Torture in 2007 noted problems with

psychological support provision to young people in St Patrick's Institution (CPT, 2007). In 2011 (CPT, 2011), the committee further recommended that psychological support should be reinforced, and that detained young people with mental health problems should be treated by psychiatrists and psychologists specialising in child and adolescent mental health, not by adult psychiatrists. The recent extension of the remit of the Ombudsman for Children to St Patrick's Institution is a welcome development. Since the government indicated its intention in 2010 to remove 16-year-olds from St Patrick's there has been a threefold increase in 16-year-olds detained by court order (Minister of Children and Youth Affairs, 10 May 2013; www.dcya.gov.ie).

MENTAL HEALTH SERVICES

A model of services to address the mental health needs of young people in the care and youth justice systems exists in Ireland. This spans a range of agencies and disciplines. It aspires to deliver a continuum of care, from community-level and support services designed to prevent the development of mental health difficulties, to tertiary level specialist mental health services providing support for those with psychiatric disorders.

Support for children and young people in the care system may be provided by many disciplines, across various agencies. HSE social work teams provide ongoing support, as do child care leaders, often working as part of social work teams in local areas. Family support workers, either through HSE family support services or through Family Support Agency services, provide support and therapeutic services to young people and families. Psychological support and therapy is provided by HSE primary care or community psychology services. The HSE and other government departments also provide grants to community services that provide counselling and psychological support to young people and their families.

The Mental Health Commission (2012), an independent statutory body established under the Mental Health Act 2001, has emphasised the need for early mental health intervention. Researchers agree that the long-term returns from such early intervention are positive, and that the earlier the intervention (whether early in the life of the child, or early in the life of the problem), the better the chance of success (Aos, 2004; Feinstein, 2002; Heckman, 2006; Meisels & Atkins-Burnett, 2006).

Population-level preventative programmes work with expectant mothers identified as being at risk, to improve maternal health and build parenting skills. According to the Irish Penal Reform Trust, Barnardos, and Irish Association of Young People in Care (2010), primary interventions should focus on "ensuring the family is fully supported, the child's mental health is promoted and his/her involvement in education is prolonged" (p. 7). They note that early intervention plays a significant role in breaking intergenerational cycles of poverty; investment in early-years education is particularly important. McAra and McKie (2010) argue for universal targeting of support mechanisms for all children and families in areas where poverty and risk factors associated with offending are high. In Ireland, three pilot programmes are undergoing evaluation: **Preparing for Life**, **Tallaght West Child Development Initiative**, and **youngballymun**.

Despite evidence for its effectiveness, early mental health provision is not always in place in Ireland. Youngballymun (2010) questions whether services for children and families in Ireland have struck the right balance between prevention, early and late intervention, as intervention late in the life of a problem is costly and "there is considerable international evidence that investing earlier could produce a much higher rate of return" (youngballymun, 2010, p. 46). Failing to help earlier is likely to be costly not just for young people but also for society; young offenders can experience "a lifetime of declining health and worsening offending behaviour, with significant long-term costs to the tax-payer, and to the victims of these crimes" (Newman, Talbot, Catchpole & Russell, 2012, p. 6). However, it should be borne in mind that recent research suggests that certain kinds of youth justice agency contact, where this is experienced as punitive, may be counter-productive and increase rather than diminish offending (McAra & McKie, 2010). McAra and McKie argue that is therefore important to operate on principles of maximum diversion.

As of September 2011, there were 393 **primary care** teams in place (HSE, 2011), which can include General Practitioners (GPs), social workers, nurses and occupational therapists. Primary care teams are intended to work with community- or hospital-based primary care networks. The Department of Health proposal for primary care, in the **Quality and Fairness** document (Department of Health and Children, 2001a), indicates that community mental health nurses and social workers should be based in primary care centres as well as specialist mental health and childcare teams as part of the primary care network. Psychologists and other mental health professionals are employed both in CAMHS and in the primary care network. A recent survey of psychology resources across the country indicated that of the 710.02 whole time equivalent (WTE) psychology posts in place, 58.4 were in CAMHS while an additional 54.23 worked in child and adolescent primary care networks. A further 41.7 worked in lifespan services, which also provide services to children and adolescents (Kelly, Byrne & Faherty, 2012). These authors note that despite increasing demand for services in the past decade, the WTE growth rate has slowed to 3.23% per annum since 2008 compared to an increasing annual growth rate from 2004 to 2008. At the time of the survey in 2011, there was a shortfall of 29.24% (209.64 WTE) in meeting the accepted 1:5,000 psychologists to population ratio.

A further community-level service, **Jigsaw**, is provided by Headstrong, the National Centre for Youth Mental Health. There are six Jigsaw projects in Ireland: community-based mental health services bringing together a range of professionals for young people aged 12 to 24, building on each community's existing resources (Headstrong, 2013). Central to the Jigsaw model is the Youth Advisory Panel which is involved in all decision-making for each project and which assists service development according to young people's preferences. The Jigsaw sites are currently being evaluated.

Community-level supports should also be found in the education system. A recent report by the Ombudsman for Children's Office (OCO, 2013) highlighted that a positive school climate and good relationships with teachers can positively affect a student's engagement, and emphasised that inter-agency work by dedicated individuals (including foster parents,

carers, teachers, and other professionals) who place a high value on education is likely to have a positive impact on the educational experiences of children in care. Some Jigsaw projects work with schools to promote mental health awareness and to create supportive environments for young people. The **National Educational Psychological Service** (NEPS) employs 178 psychologists through the Department of Education and Skills. Their psychologists work with both primary and post primary children and are concerned with learning, behaviour and social and emotional development (www.neps.ie). Each psychologist is assigned to a group of schools and offers a range of services. The core work of NEPS psychologists in schools has four main strands: provision of support for individual students; provision of support for those who work with individual students (parents and teachers); project work in schools for the general benefit of students and advice to schools on the development of a psychologically supportive environment. The **National Behaviour Support Service** (NBSS) provides school based services for children with behavioural and emotional difficulties that are impeding their educational development. The NBSS provides whole-school support, targeted interventions, and individual interventions following referral and assessment (NBSS, 2013). The **Special Education Support Service** (SESS) operates under the remit of the Teacher Education Section (TES) of the Department of Education and Skills and co-ordinates, develops and delivers a range of professional development initiatives and support structures for school personnel working with students with special educational needs in mainstream primary and post-primary schools, special schools and special classes (DES, 2012). The **National Council for Special Education** (NCSE) was established in 2003 as an independent statutory body to improve the delivery of education services to persons with special educational needs arising from disabilities (which includes children with mental health problems) with particular emphasis on children. The NCSE has a national network of Special Educational Needs Organisers (SENOs) who interact with parents and schools and liaise with the HSE in providing resources to support children with special educational needs. The remit of the Council will be significantly extended with the Education For Persons with Special Educational Needs Act (EPSEN), 2004. While certain sections of the Act have been commenced, the implementation of key sections that confers statutory rights to assessment, education plans and appeals processes on children with special educational needs has been deferred due to the current economic circumstances (NCSE, 2012).

Catering for a higher level of need, the **Child and Adolescent Mental Health Services** (CAMHS) provide a community-based, multi-disciplinary team service; most of the existing 63 teams are provided directly by the HSE (n=52) and the rest by voluntary HSE-funded agencies (n=11). There are three paediatric hospital liaison teams; two day hospital teams; and 58 community teams offering services to geographically defined catchment areas (HSE, 2012b). As part of the CAMHS multi-disciplinary model, it is recommended that the team consist of a consultant child and adolescent psychiatrist, junior medical staff, two psychologists, two social workers, two nurses, a speech and language therapist, an occupational therapist and a child care worker (HSE, 2012b). **A Vision for Change** states that each community team should adopt a recovery-oriented model of care and involve users and carers at every level of service delivery and planning.

CAMHS reports note that the proportion of children attending CAMHS who were in contact with social services was 10% in November 2010-2011 (HSE, 2011) and 20% in November 2011-2012 (HSE, 2012b).

Unfortunately, CAMHS services remain underdeveloped and understaffed. The Independent Monitoring Group (IMG, 2012) for **A Vision for Change** stated that implementation of this policy has been "slow and inconsistent" (Department of Health, 2012, p. 3) and noted there is no consistent framework for developing mental health specialities; a need for a comprehensive, time-lined and costed implementation plan; and a lack of coherence in the development of community mental health services (Department of Health, 2012). According to the CAMHS 2012 **Annual Report** (HSE, 2012b), the staffing levels recommended by A Vision for Change fall far short of target. Only 58.9% (63 of 107) teams are in place, and staffing is at just 38.1% of levels recommended. In addition, CAMHS was originally designed to provide services to young people aged up to 15 and their families; its remit has been extended to young people aged 17 years, but only 25% (14) community-based CAMHS teams accept referrals of children up to and including 17 years and some children are still being discharged to adult mental health services when they reach 16. The HSE directed that as of January 2013, all new cases of children aged 16 would be seen by CAMHS and all 17-year-olds will be seen from 2014. However, at the time of writing (June 2013) not all CAMHS teams are compliant with the directive regarding 16-year-olds.

Furthermore, at the time of writing, just 39 of the 100 children's mental health inpatient beds recommended in A Vision for Change are in place (personal communication, Department of Health, June 2013). The new Children's Hospital will have 12 mental health inpatient beds and a national specialist eating disorder service with eight inpatient beds. This is due to be completed by end 2017 or early 2018 (HSE, 2012b). Dedicated child and adolescent forensic teams are also lacking, although the HSE has secured funding to provide a forensic CAMHS team and recruitment is ongoing (personal communication, HSE, June 2013). Building for the new **National Forensic Hospital**, which will include a 10-bed child and adolescent secure unit, started in 2012 and is scheduled for completion in 2017.

Other deficiencies in service provision were highlighted in A Vision for Change and remain unresolved. These are: inequitable variation in the distribution of CAMHS services across the country; a lack of national dedicated adolescent mental health services; a lack of paediatric liaison services in most major hospitals (except the three Dublin-based national children's hospitals); a lack of mental health services for autism and autistic spectrum disorders; and insufficient inpatient and day hospital facilities (DoHC, 2006).

Finally, the **HSE Forum Report on Child and Adolescent Psychiatric Inpatient Capacity** (HSE, 2006a; 2006b) stresses the importance of developing community and inpatient services simultaneously, due to the interdependencies between them. The **Second Forum Report** (HSE, 2006b) sets out a requirement that a range of services should work together including primary care and general practice, NEPS, home care, day hospitals, inpatient beds, and out-of-hours services.

ONGOING SERVICE DEVELOPMENTS

A number of service developments, relating to children in care and mental health, are in train at the time of writing this report.

The **Child and Family Agency** (CFA) will assume responsibility for a range of children and family services, with particular emphasis on primary prevention and multi-disciplinary intervention, but also including many secondary and tertiary services. The Task Force for the CFA (DCYA, 2012) highlights current deficits in access to, and coordination between, specialist mental health services and other services for vulnerable children and families, and the need for additional flexibility in all services and professional groups where complex needs arise. The report acknowledges that young people with emotional and behavioural difficulties sometimes fall between services; that the model of CAMHS is predominantly a medical model; and that there is a difficulty with a lack of consistent services for 16- and 17-year-olds (DCYA, 2012). The CFA task force was of the view that it is essential to integrate CAMHS with child welfare and protection work in the community.

The **Task Force Report** (DCYA, 2012) also emphasised the need for inclusion of children's services, education, justice, and health, and the importance of access to mental health services for vulnerable children and young people, particularly children in care. It was recommended that the CFA should directly provide public health nursing, speech and language therapy, CAMHS, psychology services, Garda diversion projects, probation services, detention schools, domestic and sexual violence services, hospital social workers, and the **National Education Welfare Board** (NEWB), resulting in "an integrated system of children's services that have formal linkages with external services and that have established processes and procedures that have children's well-being as their focus at all levels of need" (p. xiii).

The extent to which the recommendations of the Task Force will be implemented remains to be seen. The government has decided that from its establishment, the new CFA will have responsibility for child welfare and protection service, including family support and alternative care; pre-school inspections, domestic, sexual and gender based violence services; the NEWB and community-based psychology services, which will not include psychologists operating within acute, disability, mental health or other specialist services (www.dcya.ie). However at the time of writing, the establishment of the CFA has been delayed as community psychology services are not in agreement with this transfer. It is unclear whether other agencies will transfer at a later stage.

The Mental Health Commission (MHC, 2012) has recommended that CAMHS should remain independent from the CFA but should develop close working relationships. In order to achieve this, the MHC suggested priority should be given to primary care, and that staff in universal services need a better understanding of mental health and their role in identifying need. Finally, the MHC recommends integrated working and inter-agency collaboration and communication to address the mental health needs of children in care and in contact with child protection services.

Children's Services Committees (CSC) are a recent and ongoing development in Ireland. Beginning in 2007, four pilot CSCs in Dublin City, South Dublin, Donegal and Limerick City were established to test and refine the model (Burke, Owens & Ghate, 2010). To date, there are 16 CSCs in operation, mostly matching local authority boundaries, with the aim of bringing together agencies who work with children. These are responsible for policy implementation through the co-ordination of services and the facilitation of local decision-making processes.

Finally, the **Assessment, Consultation and Therapy Service** (ACTS) was established in 2012 to provide multi-disciplinary therapeutic interventions to children with complex needs, including those in High Support, Special Care, and detention, or at risk of entering these services (HSE, 2012d). The ACTS service provides clinical governance and support to clinicians in specialist work with vulnerable young people, with whom engagement may be challenging. One of the defining features of ACTS is the provision of flexible services within care settings rather than on an appointment basis in specialist clinics. In addition, ACTS clinicians cross traditional service boundaries to provide continuity of therapeutic support to young people moving placements.

As noted, 2013 is a time of great change in service development in Ireland, particularly with regard to services that could potentially impact significantly on the lives of the children and young people in our State care and youth justice systems. Given the diversity of services currently responding to these young people's needs, under the aegis of different governmental departments and voluntary agencies, the need for effective inter-agency working is paramount. While services do exist at all levels of the Hardiker model, ranging from universal services to those targeting young people requiring more specialist tertiary level services, considerable gaps in their availability are evident. The responsibility for co-ordinating responses to young people in need does not rest with any one agency, thus the challenge of adequate and effective service response is even greater.

CHAPTER 5
HUMAN RIGHTS, LEGAL AND POLICY CONTEXTS

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INTRODUCTION

This chapter explores Ireland's human rights obligations, under international and European human rights instruments, to children and young people in the care and youth justice systems. Irish law, policies and standards are also outlined. Some recent findings of inspections of care settings and youth justice facilities are summarised. The chapter concludes with specific proposals for strengthening the legal and policy frameworks in Ireland to address the mental health needs of children and young people in different points in the care and youth justice pathways.

This chapter sets out the most relevant international human rights standards in relation to children's mental health, children in the care system and in the youth justice system.

THE HUMAN RIGHTS CONTEXT

The UN International Covenant on Economic, Social and Cultural Rights, applicable to all, enshrines "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12). Furthermore, several international human rights instruments are particularly relevant for children in the care of the state and in the youth justice system, such as the UN Convention on the Rights of the Child (CRC), the European Convention on Human Rights (ECHR) and the **UN Guidelines for the Alternative Care of Children**. These set out rights applicable to all people as well as provisions relating more specifically to the mental health of children in the care and youth justice systems.

INTERNATIONAL HUMAN RIGHTS LAW AND GUIDELINES: CHILDREN AND MENTAL HEALTH

The most significant international instrument in relation to children's rights is the CRC (United Nations, 1990a), the most universally accepted of all international human rights treaties, which was ratified by Ireland in 1992. Article 27.1 recognises "the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development". A right to health care was also recognised in relation to children under Article 24.1, acknowledging "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health".

The CRC also contains key principles which are significant to children with mental health problems, particularly the 'best interests' principle in Article 3, one of the CRC's four key principles as identified by the UN Committee on the Rights of the Child. This requires that the best interests of the child or young person be the primary consideration in all actions concerning them. The concept of the 'best interests' of the child or young person should be interpreted and applied in light of the need to respect their evolving capacities (Article 5) and their right to be heard and to participate in decisions affecting them (Article 12).

The European Convention on Human Rights (ECHR) also sets out rights applicable to all people. It was incorporated into Irish law by the European

Convention on Human Rights Act, 2003; therefore, its provisions are of particular relevance, as is the case law of the European Court of Human Rights (ECtHR), which has produced a substantial body of jurisprudence dealing with the treatment of children in alterative care (see Kilkelly, 2008). In this context, Article 3 of the ECHR, which prohibits torture, inhuman and degrading treatment or punishment and Article 8, which guarantees a right to respect for private and family life are particularly significant. In the context of children in the juvenile justice system, the ECtHR has found infringements of Article 5 (which deals with the right to liberty and security), Article 3 and Article 6 in circumstances where a minor was held for an excessive time in pre-trial detention in an adult prison and did not receive adequate medical care despite psychological problems and suicide attempts (Güveç v. Turkey, 2009; ECtHR no. 70337/01), and violations of Article 2 in a case where a minor had died by suicide while detained in an adult prison without any medical or specialist care (**Çoselav v. Turkey**, 2012; ECtHR no. 1413/07).

Ireland is also a signatory to the UN Convention on the Rights of Persons with Disabilities (CRPD), which includes mental health problems. The CRPD entered into force in May 2008, but Ireland has yet to ratify it and is not yet bound by its provisions. The government has indicated its intention to ratify the CRPD following the enactment of capacity legislation which it says is necessary. At the time of writing, the Bill is on the A list of the government **Legislative Programme**.

The CRPD provides a 'paradigm shift' in attitudes and approaches to people with disabilities, moving towards a social model of disability. While the CRPD does not create any new international human rights; it reaffirms that all people with disabilities enjoy all human rights and fundamental freedoms on an equal basis with others. Article 3 recognises the need to have respect for the evolving capacities of children with disabilities, while Article 4(3) requires States to closely consult with and actively involve children with disabilities and their representative organisations in the development and implementation of legislation and policies to implement the CRPD.

The CRPD also reiterates the importance of the best interests of the child as a primary consideration in all actions concerning children with disabilities. In doing so, it requires State parties to ensure that children with disabilities have the right to express their views freely on all matters affecting them and that their views are given due weight in accordance with their age and maturity, including through the provision of appropriate assistance to realise that right (Article 7). Reference is also made to the right to the highest attainable standard of health and the CRPD expressly requires State parties to provide people with disabilities with services they need, including early identification and intervention as appropriate (Article 25).

In 1991, the UN adopted **Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)**. While these principles do not have the status of binding international law, they provide useful guidance on the human rights of people experiencing mental health problems. Although certain aspects are outdated, the

principles emphasise the right to care and treatment in the community (Principle 7) and to the least intrusive treatment in the least restrictive environment in accordance with an individually prescribed treatment plan (Principle 9). The situation of criminal offenders (although not specifically young offenders) is addressed in Principle 20, which states: "All such persons should receive the best available mental health care."

In 2004, the Council of Europe issued a **Recommendation Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorders**. Article 10 states that Member States should ensure that there is sufficient provision of hospital facilities with appropriate levels of security, as well as community-based services to meet the health needs of people with mental problems involved with the criminal justice system. Article 19 states that a minor should not be placed in a facility with adults unless it would benefit the minor.

INTERNATIONAL HUMAN RIGHTS LAW AND GUIDELINES: YOUNG PEOPLE IN CONFLICT WITH THE LAW

A number of human rights instruments address the situation of young people in conflict with the law; many are relevant to their mental health. The UN Committee on the Rights of the Child outlines the core elements of a comprehensive juvenile justice policy in its General Comment 10. The Committee urges State parties to implement the **UN Guidelines for the Prevention of Juvenile Delinquency (the Riyadh Guidelines)**, which have a particular focus on prevention policies that facilitate socialisation and integration of all children (Guideline 3). The Committee recommended that:

> **The States parties should also develop community-based services and programmes that respond to the special needs, problems, concerns and interests of children, in particular of children repeatedly in conflict with the law, and that provide appropriate counselling and guidance to their families.**
> **(General Comment 10, para 18)**

Articles 37 and 40 of the CRC specifically address the situation of children in the youth justice system. Article 37(d) provides that children "deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age". Article 40.4 provides that a variety of options should be available as alternatives to institutional care, including "care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives". As well as being proportionate to circumstances and offences, these options should ensure that children "are dealt with in a manner appropriate to their well-being".

The Committee on the Rights of the Child in its General Comment 10 stressed that disciplinary measures in violation of Article 37 of the CRC must be strictly forbidden, including closed or solitary confinement, or any other punishment that that may compromise the physical or mental health or well-being of the child concerned. Further, it recognised the need for the establishment of "specialised services such as probation, counselling or

supervision" in juvenile justice systems, as well as effective co-ordination of these services (at para 94).

The **UN Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules)** also place considerable emphasis on the well-being of the young person in conflict with the law. The Beijing Rules recognise the importance of diversion and emphasise that placing a young offender in an institution should be a measure of last resort and for the shortest necessary period of time. The Rules also state young people in institutions should "receive care, protection and all necessary assistance – social, educational, vocational, psychological, medical and physical – that they may require"(Rule 29.2).

The **UN Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules)** stress that a juvenile justice system should uphold their physical and mental well-being (Rule 1). These Rules state that "a psychological and social report identifying any factors relevant to the specific type and level of care and programme required by the juvenile should be prepared as soon as possible after their admission to the institution in which they are to be detained" (Rule 27). The conditions of their detention should also be cognisant of their needs, status and any special requirements, as well as their mental and physical health (Rule 28). Rule 53 states:

> **A juvenile who is suffering from mental illness should be treated in a specialised institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.**

Human rights standards at the regional Council of Europe level are also relevant to the needs of young people in conflict with the law. The **European Rules for Juvenile Offenders Subject to Sanctions and Measures** stipulate that particular attention should be given to the needs of young offenders with physical or mental health problems and provide that young offenders to be deprived of their liberty who are experiencing mental illness should be held in mental health institutions (Rule 57). The Rules also highlight the importance of activities such as aggression-management, addiction therapy and individual and group therapy (Rule 77).

The **Guidelines of the Committee of Ministers of the Council of Europe on Child-Friendly Justice**, adopted in 2010, state that in relation to young offenders with mental health problems, children should be treated "with care, sensitivity, fairness and respect throughout any procedure or case, with special attention for their personal situation, well-being and specific needs, and with full respect for their physical and psychological integrity" (Part 3, Guideline C1). In addressing the situation of young people in conflict with the law, Guideline 82 recommends that measures and sanctions should always "be constructive and individualised responses to the committed acts, bearing in mind the principle of proportionality, the child's age, physical and mental well-being and development and the circumstances of the case".

While it is of crucial importance that Ireland adheres to international human rights standards in relation to vulnerable children, it is also important to recognise the limitations of human rights standards in some contexts. This is particularly pertinent in relation to child imprisonment. Goldson and Kilkelly (2013) argue that, while recognising the "vital **potentialities** of the human rights standards – to pacify the more problematic excesses of child imprisonment", one should remain cognisant of their practical **limitations** and reserve a sense of scepticism in respect of the concept of 'rights-based approaches' to the penal detention of children. When it comes to depriving children of their liberty, it should be borne in mind that a significant body of international evidence indicates that such practices, particularly penal detention, are damaging to children (Goldson & Kilkelly, 2013); the ultimate goal should therefore be to abolish penal detention for children. Furthermore, interventions that serve to restrict liberty should be used as a measure of last resort and for the shortest appropriate period of time, as required by international human rights law and should only be used "for the small number of children whose behaviour is legitimately deemed to place them and/or others at **demonstrable serious risk**" (Goldson & Kilkelly, 2013). These interventions must be rigorously monitored and tested against international human rights standards as a minimum.

INTERNATIONAL HUMAN RIGHTS LAW AND GUIDELINES: CHILDREN IN CARE

The **UN Guidelines for the Alternative Care of Children** are rooted in the CRC. They set out in detail what the CRC requires of States with respect to the alternative care of children; in particular, they focus on ensuring that children are not placed in alternative care unnecessarily and that out-of-home care is delivered under appropriate conditions responding to the child's rights and best interests. Specific provisions deal with the promotion of children's health and arrangement for medical care, counselling and support (Guidelines 84); the legal responsibility of those involved in providing formal alternative care for the child (Guidelines 101 – 104) and the preparation of children who leave care, for example through the provision of appropriate financial support and access to social, legal and health services (Guideline 136).

Guideline 84 stipulates that: "Carers should promote the health of the children for whom they are responsible and make arrangements to ensure that medical care, counselling and support are made available as required." Guidelines 101-104 provide for the appointment of a person who would have "the legal right and responsibility to make such decisions in the place of parents, in full consultation with the child"; this person's responsibilities would include: "Ensuring that the rights of the child are protected and, in particular, that the child has appropriate care, accommodation, healthcare provision, developmental opportunities, psychosocial support, education and language support". Guideline 136 states that a young person leaving care and during after-care should have appropriate financial support as well as access to social, legal and health services.

THE IRISH LEGAL CONTEXT

This section reviews relevant Irish legislation that provides the basis for the care and youth justice systems and for mental health treatment.

THE IRISH CONSTITUTION: THE POTENTIAL OF ARTICLE 42.1

In November 2012, a referendum was passed in Ireland to amend the Constitution, Bunreacht na hÉireann, to insert specific provisions in relation to children. At the time of writing, however, the amendment Bill is frozen until a case challenging the validity of the referendum is heard by the High Court. The passing of the amendment is a welcome development and, provided the courts uphold the validity of the referendum, the Irish Constitution will contain a stand-alone article in relation to children.

Since Ireland has a dualist legal system, international agreements that have been ratified by Ireland also need to be incorporated into Irish law so that they can be relied upon as part our domestic legal system. The UN Committee on the Rights of the Child has called upon the Irish government to incorporate the key provisions of the CRC into domestic law, including through the Irish Constitution. Disappointingly, however, the recent amendment does not introduce general provisions on best interests and voice of the child or a non-discrimination clause into the Constitution. Rather, the wording of the amendment places an obligation on the state to legislate for the voice and the best interests of the child only in very specific and narrow circumstances. This only applies in relation to child care proceedings brought by the State, and to adoption, guardianship, custody and access proceedings. Furthermore, the new provision creates an obligation to legislate rather than a direct constitutional provision.

As a first step, the amendment is a positive development. Provision for the adoption of children in long-term foster care is welcome, as is the provision that State intervention to protect children must be by proportionate means, which will oblige the State to show that it has endeavoured to apply alternative measures prior to taking a child into care. It is hoped that this provision will lead to better support for families where appropriate. The constitutional amendment also has the potential to create a new culture of respect for children's rights. In the new article 42.1, the State recognises and affirms the natural and imprescriptible rights of all children and shall, as far as practicable, by its laws protect and vindicate these rights. Kilkelly (2012) points out that this clause has the potential to bring about a fundamental change in the relationship between the State and children by affirming in our Constitution that children are rights-holders and it is the State's responsibility to uphold those rights. This provision, Kilkelly argues, offers the potential for constitutional protection of a wider array of children's rights, allowing advocates to argue for a more expansive approach and leading to the development by the courts of children's rights law for the Irish context.

VOICE OF THE CHILD IN IRISH LAW

As described above, Article 12 (2) of the CRC requires that where children are capable of forming their views they be provided with representation

to enable their views to be heard in relevant proceedings that affect them. Kilkelly (2008) has highlighted that there is currently an absence of effective mechanisms in Irish law to ensure that children's views are recognised. As Kilkelly states, "ascertaining the views of children is a delicate process and conveying their views to the court should be undertaken by those well placed to expertly guide the court in the weight it attributes to those views" (Kilkelly, 2008, p. 177). The recent Constitutional amendment, yet to come into force, places an obligation on the State to legislate for the voice of the child and the best interests of the child but only in relation to very specific circumstances. Currently in Ireland there are two mutually exclusive formal forms of legal representation – advocacy representation by a guardian ad litem and legal representation by a solicitor (Shannon, 2008).

A guardian ad litem (GAL) is effectively an independent representative appointed by the court in a limited number of circumstances to represent the child's personal and legal interests. A prerequisite of appointment of a GAL is that it must be in the child's best interests, or that there must be "special circumstances". This is in stark contrast to the UK model where there is an effective presumption in favour of the appointment of a GAL in a wide range of areas (Shannon, 2007). In public law proceedings, a GAL can be appointed under Part IV and Part VI proceedings under the Child Care Act, 1991. In private law proceedings, only custody or access disputes and guardianship applications allow such an appointment. There is no central body regulating the guardian ad litem system in Ireland for training and employment of GALs (Shannon, 2009). The Children Acts Advisory Board (CAAB) published guidelines on GAL appointment, role and qualifications (CAAB, 2009a). These include criteria that must be satisfied for appointment (based on both experience and skills); standards for training; and standards for the manner in which GALs are to conduct themselves throughout the process from the preliminary inquiry stage to post case care. The guidelines provide some clarity and should be enacted on a statutory basis (Shannon, 2009).

In contrast to a GAL, where a solicitor is appointed to represent a child, the solicitor is not required to judge the best interests of the child but must follow the child's instructions. Therefore, the representation provided is of a limited nature if the wishes of the child client do not coincide with the child's best interests. Lawyers are generally not qualified to tell the court what is in the child's best interests. The solicitor must be satisfied that their client fully understands the nature of the proceedings. Where a child is experiencing a mental health problem, their lawyer may wish to seek directions from the court (Law Society's Law Reform Committee, 2006).

Section 26 (4) of the Child Care Act, 1991 Act provides that if the court decides to add a child as a party to the proceedings under s 25, any prior appointment of a GAL in respect of the same child shall be deemed to have ceased. This raises difficulties since the GAL does not currently have a statutory role to advocate for the rights of the child, nor is this recommended in the CAAB guidelines. It is important, particularly given complex issues in relation to mental health, that a child can be provided with both a GAL and legal representative. While this will not be necessary in all cases, it is crucial in cases where the child's views differ to that

of the GAL and where complex legal issues arise, to ensure the child's constitutional and other rights are vindicated.

MENTAL HEALTH LEGISLATION IN IRELAND

The primary piece of legislation in Ireland relating to children and mental health is the Mental Health Act, 2001, which contains specific provisions for the admission of children to approved mental health inpatient centres; the involuntary detention of children with a 'mental disorder'; and the administration of mental health treatment. Currently, the Mental Health Act does not require that admission or detention be to a child inpatient unit; or to an area separate to adults in an age appropriate environment; and in the least restrictive environment available, as recommended by the international principles for people with mental health difficulties such as the United Nations MI Principles (1991) and the Council of Europe (2004) Recommendation. The Mental Health Act established the Mental Health Commission, an independent body tasked with establishing and maintaining high standards and good practices in mental health services and protecting the interests of people detained in approved centres.

The Mental Health Act provides for independent review of all involuntary detentions through Mental Health Tribunals, but Tribunals do not have a role in children's admission or treatment. Instead, the District Court has jurisdiction to order the detention of a child in an approved centre. Applications for admission or detention of children are made by the HSE with or without the consent or co-operation of the child's parent or guardian; or a child may be admitted on a voluntary basis provided there is parental consent. There is therefore currently a discrepancy between Section 23 of the Offences Against the Person Act, 1997 and the Mental Health Act regarding the age at which a young person may legally consent to or refuse treatment. The Law Reform Commission (Law Reform Commission, 2011), and the Department of Health's Steering Group in their **Interim Report of the Review of the Mental Health Act** (DoH, 2012) therefore recommend that children aged 16 and 17 years should have capacity to consent to or refuse admission and treatment under the Mental Health Act. In addition, the Law Reform Commission has recommended that a separate category of informal admissions be established in relation to children under 16 who are admitted on the basis of parental consent (Law Reform Commission, 2011).

The question of a child's decision-making ability is one which must be dealt with in greater detail by the Expert Group currently examining the Mental Health Act 2001 in light of the requirement to take into account the voice of the child and their evolving capacities as outlined in the CRC and the CRPD. The difficulty in addressing the question of a child's decision making ability was recently highlight by the High Court in **HSE v J.M. & Anor** ([2013] IEHC 12), where a child aged 15 years disagreed with her doctors and parents regarding the provision of medication. In a recent High Court decision, where judicial review proceedings had been initiated challenging an earlier District Court decision, Judge Birmingham made orders allowing the HSE to continue treating a 16-year-old girl with anti-psychotic medication, despite objections from the girl's mother. The girl had been admitted to a HSE child and adolescent mental health inpatient facility in Dublin after

being taken into voluntary care in January 2013 following a 'psychotic episode'. When the girl's mother raised concerns about her treatment with anti-psychotic medication, the HSE obtained a District Court Order to detain the girl under provisions of the Mental Health Act, 2001. The judge criticised the ex-parte procedure used by the HSE to obtain this order, with no opportunity for the girl's mother to be heard. In High Court proceedings, the girl's mother raised concerns about the anti-psychotic drugs, which are not licenced in Ireland for use in children or adolescents and for which medical evidence showed serious side-effects could include dyskinesia, a disorder of the nervous system. Mr Justice Birmingham said he would make an order continuing treatment to see what progress was made but would not finalise the matter and would consider further legal issues in June (**Irish Times**, 24 April 2013). It is notable that in this case, the child had a Guardian ad litem (GAL) who was in agreement with the treating consultant psychiatrist. Despite the fact that the girl was 16 and issues were raised about her medication, this young person was not legally represented and, although she did have a GAL, her own voice was not heard in these proceedings.

The Mental Health Act, 2001 is currently under review by an Expert Group appointed by the Minister of State with responsibility for Disability, Older People, Equality and Mental Health, Kathleen Lynch TD. The Interim Report of the Department of Health's Steering Group (DoHC, 2012) contained recommendations that the Act should contain a separate section relating to children that would have its own set of guiding principles. While these recommendations are welcome, it remains to be seen whether the Expert Group will reiterate and expand upon them in their forthcoming report.

YOUTH JUSTICE LEGISLATION IN IRELAND

The primary piece of legislation governing the youth justice system in Ireland is the Children Act, 2001. Under this legislation, a number of options are provided to address offending behaviour. There is a strong focus on measures aiming to rehabilitate and to divert young people away from the criminal justice system at an early point, and on attempting to encourage desistance from further offending behaviour. A young person's progress through the criminal justice system may bring them into contact with An Garda Síochána, Young Persons' Probation, the Children Court and staff in the Children Detention Schools, among others.

THE LAW AND YOUNG PEOPLE
THE GARDA YOUTH DIVERSION PROGRAMME

The Garda Youth Diversion Programme provides an alternative mechanism for addressing offending behaviour for children aged between 10 and 18; Part 4 of the Children Act sets out its operation. The age of criminal responsibility under the Children Act, 2001 is 12. However, as children aged 10 or 11 can be charged with murder, manslaughter, rape and aggravated sexual assault, they can be admitted for diversion in respect of these offences.

Youth Diversion aims to divert a young person from further criminal or anti-social behaviour; it is co-ordinated by the Garda Office for Children

and Youth Affairs in Dublin and the Programme Director makes the final decision on admission (Garda Office for Children and Youth Affairs, 2010, 2011). The scheme includes formal and informal measures. An informal caution is given by Garda Juvenile Liaison Officers (JLOs) for first-time minor offences; those receiving formal cautions are placed under the supervision of a JLO for 12 months. As part of the Diversion Programme, the Children Act also includes the possibility of holding a conference underpinned by the principles of restorative justice (Seymour, 2012). The aim is to bring relevant people together to discuss how the child became involved in criminal behaviour and how the family and others connected to the child can help prevent such involvement. An action plan is formulated and agreed upon at the conference.

THE CHILDREN'S COURT AND THE SENTENCING PROCESS

Where diversion has not been possible, young offenders' cases are typically dealt with by the Children's Court. Research by Kilkelly into the operation of the Children's Court found that "the court does not fare well when measured against international standards" (Kilkelly, 2008b, p.53). Kilkelly concluded that while the Children Act, 2001 attempts to distinguish the Children's Court from adult courts, "the fact that its provisions are inadequately implemented in practice meant that, at best, the process is slow and inefficient and, at worst, it is failing to minimise the negative impact for a young person of the appearance in court, contrary to the Act's objectives" (p.53). The young person may avoid a criminal conviction under Section 78 of the Children Act, where the Court may adjourn proceedings and order that a family conference be held (arranged by Young Persons' Probation) to consider matters relating to the child.

Most children are released on bail while awaiting the finalisation of their case, which often involves several further court appearances (Seymour, 2012, p.174). They often remain unsupervised while on bail and are therefore at risk of accumulating further charges (Seymour & Butler, 2008). Seymour points out that this is exacerbated by the absence of a bail support programme in Ireland to assist the most vulnerable children to comply with their bail conditions.

A particularly important inclusion in the Children Act is the principle that detention should only be imposed as a measure of last resort, as set out under Sections 96 and Section 143, which specifies that a detention order will not be made unless the Court is satisfied "that detention is the only suitable way of dealing with the child". This reflects a large body of opinion that detention is particularly harmful to young offenders (Goldson & Muncie, 2006). In the case of a conviction, the Court can utilise a wide range of sanctions, set out under Part 9 of the Act and "designed to ensure that there is an appropriate measure available for each child regardless of his/her needs or problems" (Kilkelly, 2006, p.171). These can include a day centre order, a probation (training or activities programme) order, a probation (intensive supervision) order, a probation (residential supervision) order, a suitable person (care and supervision) order, a mentor (family support) order, a restriction on movement order, or a dual order. Before any sentence is imposed, the Court will require a report from Young Person's Probation. Section 151 provides for the option of making a

detention and supervision order. This provides for detention followed by a period of supervision in the community.

Under the Children Act, children can be detained on remand for the purposes of preparation of a report. Children continue to be detained on remand for the purposes of carrying out a psychiatric assessment, despite the fact that the Children Act states that children cannot be detained on remand for welfare reasons alone. This situation often arises because community mental health services are not available to the child for assessment and treatment purposes (professionals' consultation). As noted in chapter four, many child and adolescent community mental health teams do not currently provide access to 16- and 17–year-olds and there are shortages of child and adolescent inpatient facilities. Although some improvements have been made in this regard, many children continue to be treated in adult facilities each year and there is no option under the Children Act 2001 for a judge to remand a young person to a child and adolescent mental health inpatient facility to facilitate the preparation of a mental health assessment.

CHILDREN IN THE CIRCUIT COURT AND CENTRAL CRIMINAL COURT

While the majority of offences committed by young people under 18 in Ireland are dealt with by the Children Court, children can be sent forward to the Circuit or Central Criminal Court in relation to more serious offences. There is a lack of research to ascertain the extent to which the circuit and central criminal courts are adhering to international standards of youth justice, but Kilkelly (2006) has stated that children appear to be tried in these courts as adults, with little concern for the principles of youth justice. In this context, it is particularly important that a range of options are in fact available to the circuit and central criminal courts to identify young offenders with mental health problems and divert them away from custody towards a therapeutic environment.

Research is also needed to investigate whether the 'fitness to plead' provisions under section 4 of the Criminal Law (Insanity) Act, 2006 are invoked in relation to children, particularly given the absence of forensic mental health facilities for children. Screening and assessment to identify the mental health needs of young people in conflict with the law is also part of the obligation to ensure due process rights of young offenders (Halpin, 2012). Nacro (2012) has noted that for children and young people in trouble with the law, in an attempt to avoid stigmatising the young person, practitioners often favour the youth justice pathway over the mental health pathway. In the UK, Nacro noted, this often offers the line of least resistance and least local cost.

LEGISLATION FOR THE CARE SYSTEM IN IRELAND

The system for providing for children in care in Ireland is governed primarily by the Child Care Act, 1991. Part II of the Act deals with the promotion of the welfare of children, and under Section 3, there is a duty on the HSE to promote the welfare of children who are not receiving adequate care and protection. The 1991 Act provides the State with a number of

different options including applications for voluntary care, a supervision order, an emergency care order and an interim care order. The Act was amended in 2011 to provide a statutory basis for Special Care orders and interim Special Care orders. These provisions (not yet commenced at the time of writing) will, for the first time, provide a legislative basis for Special Care orders. Under the new Section 23(c), Special Care means the provision to the child of "(a) care which addresses – (i) his or her behaviour and the risk of harm it poses to his or her life, health, safety, development or welfare, and (ii) his or her care requirements, - and includes medical and psychiatric assessment, examination and treatment, and (b) educational supervision" in a Special Care unit. This is used to deal with a situation where a child between the ages of 11 to 18 is at risk by virtue of her or his own behaviour.

CHILDREN IN THE CARE OF THE HSE

Part VI of the Child Care Act, 1991 deals with children who are in the care of the HSE. This may include the placement of the child with a foster parent; in residential care; with a suitable person with a view to adoption, if appropriate; with a relative; or in another suitable arrangement. Section 38 requires the HSE to ensure that there are an adequate number of residential places available for children in care.

THE ROLE OF THE DISTRICT COURT

Section 47 of the 1991 Act provides that where a child is in the care of the HSE, the District Court may, of its own motion or on the application of any person, give such directions and make such orders on any question affecting the welfare of the child as it thinks proper or may vary or discharge any such direction or order. The courts have interpreted this section as giving the overall control of children in care to the District Court (Kilkelly, 2008). Seeking a Section 47 order from the District Court is often the only avenue open to practitioners and representatives of the child to obtain a court order in respect of a child. Section 47 orders are often invoked in circumstances where mental health assessments and access to suitable placements, services and supports have not been forthcoming in relation to children in care. Where a request arises under Section 47 of the Child Care Act, 1991 to provide family services for parents as well as for children, there is anecdotal evidence to suggest that such applications are resisted by the HSE on the basis that Section 47 is confined to the child (Shannon, 2011).

AFTER-CARE, CHILDREN WHO ARE HOMELESS, AND SEPARATED CHILDREN

Section 45 of the Child Care Act, 1991 provides that the HSE may provide for assistance to the young person on leaving state care. This after-care can be provided if assistance is needed up until the age of 21, or possibly beyond the age of 21 if assistance continues to be necessary to allow the young person to complete a course of education. The fact that the wording contains a 'may', rather than a 'shall', means that after-care remains at the discretion of the HSE.

There is a positive duty on the HSE under Section 3(2) to take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children. Shannon (2011) has pointed out that a notable aspect of the HSE's duty here is that it applies "regardless of whether the child is a 'resident' of the functional area or not. Any child who is found 'in' the functional area of the HSE is deemed to be its responsibility" (Shannon, 2011, p.1). This is particularly significant when considering the situation of children who are homeless or separated children. Section 5 of the 1991 Act directly addresses the question of children who are homeless.

There are many legal issues in relation to the situation of separated children which are beyond the remit of this report but which need to be addressed (Arnold & Collins, 2011). Many separated children have particular health and mental health needs arising from pre-flight trauma. Section 8 of the Refugee Act, 1996, as amended, provides that an immigration officer should inform the HSE when an unaccompanied minor (or separated child) arrives in the State, and from then the provisions of the 1991 Act apply to the child. There have been inconsistencies in the manner in which these young people are brought into care, with some being placed in voluntary care under Section 4 of the Child Care Act and others being placed in accommodation for homeless children under Section 5. The mental health of these children can suffer as a result of inadequate or lack of aftercare support, having to transfer from care to direct provision centres and in light of the sometimes traumatic circumstances that these young people arrived into the country.

SPECIAL CARE

Special Care orders developed in response to situations where the mainstream residential care system could not cater for the needs of children with severe behavioural problems or personality disorders and where the behaviour of the child posed a risk to her or his safety or welfare. In the absence of legislation or appropriate placements to deal with such situations, the High Court began to use its inherent jurisdiction under Article 40.3 (personal rights) of the Constitution and Article 42.5 (State intervention where parents have failed in their duty towards the child) to detain the child in a secure placement. Case law in this area, well documented elsewhere (Dillon, 2012; Kilkelly, 2008), has shown a history of a lack of appropriate placements to meet the needs of these children, as well as the absence of any legislative basis for Special Care (Dillon, 2012; Kilkelly, 2008).

The third edition of the **Criteria for Admission to Special Care and Guidance Applying for a Placement in Special Care** (DCYA, March 2012) outlines circumstances in which placement in a Special Care unit is not an appropriate option, including where the primary reason for seeking placement is that the young person has an acute psychiatric or medical illness requiring intensive medical supervision or where s/he has a learning disability. Brierley (2010) provides an overview of the applications for admission to Special Care made by the HSE Local Health Offices in 2007 and traces and tracks outcomes for the children who were subject of those applications up to November 2009. The report details characteristics

of cases subject to an application for Special Care (70 applications of 59 individuals). It looked in detail at demographic profile, risk factors present, previous placement history and other case characteristics such as offending, education and health (including mental health). The report also details the application process, including the previous service/intervention history of applicants and looks at outcomes by November 2009, based on interviews with representatives from social work departments. Social workers, GAL/solicitor discussion groups and some parents/carers were not satisfied with the availability of psychiatric and psychological support for young people in special care (Brierley, 2010).

Brierley found that almost all of the children were receiving psychiatric interventions or had received a psychiatric assessment/intervention in the past. The research found that the nature of these assessments and interventions was very unclear in the application paperwork and would benefit from more detailed examination in the future. The report recommended that further research into Special Care outcomes should identify in detail "the number of children who have accessed psychiatric services prior to the application the range of supports offered both before and since the application , any issues with regards to accessing them and the effectiveness of this supports" (p. 126). The report also recommends that "the application form for special care should be amended to ensure that, where a child subject to a special care application has previously had contact with psychiatric services, it is clear whether they engaged with those services and whether they received an assessment only or went on to receive service interventions" (p. 126).

Section 10 of the Child Care (Amendment) Act, 2011 amends Part IVA of the Child Care Act, 1991 (as amended by the Children Act 2001) by substituting it with a new part 1VA. This new section of the Child Care Act, 1991 puts the admission criteria on a statutory footing. However, this section has not yet been commenced. Once this section of the Act is commenced, the High Court must be satisfied, when granting a Special Care order, that alternative care, including mental health care, would not meet the child's needs. This raises a question as to the availability of suitable child and adolescent inpatient facilities to provide alternative multi-disciplinary care to meet the needs of the child. Under Section 23(b)(2) of the Child Care Act, 1991, the HSE is required to provide appropriate care, education and treatment for a child in secure care. The Act should be amended to specify the elements of this care, particularly appropriate multi-disciplinary mental health care adapted to meet the specific needs of the child.

THE POLICY CONTEXT

This section addresses Irish policy and standards for the care of children for whom the State is responsible, and also considers inspection reports and the need for legislative and policy change. First, general policies for services supporting the well-being of all children in Ireland are summarised. After this, standards and policies of care for children in care of the State are outlined; these consider foster, residential, special, and after-care; homeless children; asylum seekers; and children in the youth justice system. Some research considering limitations of these standards, policies and procedures is presented. After this, the

aspirations of the national mental health policy, **A Vision for Change**, are described. Following from this summary of relevant national policies, brief summaries of findings of recent inspection reports of services for children in care of the State are given. These indicate that while there are some areas of good practice, poor practice and care is still seen. Therefore, the section concludes with a summary of the legislative and policy changes required to address these and other lacunae.

NATIONAL POLICY FOR ALL CHILDREN

In the **Agenda for Children's Services**, the Department of Children and Youth Affairs (DCYA) articulated seven outcomes for children, the first of which is that children will be "healthy, both physically and mentally" (Office of the Minister for Children, 2007). The Agenda builds on the **National Children's Strategy** (DoHC, 2000b), which refers to the physical, mental, and emotional well-being of children. A new strategy is due for publication in 2013 and will include the first early strategy for children up to six years and one for young adults up to 24 years.

The three goals of the current National Children's Strategy are that children will have a voice in matters that affect them; that their lives will be better understood and they will benefit from research and evaluation of their needs, rights and the effectiveness of services; and that they will receive quality supports and services to promote all aspects of their development. These goals – that children will have a voice, that their lives will be better understood, and that they will receive quality supports and services – are clearly of particular relevance to children in the care of the State and children in the youth justice system.

POLICIES FOR CHILDREN IN CARE

To build on legislation and develop best practice in the field, statutory agencies have developed a series of 'national standards' in relation to children in alternative care in Ireland; HIQA carry out regular inspections of care services based on these standards. There are also policies relating to children and young people who are homeless; separated children; and young people leaving care and after-care. These are summarised in this section.

NATIONAL STANDARDS FOR SERVICES FOR CHILDREN IN CARE

For children in foster care, the **National Standards for Foster Care** (DoHC, 2003) refer to children's rights, positive sense of identity, health and development, assessment, care planning, and preparation for leaving care. The National Standards govern the pre-placement procedures the HSE must follow when placing a child with foster parents or with relatives. Before placement, either with relatives or foster carers, the HSE must carry out an assessment of the child's circumstances. Crucially, the HSE must prepare a care plan for the child, which should include, among other matters, the aims and objectives of the placement; support to be provided to the child, relatives concerned and, where appropriate, the parents of the child. These care plans should be informed by assessments of the child's needs. The duties of carers are also set out; there is a general duty

on carers to take reasonable measures to promote the child's "health, development and welfare"; however Kilkelly (2008) has noted that of the ten specific duties listed, only one refers directly to the child's welfare. The standards include guidelines for the assessment, training, and supervision and support of foster carers. The HSE is also required to make support services available to foster parents and relative carers, including advice, guidance and training.

The **National Standards for Children's Residential Care** (DoHC, 2001b) apply to the residential care sector. These are comprehensive, reflect best practice and are an important source of guidance for all those working with children in residential care, notwithstanding that they do not enjoy the legal status of a statutory instrument (Kilkelly, 2008, p. 355). Standards 5.27-5.31 (DoHC, 2001b, pp. 18-19) refer to emotional and specialist support:

> **That staff are aware of the emotional and psychological needs of young people and through the key worker role and the general ethos of the centre facilities the assessment and meeting of those needs; The external manager arranges for external support to staff to provide for assessments, consultancy and treatment or counselling for individual young people; All children in care shall have access to specialist services they may require. Supervision social workers and centre staff should keep a record of attempts of access these services; All professionals with the young people will co-ordinate their work and will ensure that any interdisciplinary differences are overcome in the best interests of the young person; The findings and recommendations of specialist professionals are reflected in the care plan and the work of the centre with the young person.**

The **Standards for Special Care** (DoHC, 2000a) indicate that care plans, including assessment of behavioural, social, and emotional needs, should be prepared before admission to Special Care or within three working days for emergency admissions. They should be reviewed within two weeks and every four weeks thereafter. Responsibility for implementation, and for the transition out of Special Care, remains with the social worker. The standards specify that children should have access to specialist mental health services, through inter-agency agreements negotiated by the centre manager. Special Care centres are required to ensure adequate staffing and adequate accommodation, having regard to the number of children and the nature of their needs. Adequate arrangements must be in place for General Practitioner services and referral to medical, psychological, dental, ophthalmic or other services as required. Under the Child Care (Special Care) Regulations, referral to counselling, therapeutic or other specialist services is included. These regulations also require the HSE to monitor placements by keeping registers and case records for all children they place, including information such as medical reports, the care plan and any significant incident.

There are also duties on the HSE in relation to the monitoring of placements. Under Article 12 of the Child Care (Placement of Children with Relatives) Regulations, 1995, in particular, the HSE is required to keep registers of the particulars of children placed by them. There is a further

requirement to keep case records on each child, which should include information such as (but not limited to) medical reports, the care plan and every significant incident relating to the child. Additionally, the HSE is required to make available to foster parents and relative carers "support services, including advice, guidance and training".

Finally, provision is further made, regardless of the type of care the child is placed in, for the supervision and visiting of the child's placement by the HSE, and also for review of cases by the HSE.

NATIONAL POLICY FOR AFTER-CARE

The **HSE Leaving and After-care Services National Policy and Procedures Document** (2011) caters for young people over the age of 18 but contains several limitations in terms of its remit and implementation. It does not include a statutory right to after-care; it excludes children who came into care at 17 but have not spent 12 consecutive months in care, and children who have had multiple short placements; and its implementation has been hampered by a lack of resources (PILA & Barnardos, 2012). The importance of a statutory right to after-care is highlighted in a case reported by the recently established Child Care Law Reporting Project (2012) where the District Court judge ruled that evidence on an after-care plan could not be brought before the court because the child had reached the age of 18 and the court no longer had jurisdiction. In the context of Special Care, the Brierley report found difficulties in securing onward placement was a significant theme, particularly difficulty accessing mainstream residential placements (Brierley, 2010).

Research has identified that young people leaving the care system are often vulnerable to mental health problems; 39% (25 of 65) of care leavers in a recent Irish study had mental health needs (Daly, 2012). The transition from the Child and Adolescent Mental Health Service (CAMHS) to adult mental health services is difficult and requires support; without an assigned person to refer the individual to the appropriate mental health service, managing this transition is challenging. It has been recommended that mental health initiatives such as the services provided by Jigsaw, are essential and their development should be mainstreamed (EPIC, 2013).

NATIONAL POLICY FOR CHILDREN WHO ARE HOMELESS AND SEPARATED CHILDREN

The HSE Leaving and After-care Services National Policy and Procedures Document (2011) is further limited in that it does not include statutory obligations regarding children who are homeless under Section 5 of the Child Care Act, or for separated children. However, following a national review, a new HSE National Policy and Procedure on the Use of Section 5 of the Child Care Act 1991 was introduced (HSE, 2011). Under this new policy, children under 16 presenting as homeless or at risk of homelessness will be categorised as child protection and welfare concerns; risk assessed under **Children First: Guidelines for the Protection and Welfare of Children** (DoHC, 1999); and taken into care if they cannot be returned to their parents. They are entitled to accommodation, a key worker and a detailed placement plan which should be reviewed by a social work team.

However, they are still not entitled to an allocated social worker or a care plan. In the context of special care, Brierley found that the needs of children who are at acute risk who have experienced homelessness are not being addressed adequately (Brierley, 2010).

For separated children in Ireland, asylum seeking young people leaving care "may be eligible to access a Leaving & Aftercare service on the basis of their individual needs assessment" under the Leaving & Aftercare Services policy (HSE, 2011, p. 21). However, professionals expressed concerns about the discretionary nature and a lack of transparency regarding decisions to allow young adults to remain in placements (e.g., foster care or supported lodgings) rather than being sent to direct provision (Ní Raghalligh, 2013).

Most separated young people are vulnerable, and professionals questioned whether their complex needs and requirements, as mentioned in the HSE's aftercare policy (HSE, 2011) can be met in a direct provision environment. Participants felt the threshold of vulnerability had been set too high by the HSE; for example, one stakeholder had advocated for a young adult with serious mental health problems, suicidal ideation and who had lost two stone in weight during the move from foster care to direct provision; she stated that the HSE had indicated however that this was "not vulnerable enough" (Ní Raghalligh, 2013).

POLICIES FOR THE YOUTH JUSTICE SYSTEM

The **National Youth Justice Strategy 2008- 2010** (Irish Youth Justice Service, 2008a) outlines the mission statement and high-level goals of the IYJS. It also contains detailed objectives, actions, outcomes and performance indicators in relation to youth justice. The strategy acknowledges that depression and stress are key issues among young offenders and that access to counselling and mental health services for children and young people are helpful in reducing the risk of offending. The **Garda Youth and Children Strategy 2009-2011** was published in 2009, following on from the National Youth Justice Strategy. The mission statement of the strategy includes a commitment to be sensitive to the needs and rights of children and the startegy commits to ensuring the provisions of the CRC are upheld in garda interaction with children. The strategy also commits to ensuring the highest level of international best practice in dealing with children in conflict with the law and to multi-agency approaches to the needs of young people (An Garda Síochána, 2009). The more recent **Garda Youth and Children Strategy 2012-2014** is closely alligned with the aims and objectives of the previous strategy and while the strategy makes broad commitments in relation to the needs of children, it does not contain specific objectives in relation to the underlying needs of the child and there is no reference to mental health needs in either strategy.

Also notable is a recent protocol introduced by the IYJS between HSE Social Workers and Children Detention Schools which aims to promote coordinated and collaborative practice, and provides guidance on joint working with children who have been identified as having on-going welfare needs (IYJS, 2012). This includes both children in care under the Child Care

Act, 1991 and also children who, although not in care, have been allocated a social worker after a HSE assessment of their needs (IYJS, 2012). This is a welcome development and progress towards recognition that children with offending behaviour have welfare and other unmet needs.

In 2008, the Department of Justice, Equality and Law Reform issued its **Standards and Criteria for Children Detention Schools** (IYJS, 2008b) which govern the inspections undertaken by the Health Information and Quality Authority of all three Children Detention Schools in Ireland. The standards require that the care received by children in detention safeguards their rights and actively promotes their welfare. A written care plan is required for each child in detention. While healthcare is identified as an essential element in the arrangements for the care of children in detention and there is a requirement to promote healthy lifestyles and provide emotional and other specialised support as required, the standards do not contain any specific requirements in relation to meeting the mental health needs for children in detention (Halpin, 2012).

The Office of the Inspector of Prisons and Places of Detention was established in 2002 and placed on a statutory footing by the Prisons Act, 2007. The Inspector of Prisons carries out announced and unannounced inspections to all prisons, including St Patrick's Institution. The **Standards for Inspection of Prisons in Ireland: Juvenile Supplement** (Reilly, 2009) recognise that detention of children should only be used as a measure of last resort and the foreword to the standards highlights the requirement to treat children in detention in a manner which complies with international human rights obligations. The Standards include requirements for health information to be made available to children and young people in St Patrick's Institution, as well as drug rehabilitation programmes. The Standards highlight the importance of the provision of medical care equivalent to that which is available in the community and the need for health professionals working with children in custody to have appropriate training. There is also a requirement that policies in relation to self-harm and suicide prevention are put in place.

NATIONAL MENTAL HEALTH POLICY

In chapter four, recommendations from A Vision for Change (DoHC, 2006), Ireland's national mental health policy, were summarised; the policy sets out a framework for providing accessible, community-based, specialist services for people experiencing mental health problems. The policy is underpinned by principles including citizenship, community care, partnership, effectiveness, accountability, quality, equity, inclusiveness, respect, recovery and non-discrimination. Among the recommendations is the adoption of a recovery orientation approach in contrast to the predominant bio-medical model.

For children and adolescents A Vision for Change specifies the need to prioritise the full range of mental health care, from primary care to specialist mental health services; provision of mental health services to all aged 0-18 years; and transitional arrangements to facilitate the expansion of current service provisions. It recommended the development of multi-disciplinary community and specialist CAMHS teams. As noted in chapter

four, however, many of these have yet to be implemented. The placement of children in adult mental health wards is specifically noted as poor practice under international standards for mental health care. While the Mental Health Commission's **Code of Practice** (Mental Health Commission, 2009) stated that such placement of would be phased out by the end of 2011, with no child under 16 being placed in adult wards from July 2009 and no child under 17 being placed in an adult unit by December 2010, these deadlines have not been met. In 2011, the Mental Health Commission was notified of 421 admissions of which 31.4% (132) were to adult units (Mental Health Commission, 2011). Of the 303 admissions of children under 18 years between January and September 2012, 24.8% (75) were to adult units (HSE, 2012a).

POLICY FOR MENTAL HEALTH IN EDUCATION

In January 2013, the Department of Education and Science launched **Well-being in post-primary schools: Guidelines for mental health promotion and suicide prevention** (Department of Education and Skills, 2013). The guidelines aim to support schools in developing a whole school approach to mental health promotion and suicide prevention. They follow the National Educational Psychological Service (NEPS) continuum of support framework reflecting the need for different types and levels of support for different groups of children within schools. They highlight the need for a holistic approach whereby school organisation, ethos and climate, curriculum, and community links and partnerships are all interconnected. However, the structures to support schools to develop a whole school approach to mental health have not been developed. Crucially, the guidelines do not provide a framework for multi-agency collaboration between the various education agencies such as NEPS, SESS, NEWB and CAMHS in relation to the mental health needs of students. The guidelines leave the responsibility for mapping referral pathways and for liaison with these agencies to individual schools.

INSPECTION REPORTS OF SERVICES

The Health Information and Quality Authority (HIQA) is responsible for carrying out inspections into care settings to ensure that standards and policies are being met in children's residential homes, foster care services and secure settings including High Support Units, Special Care Units and the Children Detention Schools. Placing the HIQA Inspectorate's office and functions on a statutory basis and within a framework of quality and standards control has been important (Kilkelly, 2012). Recent HIQA reports provide insight into the standards of general, emotional and specialist care provided for children and young people, and how their mental health needs are met within the care system. The findings are summarised in the next sections, where all references are to HIQA reports.

HIQA FOSTER CARE REPORTS

HIQA foster care inspections published in 2012 and 2013 were carried out during 2011 and 2012 in Tipperary (HIQA, 2012a); Dublin North-West (HIQA, 2013a); Dublin South-East (HIQA, 2013b); Louth (HIQA, 2013c); Kerry (HIQA, 2013d); Limerick (HIQA, 2013e); Dublin South/Dun Laoghaire (HIQA, 2013f)

and Wexford (HIQA, 2013g). These reports span different socioeconomic areas, with HIQA reports noting that some experience some of the highest levels of deprivation in Ireland (e.g., Dublin North-West, Louth) while other areas are less deprived (e.g., Dublin South-East, Tipperary).

It is encouraging to note that, across these reports, inspectors consistently remark that children in foster care in Ireland were generally valued, respected and well cared for by foster carers and that their rights and identity were supported. However in Dublin North-West, which has a particularly high number of children in foster care, this was not always the case, and in several inspected areas across the country, there was poor record-keeping or implementation of Children First guidelines (DoHC, 1999).

In general, while practice was noted to be good in maintaining contact with birth families, a concern across reports was that facilities for birth family access visits were inadequate or very poor (e.g., in Limerick, Dublin North-West, and Louth). Inspectors in Dublin South-East further noted with concern that foster carers were not supporting birth family access visits in their homes. When noting specifically how children's health and development needs are met, some inspections refer to mental health (e.g., in Kerry and Dublin South-East, emotional or psychological needs are referred to), but most focus on medical, dental and immunisation record-keeping. Assessments were found to be of a good standard in some areas but not in Dublin North-West or Limerick. In addition, inspection reports consistently note that even though educational needs were often given high priority, there is no evidence of systematic recording of children's educational outcomes and therefore the opportunity to follow up or improve these is lost.

Nearly all children in these inspected areas had an assigned social worker, with the exception of Dublin South/Dun Laoghaire, where only 65% children had a social worker, and where carers and children noted that there were frequent changes of social workers. In addition, in Dublin North-West, inspectors noted that a substantial number of children had been allocated a social worker in the weeks immediately preceding the inspection. There were substantial gaps in some areas in the provision of link social workers, whose role is to support carers in caring for children through regular supervision and advice: the proportion of carers with link workers in Dublin South/Dun Laoghaire was 87%, where it was noted that the standard of supervision by link workers varied; in Louth 77% carers had a link worker, in Dublin North-West, 64%, and in Tipperary, 26%. Several reports also noted either an absence of training opportunities for foster carers, or poor uptake by foster carers of training opportunities provided. In Kerry, for example, inspectors concluded that this "undermined foster carers' acquisition of the necessary skills and knowledge and their continuing capacity to deliver high quality care to children" (p.27).

A particular concern emerging from these inspections is that all reports note the lack of available foster carers, the inability of local health authorities to match children with foster carers who have the capacity or skills to meet their needs, and subsequent multiple placements. As a result of these failures to match children with suitable carers, children's

care, potential and outcomes are compromised. The Louth inspection report, for example, notes: "The impact on some children… was placement breakdown and in some cases, multiple short-term placements over a short period of time" (p.21). None of these inspected areas had Special Care foster placements available, with the exception of Limerick and one place in Wexford. Across reports, inspectors have noted that this is a concern as it means that specifically trained and skilled foster carers are not available to support children with serious behavioural issues. Finally, the reports note that after-care services were not consistently delivered in any areas inspected, and that where services were better, referrals to after-care were lacking.

HIQA RESIDENTIAL CENTRE REPORTS

As with the foster care reports, the most recent HIQA reports of children's residential centres indicate that experiences seem to vary across centres, identifying both good practice and areas of concern. Young people in residential centres were found to be generally well-cared for (2012b; 2012c; 2012d; 2013h), with positive relationships with staff (2012e; 2012f). Positive relationships between staff and young people were considered an indicator of success of behaviour management initiatives (2012d; 2012f). Particular examples of positive intervention were found in one high support unit with good access to a psychiatrist, a clinical psychologist, a systemic family therapist and a speech and language therapist, a policy in relation to addressing bullying behaviour and incentive initiatives linked to positive behaviour (2013d). There was good access to emotional and specialist services in some; partial access in other centres (2012b; 2012e; 2013h); and some had policies relating to drugs and alcohol (2012f; 2013h).

However, serious concerns were also noted in some centres, particularly regarding deficits in providing specialist support and in devising individual behaviour management and therapeutic plans (2012c); poor access to emotional and specialist services, to be addressed urgently (2012c; 2013i) and substance misuse issues (2013i). Problematic management of young people's behaviour was also noted in several centres (2012b; 2012c; 2012e). HIQA inspectors highlighted that, even where specialist supports were available, there was sometimes a reluctance among young people to engage with them, and it was strongly recommended that young people's participation with these specialist support appointments be encouraged (2012f).

Furthermore, under Section 45 of the Health Act 2007, the Minister for Health may require the HSE to undertake the functions of Chief Inspector with regard to residential centres. In effect, this would result in the HSE inspecting its own facilities, which would clearly not satisfy the requirement of independent monitoring (Kilkelly, 2008).

HIQA SPECIAL CARE UNITS REPORTS

In an overview report of the Special Care unit services produced by HIQA in 2010, concerns were raised in relation to extremely challenging behaviour with levels of "persistent aggression, threats and assaults against staff and damage to property" and concerns about the ability of

the staff to manage this behaviour. In addition, it was noted that external professionals working in the units had expressed "concern in relation to minimum therapeutic interventions available" (2010a). Subsequently, HIQA inspectors commented on the "cyclical nature of crisis within the special care service nationally" (2012g, p. 2). However, some more recent HIQA inspection reports have indicated improvements and examples of positive practice within Special Care units.

For Ballydowd, the 2013 HIQA report described the unit as providing "a safe, protective environment within which psychological and emotional security was promoted" (2013j, p. 8) with good awareness among staff of children's emotional needs; psychiatric, psychological, medical, speech and language and educational supports and access to medical, psychological, counselling, and other health services as well as substance misuse programmes (2013j). Access to therapeutic services had improved since the establishment of the Assessment, Consultation and Therapy Service (ACTS). Improvements noted for Coovagh House were implementation of policies protecting young people from the risk of self-harm; external specialist support sourced as required; and access to a dedicated unit psychologist, who spent time with young people, and, if appropriate, with their parents, to form the basis for a strategy to meet their emotional and psychological needs (2013k). Similarly, although "a state of crisis" was reported in Gleann Alainn in a 2012 report due to poor management, it was noted that the ability of the staff to address bullying behaviour had improved (2012h) and that children had access to a dedicated unit psychologist (2012g).

HIQA CHILDREN DETENTION SCHOOLS REPORTS

HIQA inspectors (2011a; 2011b; 2011c) found that standards in Children Detention Schools in relation to mental health were partly met. A common policy on provision for the mental health and emotional needs of young people had been developed by the IYJS, but at that time each school made its own arrangements. Following the inspection, HIQA was advised that the HSE's new Assessment, Consultation and Therapy Service (ACTS) would provide an on-site service, to include psychology, speech and language therapy and a substance misuse specialism. The use of separation in Children Detention Schools was raised as a matter of concern by HIQA (2011a; 2012i). Inspectors expressed concern that excessively lengthy separations were still occurring, that conditions for separation in Trinity House School were poor, and that young people were "fearful and anxious" about being sent there (2012i,p.12). In assessing the provision of advocacy services to detained young people in Oberstown Boys' and Girls' and Trinity House, it was noted that only Trinity House School had a formal advocacy service available.

The lack of after-care provision was highlighted as a major concern, and although HIQA inspectors urged that it be addressed as a matter of priority (2011a; 2011b; 2011c), in 2012 the standards in relation to after-care still had not been met (2012i).

ST PATRICK'S INSTITUTION REPORTS

Finally, St Patrick's Institution is not inspected by HIQA but by the Inspector of Prisons who has few of HIQA's powers, a cause of concern (Kilkelly, 2012). The Inspector submits reports to the Minister for Justice and Equality who can at her or his discretion place such reports before the Oireachtas (Section 31, Prisons Act, 2007); as a result, implementation relies on persuasion (Kilkelly, 2012).

In his most recent report for St Patrick's Institution, the Inspector of Prisons, Judge Michael Reilly, detailed serious and systemic human rights abuses by a minority of prison officers, including forced stripping; clothes being cut from boys being held in special cells; inappropriate and excessive use of special cells; excessive and unrecorded use of force and punishment by staff against prisoners; and bullying and intimidation (Reilly, 2012). Illegal drugs were found to be a particular problem; while addiction services were provided, they were found not to be available to all prisoners (Reilly, 2012). Particular problems were noted in relation to prisoners who were 'on protection' in single separation cells. The Inspector found that two-thirds of prisoners were on 23-hour-a-day lock-up, including occasions of not getting minimum exercise. It was also noted that there was no role for probation to support young people on their release if they were sentenced without any other order attached, such as a Supervision Order on Release (Inspector of Prisons, 2012).

The Inspector noted that while healthcare staff worked hard to deliver a high quality service and there was a responsive approach to mental health, the psychology service is "over stretched", and that this led to a significant proportion of the work being directed at "crisis management". The Inspector described it as a matter of "utmost urgency" that a unit for vulnerable people be provided (Inspector of Prisons, 2012, p.18). This recommendation is underscored by recent research of young offenders in St Patrick's (Flynn, Smith, Quirke, Monks & Kennedy, 2012). Over 12 months, the study interviewed every third young offender (16-20 years) committed to St Patrick's (n=171). It was found that 22.8% met ultra high risk criteria for psychosis, and that this was associated with lower social and occupational functioning and multiple substance misuse. Flynn et al. argue this indicates the urgent need for psycho-educational work in a drug-free environment in St Patrick's.

The Ombudsman for Children (OCO), documenting a consultation with children and young people in St Patrick's Institution, noted that they appeared hesitant to speak about mental health issues, particularly as it could result in them being placed on protection or in a special observation cell (OCO, 2011). Concerns were expressed in relation to the effects of such 'protection' on a young person's well-being. It was also noted that young people did not appear to have any conception that meetings on committal had led to a care plan being developed; and that "comprehensive and systematic reintegration measures of the kind provided for in national and international standards", particularly prior to and following release, were absent (p.65). The Ombudsman recommended that the young people be encouraged to "become active participants in safeguarding their mental health" (OCO, 2011, p. 38).

THE NEED FOR LEGISLATIVE AND POLICY REFORM

The previous sections of the chapter have outlined international rights and recommendations, and Irish legislation and policy in relation to children in the care and youth justice system and have noted instances where it fails to make sufficient provision for young people's mental health needs. While HIQA inspection reports for foster and residential care indicate some examples of exemplary practice, in other cases concerns remain. In this section, proposals are made for specific aspects of legal and policy reform required to address the complex inter-relationships between children's mental health, their care experiences and their offending behaviours.

OVERARCHING HUMAN RIGHTS STANDARDS

Interventions in relation to children in the care and youth justice system, including treatment for mental health problems, must be continuously and rigorously monitored to ensure that they comply with international human rights standards. The principles of best interests, the voice of the child, and non-discrimination should be incorporated into the Child Care Act, 1991, the Children Act, 2001, the Mental Health Act, 2001, and all other relevant legislation. These principles should also be reflected in regulations, standards, and inspections in relation to children in care, children in the youth justice system, particularly in detention, and children in mental health facilities.

Best interests: In relation to best interests, this concept should be interpreted and applied in light of the need to respect the evolving capacities of the child or young person (Article 5 of the CRC) and their right to be heard and to participate in decisions affecting them (Article 12 of the CRC) . Each piece of legislation should set out guiding principles and factors to be considered in determining what is in the best interests of the child and should include both objective and subjective elements (Zermatten, 2010). With regard to the Mental Health Act, 2001, there should be a holistic approach to best interests which is not be limited to the medical best interests of the child but also recognises the child's life in the family or community.

THE YOUTH JUSTICE SYSTEM

Diversion: Rehabilitation and diversionary options under the Children Act 2001 and An Garda Síochána initiatives are welcome. However, diversionary options specifically addressing the mental health of young offenders are needed, to enable access at the earliest opportunity in their youth justice pathway and divert them towards community services that could address their mental health needs. While gardaí cannot be expected to diagnose a mental health problem, being able to recognise warning signs that a young offender may have such a problem is crucial. As an extension of existing diversion practices, systematic pathways for liaison and diversion are needed to facilitate the management of mental health needs. Consideration could be given to the Youth Offending Team model in the UK and the Youth Justice Liaison and Diversion scheme which is currently being extended in the UK after a recent evaluation of a pilot scheme (see chapter six for further discussion of these).

Sentencing: Courts would benefit from options in addition to the sentencing options for young people under the Children Act, 2001 that specifically address the mental health needs of young offenders, diverting them away from custody to specialist or community mental health services, including a bail support scheme.

Community and hospital orders: Many young offenders have complex health, mental health or well-being needs that may have gone unidentified or unaddressed until late in the criminal justice pathway (UK Home Office, 2009). To limit the need for remands in custody for the purposes of assessments, courts need to be able to identify inpatient and community services where a child can receive specialist assessment.

There is a need to amend the Mental Health Act, 2001 and the Children Act, 2001 to allow for sentencing options for young offenders with mental health problems, including community orders with a mental health treatment dimension and hospital orders. This would require the development of forensic mental health services for children and legislation to provide for this, as recommended by A Vision for Change (DoHC, 2006) and the Mental Health Commission. Mental health treatments should be multi-disciplinary and respect the child's decision-making ability; a young person should not undergo mental health treatment without their consent.

Children in detention schools: It is clear from inspection reports that the Standards and Criteria for Children Detention Schools are not fully met. A review of the regime and environment in St Patrick's Institution in particular, as well as the Children Detention Schools, needs to assess the extent to which they promote positive mental health and to recommend measures to improve the well-being among children and young people detained. The Irish Youth Justice Service (IYJS) developed **Guidelines for Recognising Poor Practice, Abuse, Bullying and Mental Health Problems in Children Detention Schools** (IYJS, 2010). These should be included in the Standards and Criteria for Children Detention Schools. The Standards should also require that all children have an assessment of their broadly-defined mental health needs on admission to a detention school. An independent advocacy service and an independent complaints mechanism needs to be introduced for all Children Detention Schools and St Patrick's Institution.

It is clear that St Patrick's Institution is not a suitable place to detain children and that the regime is detrimental to the psychological well-being and mental health of the children and young people detained within it. It is imperative that the mental health needs of all young people detained in St Patrick's Institution are addressed, including the urgent introduction of a strategy to reduce the high levels of protection and 23-hour lock-up, and a high support unit. ACTS could play a role in working closely with staff of the detention schools and St Patrick's Institution to create a regime that supports the mental health of the children and young people detained. In particular, therapeutic alternatives to seclusion and restraint need to be implemented. All 17-year-olds should be removed from St Patrick's Institution without delay.

Guardian ad litem: The proceedings in which a guardian ad litem (GAL) can be appointed need to be widened and the condition of it being necessary in the child's best interests or in special circumstances should be removed. While the Child Care (Amendment) Bill, 2009, when enacted, will provide an improved statutory footing for the GAL, the CAAB guidelines should be put on a statutory footing. Furthermore, the appointment of a GAL should be mandatory in all child protection proceedings, and a central governing agency in relation to the appointment, training and supervision of GALs should be introduced. Furthermore, the Child Care Act, 1991 should be amended to allow for the appointment of a solicitor to ensure the protection of the legal interests of the child.

Review of regulations: In relation to children in the care system, a review of all relevant regulations and standards needs to be undertaken and amended to ensure they specifically address mental health needs. These should also consider the training and support needs of foster parents and care staff with regard to the psychological well-being of children in their care. Mental health needs should not be interpreted to apply only where there is a formal mental health diagnosis and should include recommendations for building protective factors for the child's mental health within the foster placement. In relation to Special Care, as mentioned below, an independent oversight body should be reinstated to review each application for Special Care.

Seclusion and restraint: The Child Care Regulations 1995 need to be amended to provide safeguards in relation to seclusion and restraint, to ensure compliance with Article 37 of the CRC and in accordance with General Comment 10 of the UN Committee on the Rights of the Child. These practices should only be used in exceptional circumstances, as a measure of last resort and for the shortest period possible, where there is an immediate risk to injury to the child concerned or to others. They should never be used as a punitive measure.

Special Care: An independent oversight body reviewing all applications for Special Care orders needs to be reinstated. Standards for Special Care and inspections need to be strengthened: Section 23(k) of the Child Care Act, 1991 merely refers to a periodic inspection of Special Care units; Child Care (Special Care Regulations) 2004 and National Standards for Special Care need to provide more detailed standards in relation to mental health care provision, as well as qualifications, experience and training of staff. The application form for Special Care should be amended to ensure that, where a child subject to a special care application has previously had contact with mental health services, it is clear whether they engaged with those services and whether they received an assessment only or went on to receive service interventions. Further, the Child Care Act, 1991 needs to be amended to specify the elements of mental health care needed, particularly appropriate multi-disciplinary mental health care adapted for the specific needs of the child.

Further research into Special Care outcomes should identify in detail the number of children who have accessed mental health services prior

to the application, the range of supports offered both before and since the application, any issues with regards to accessing them, and the effectiveness of these supports, as recommended by Brierley (2010). This analysis should also inform a review of how to best engage young people in the care and youth justice systems with mental health needs. A review should also be undertaken, having regard to this analysis, of whether suitable alternative mental health inpatient facilities could be provided to meet the needs of these young people. In addition, the appropriateness of sending children with complex needs to secure units in other jurisdictions must be questioned. While the child may benefit from such treatment, questions remain as to why suitable facilities to meet their needs cannot be provided in Ireland. Their re-integration into their families and communities, and services to meet their needs when they return to Ireland, also need to be considered.

Guiding principles and safeguards need to be set out in the Child Care Act as amended in 2011, in relation to mental health treatment provided in Special Care units. This would guide both the District Court and the High Court in relation to the appropriateness of treatments provided and also adherence to international human rights standards under the CRC. These guiding principles should include: 1) the best interests of the child; 2) that the rights contained in the CRC are considered in the determination of the child's best interests; 3) that children are provided with the information and support that is necessary to enable them to participate in decisions; 4) that children have their views and wishes taken into account and given due weight according to their age and maturity in all decisions made in relation to their treatment; and 5) that children are treated in age-appropriate, least restrictive environments, and given the least intrusive and restrictive treatment in accordance with an individualised care plan.

After-care: A statutory right to after-care for all those leaving care should be established. In the short-term, services need to ensure that children and young people are adequately prepared for leaving care. This applies particularly where young people are moving to direct provision centres and specialist after-care providers, and the HSE should ensure that separated young people are provided with appropriate preparation and services for leaving care and after-care. It is essential that legislation be strengthened to ensure that counselling and other necessary supports form part of the after-care system. Young adults leaving care with mental health needs should be directed by the assigned person from the HSE to such services, and for accessing mental health supports, these young adults should be prioritised.

CHAPTER 6
INTERNATIONAL LITERATURE ON SERVICE PROVISION

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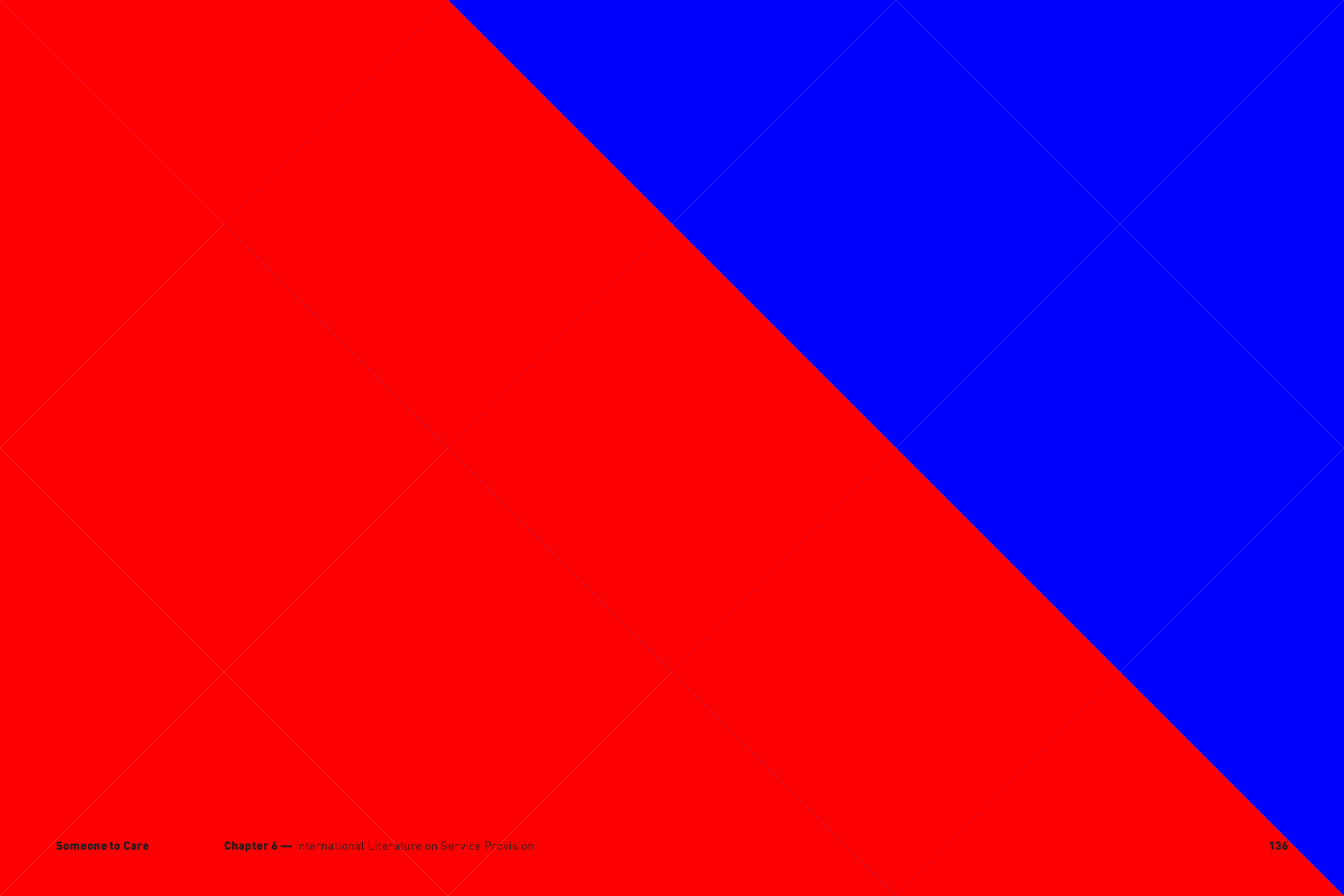


INTRODUCTION

In part one, we reported on issues identified by young adults and professionals, relating to the mental health needs of children and young people in the youth justice system or State care in Ireland. In this chapter, we consider how these issues are reflected in Irish and international peer-reviewed policy and other literature. A comprehensive, systematic review of the literature is beyond the scope of this report; here, we present a focused selection of material that contexualises and amplifies four central themes drawn from the consultations. These themes are: the complexity of children's and young people's needs; the need for quality care and mental health supports and services; the need for inter-agency collaboration; and the need for systemic change.

ASSESSMENTS

IDENTIFYING AND ASSESSING COMPLEX MENTAL HEALTH NEEDS

The young adults and professionals whose views we reported in part one reflected on the experiences of children in care and youth justice settings and their complex mental health needs. The question of complex needs has also been addressed in the research literature, as high levels of multiple mental health difficulties are reported in children and young people in the care and youth justice systems, as reported in chapter one. Given this high level of need, it is vital that mental health is quickly assessed and that assessments are accurate, and in this section we consider these issues. We also consider literature calling for mental health training for frontline professionals and consider the dominance of the medical model in mental health services.

THE NEED FOR EARLY ASSESSMENT

Researchers and clinicians agree that, to prevent escalation of need, early mental health assessment is essential (Tarren-Sweeney, 2008); they recommend that screening and assessment for acute and chronic mental health needs should take place at the point of entry to the care and youth justice systems. Many professionals consulted for this study, however, expressed concerns that mental health assessments are often not conducted, a concern echoed by other professionals in Ireland. For example, the lack of assessments for vulnerable children and young people was also noted in a recent evaluation of the inter-agency Ballymun Network (youngballymun, 2010, p. 22).

Authors have suggested that on entry to care, initial screening should take place for emergent risk within 72 hours and that standardised tests, administered by qualified practitioners, should form part of an assessment within a month of entering care (Grisso, 2010; Romanelli et al., 2009). For the youth justice system, Hayes and O'Reilly (2007) recommended that on entering the system, young people should receive a multi-disciplinary assessment of mental health, cognitive and offending difficulties; intellectual disabilities; risk of self-harm or to safety of others; and substance dependency and withdrawal. For screening on entry to the youth justice system, one measure used in the Netherlands, UK, Belgium,

Germany, Switzerland, Spain, Italy and Turkey is the Massachusetts Youth Screening Instrument (MAYSI), a 52-item questionnaire with seven scales including scales eliciting suicidal ideation, depression and anxiety (Grisso, 2010). Where screening indicates potential challenges, a comprehensive mental health assessment is indicated and should be conducted within 60 days (Romanelli et al., 2009). The authors recommend that case workers should also regularly screen informally for mental health needs.

Finally, it should be noted that assessment of need is not confined to mental health assessment. Educational assessments are also essential, as children in State care and youth justice systems are consistently found to experience higher levels of visual and auditory processing problems, speech and language disorders and specific learning disorders, and these can cause adjustment, psychological and educational challenges (Comfort, 2007). For children in care who offend, a recent report in Ireland (Brierley, 2010) noted that "children are either in the justice system or the welfare system and their needs are not generally assessed in a holistic manner, examining both offending behaviour and welfare together. This implies a silo approach to the needs of children. Models for more integrated assessment have been developed and applied in other jurisdictions ... A more holistic approach might help to improve outcomes for the children" (p 122). Brierley therefore recommended that DCYA, HSE and the Department of Justice and Equality should consider measures to increase integrated assessment of risks and needs.

APPROPRIATE ASSESSMENT AND LIMITATIONS OF THE MEDICAL MODEL

Professionals across disciplines frequently pointed to the particular limitations of the medical model of understanding the mental health needs of vulnerable children. Psychiatrists and psychologists also discussed challenges they faced in arriving at relevant and appropriate diagnoses, challenges also noted in the international literature.

By definition, children in State care have had traumatic experiences and they often experience multiple attachment- and trauma-related difficulties (Tarren-Sweeney, 2008; DeJong, 2010). High numbers of children and young people with experience of youth justice systems have also experienced acute or chronic trauma exposure – estimates range between 50% and 93% across studies (Kinscherff, 2012). DeJong (2010) points out however that the most widely used diagnostic system, the American Psychiatric Association's (APA) **Diagnostic and Statistical Manual for Mental Disorders** (DSM) (APA, 2000), often fails to identify the particular difficulties experienced by children in care and Kinscherff (2012) echoes this point for young people in youth justice systems. Tarren-Sweeney (in press) explored psychiatric symptoms among children in foster and kinship care (n=347). While 35% had psychiatric diagnoses, a further 20% displayed complex attachment- and trauma-related symptomatology that was not adequately conceptualised in psychiatric diagnostic systems such as the DSM. Kinscherff (2012) has similarly noted that over half of US youth with justice system contact display trauma-related symptomatology.

Another issue with current assessment methods is that the difficulties experienced by children in care or youth justice, rather than reaching

the threshold for a psychiatric disorder, may often be a combination of multiple 'lower-level' difficulties: for example, they may experience symptoms that are below clinical thresholds of several of the following: anxiety; depression; conduct disorder, Attention Deficit Hyperactivity Disorder and PTSD. As a result of such combinations of symptoms, they experience greater impairment than others who do reach the threshold on a single psychiatric diagnostic category (DeJong, 2010) – yet such multiple lower-level impairments may be poorly understood or even overlooked by clinicians applying the DSM or other diagnostic systems. Furthermore, it appears likely that existing diagnostic classifications do not adequately support trauma-related developmental case formulations and interventions (Kinscherff, 2012; Tarren-Sweeney, 2011).

Other standardised assessment tools, e.g., psychological ones such as the **Strengths and Difficulties Questionnaire** (SDQ; Goodman, 1997) or the **Child Behavior Checklist** (CBCL; Achenbach, 1991), are designed for the general population, and may not identify the complex needs of children in care. Clinicians therefore currently argue that more valid standardised measures of attachment and trauma-related psychopathology are required (DeJong, 2010; Kinscherff, 2012; Tarren-Sweeney, 2011). One example is the **Trauma Symptom Checklist for Children** (TSCC; Briere, 1996). Another set of measures has recently been developed in New Zealand specifically from clinical observations of children with experiences of trauma or deprivation. The **Assessment Checklist for Children** (ACC; Tarren-Sweeney, 2007) and the **Assessment Checklist for Adolescents** (ACA; Tarren-Sweeney, 2013a) are carer-report scales, designed to assess children and young people in various types of alternate care including residential care. The ACA subscales for adolescents have been adapted from the ACC to reflect adolescent experiences.

Most recently, brief screening versions of these scales, the 20-item **Brief Assessment Checklists** for children and for adolescents (BAC-C, BAC-A) have been developed (Tarren-Sweeney, 2013b). These screening checklists are designed specifically for health and social care professionals as distinct from child and adolescent mental health clinicians, and may be used as casework monitoring tools by foster care and adoption agencies, and also for treatment monitoring in Child and Adolescent Mental Health Services (CAMHS). Initial comparisons of their psychometric properties with existing screening instruments, including the SDQ and the CBCL's Brief Report version, suggest the BAC-C and BAC-A compare favourably (Tarren-Sweeney, 2013b).

The ACC, ACA and BAC seek to address limitations of existing assessment tools in identifying difficulties that often arise for children in State care. It could be argued that they remain rooted in similar values underpinning existing diagnostic approaches. From a psychosocial developmental perspective, a well-resourced, well-supported and well-organised social work service, that would be able to establish on-going, meaningful relationships with children, with therapeutic supports where indicated, would be ideal. However, where mental health resources are limited, tools such as the Brief Assessment Checklists, that focus on specific trauma-related and other symptomatology, have the potential to increase the accuracy and relevance of mental health screening. In this regard, they

are a welcome addition to clinical tools for evaluating mental health needs. Their usability by non-clinical staff is also a practical advantage.

Finally, it should be noted that almost all professionals participating in our consultation, including some psychiatrists, expressed concerns about the privileging of the medical model in mental health and youth justice systems, particularly in the courts, but also as psychiatric diagnosis is often required to trigger mental health provision and educational supports. The medical model understands and treats mental health difficulties as primarily biological and/or neuro-chemical in origin, and often fails to focus on socio-cultural, contextual and causal factors. The dominance and usefulness of this model is increasingly coming into question, with current criticisms focused on the publication of the 5th edition of the DSM in May 2013 (APA, 2013). International psychological associations, including the American Psychological Association, the British Psychological Society and the Psychological Society of Ireland have expressed concerns about the limitations of the DSM and the effects it has on approaches to treatment, and the need for a more inclusive approach to responding to mental health difficulties that takes account of psychological and social aetiology.

STAFF TRAINING NEEDS

A final assessment-related concern is the pressing issue of training needs across the care and justice systems. Care and frontline staff such as social workers are often not able to identify mental health issues in children in their care, due to a lack of training in mental health (Ross, Hooper, Stenhouse & Sheaff, 2009). In Ireland, the **Independent Child Death Review Group Report** (ICDRG, Shannon & Gibbons, 2012) noted that child protection professionals had not recognised emerging mental health issues or treated warning signs with sufficient seriousness; the authors recommended awareness training for all those working in child welfare and protection. Dorsey, Kerns, Trupin, Conover and Berliner (2012) argue that case workers should be able to: identify emotional or behavioural problems that require intervention; be knowledgeable about evidence-based interventions for common, specific mental health problems; know which evidence-based interventions are available and how to access them; be able to assess provider appropriateness for particular mental health needs; know how to maintain contact throughout the intervention to ensure progress toward identified treatment goals; and when necessary, identify incentives or supports to facilitate engagement and participation in treatment.

Some studies have considered key workers' training needs for recognising mental health challenges and facilitating access to interventions and services. In a sample of 92 social workers in Ireland, half (49.1%) reported no prior mental health training, despite all having completed third-level qualifications in social work and related disciplines (McNicholas & Bandyopadhyay, 2013), although it should be noted that social workers undertake clinical placements as a part of their training. When asked about training needs, 98% said they would like further training; mental health disorders, abuse and neglect were considered the most important topics. **Project Focus** (Dorsey et al, 2012), is an example of a training and case-based consultation programme to improve caseworkers' skills

in recognising mental health needs and enabling them to link children with evidence based treatment programmes. This American programme includes lectures, small group activities, video demonstrations, engagement training, and bi-weekly supervision to review cases for four months following training. Few studies have evaluated it, but Dorsey and colleagues conducted a randomised control study in four child welfare offices with 51 caseworkers in Washington State; they found an improvement in awareness of interventions, but no increase in referrals.

Specifically in relation to youth justice, Kinscherff (2012) has argued that there is a clear need for good quality training in adolescent development and mental health for all professionals in the youth justice system, frontline and direct contact professionals such as police, probation officers, social services, all detention unit staff and judges as well as senior administrators in all systems.

QUALITY CARE

CHARACTERISTICS OF GOOD, CHILD-CENTRED CARE

Even if mental health needs are assessed, this is only of value if supports and services are in place to meet it. The professionals' and young adults' consultations in this study made it very clear that the psychological well-being of children and young people in care and youth justice systems can only be supported if good quality care and youth justice services and mental health supports are provided. As we noted in chapter three, if good quality care is not provided, the system can further traumatise those whom it is intended to help. Kinscherff (2012) underlines this in relation to youth justice, where focusing on behavioural control may exacerbate defiant, aggressive or provocative behaviours originating in response to trauma exposure. In the care system, researchers have pointed to placement and therapeutic instability, that exacerbates difficulties with attachment and capacity to engage (DeJong, 2010; Golding, 2010).

In this section we consider, first, some literature relating to the qualities of good care. After that, we consider issues highlighted in the research relating to mental health interventions for children in the care and youth justice systems. We then introduce research addressing adults' capacity to care and the necessity of supports for all working in these systems, whether as foster parents, social care staff or mental health professionals.

QUALITIES OF GOOD CARE

For psychological well-being, the primary importance of good, stable child-centred care emerged as critical in the consultations with young adults and with professionals in this study. Child-centred care is also a consistent theme in research about children and young people in State care and after-care and in the youth justice systems. Research indicates a number of core features that support beneficial outcomes in the care and youth justice systems. These are: child-centred care; placement stability; continuity of care; having a link or case worker; having supportive relationships with adults; and receiving support at times of transition. To achieve child-centred care, it is important to pay close attention to children's views in practice and planning (Jones, 2008): children must be

involved in all decisions that affect them, including the need for care, the types of care that are offered to them, their living conditions and contact with parents. From children's rights, ethical and policy perspectives, such an approach is in line with one of the key principles of the **National Children's Strategy** (Department of Health and Children, 2000b), that children's voices will be heard, and with Article 12 of the UN Convention on the Rights of the Child (1990a). Furthermore, from a pragmatic perspective, research has found that care plans have a better chance of succeeding when children are involved in developing them (Timms & Thoburn, 2003).

However, children and young people in care are not as engaged with the care planning process as they could be (Kane, 2007). Competing interests and intentions within organisations mean that full congruence with a principle such as child-centeredness can be difficult to achieve (Anglin, 2004), and service and agency factors (such as operational efficiency, staff preferences or reducing budgets) may dominate decision-making. In some European countries, advances are being made: in Belgium, for example, a standard 'care contract' between adolescents and the facility is developed that explicitly guarantees the legal relationship between client and care facility (Hellinckx, 2002).

Children in care who experience placement stability are less likely to have mental health needs and more likely to have good general health; foster care instability during the first year in care is associated with higher mental health costs (Munro & Hardy, 2006; Rubin et al., 2004). Placement instability has many associations with diminished psychological well-being and associated poorer mental health, social and life outcomes during and after leaving care: it reduces children's opportunity to develop permanent, secure attachments (Leathers, 2002); and is associated with conduct problems (Fratter, 1991; McCarthy, 2004), poor outcomes in terms of social relationships, employment, financial management and housing (Biehal, Clayden, Stein & Wade, 1995) and accommodation instability after leaving care (Daly, 2012a, 2012b).

Closely associated with placement stability is the issue of continuity and quality of care. Jones (2008) found that in the care system, changes in carers were associated with more behavioural problems; that children with house parents had higher levels of continuity with carers than those with child care workers; and that placements with warm, child-oriented carers were more successful. Such findings emphasise that both care continuity and selection of carers are crucial for outcomes. However, some researchers have noted that the pressures of working with traumatised children can reduce the capacity of staff to relate to the children in their care, and we return to this below.

In the youth justice system, it is particularly important that staff in justice facilities recognise that trauma exposure can lead young people to display misperceptions of threat; mistrust; emotional reactivity and dysregulation; extremely short-term perspectives; risk-taking; and efforts to block negative emotions by substance abuse or high-intensity behaviours (Ford, Chapman, Hawke & Albert, 2007; Kinscherff, 2012).

Related to care continuity, having a case-worker assigned to work with a child over a long period of time can be valuable in both the care and youth

justice systems. The principle is that one adult, whose role includes co-ordinating multi-disciplinary services, is the single point of contact and support for the young person. In one study of children in foster and kinship care in New South Wales, Australia, having an assigned caseworker was the only independent predictor of seeking or receiving clinical services (n=347, Tarren-Sweeney, 2010b). The need for someone to turn to for advice and support does not end at the age of 18; after-care workers and care leavers identified this as the most-needed factor (Daly, 2012a, 2012b). In Northern Ireland, for the transition from care to independent living, each young person has a personal advisor to assist with the pathway plan through this transition (Allen & Gilligan, 2012). Brierley (2012) estimated that 1,153 young adults were linked in with after-care services in Ireland in 2011.

The mental health risks children and young people face are exacerbated at periods of transition: primary to secondary school, junior to senior cycle, and leaving school. Children in the youth justice system or in care typically have little or no family support; for them, there is even more pressure on these transitions. Leaving care is a particularly vulnerable time and there is evidence that better supported transitions help young people to cope with independence better, and to build on gains made while in care. In Ireland, studies have pointed to the need for statutory supports and official data on care leavers' outcomes (Daly, 2012; Gilligan, 2008). After-care workers note that mental health needs are high and that practical supports relating to finances, accommodation needs and independent living skills are particularly needed (Daly, 2012b). Studies have assessed the benefits of allowing foster youth to remain in care until they are 21–years-old. In one study, a higher proportion of young adults who stayed in care were also pursuing higher education than those who did not (Peters, Dworsky, Courtney & Pollack, 2009).

Finally, the consultations with young adults emphasised the importance of on-going relationships with a caring adult. Many of these relationships with care staff were based on informal ongoing contacts and they often extended beyond the young person's time in a particular setting or the staff member's responsibility for them. DuBois and Silverthorn (2005) studied informal mentoring relationships in a representative sample of 18–26-year-olds in the US. Nearly three-quarters reported having such a relationship, most frequently with non-parental family members, teachers or guidance counsellors. Other informal mentors were sports coaches, religious leaders, employers, co-workers, neighbours, friends' parents, doctors, therapists or others. The average length of these relationships was nine years. Young people reporting a mentoring relationship had more favourable outcomes in education or work and better psychological well-being and physical health. Recent Irish research into young people's mental health also underscores the importance of 'one good adult' for their well-being (Dooley & Fitzgerald, 2012).

Research underlines that this need for constructive, ongoing relationships with caring adults also applies to young people in care (Daly, 2012b) and youth justice (Griffin, Germain & Wilkinson, 2012; Kinscherff, 2012; McAra & McKie, 2010). In a more formal context, mentoring programmes aim to develop positive, supported, professional relationships between

at-risk youth and caring adults. A meta-analysis, conducted by Du Bois, Holloway, Valentine & Cooper (2002), reviewed 55 evaluations of mentoring programmes in various contexts in the United States and generally found small but significant effect sizes. The largest mentoring effect sizes related to the presence of environmental disadvantage, but no overall favourable effect was found for young people with significant personal problems. A later study found that other types of mentoring such as work-based programmes were more effective (Eby, Allen, Evans, Ng & DuBois, 2008). A recent report published by the Northern Ireland Commissioner for Children and Young People highlighted the positive impact and role of significant adults in the lives of young people in contact with the criminal justice system (Walidin, Martynowicz & Moore, 2012); and McNeill (2006) has highlighted the crucial role of an ongoing one-to-one relationship with a key worker, who advocates for a young offender, and supports them in a 'desistance paradigm' to construct a non-offender identity.

QUALITY MENTAL HEALTH SUPPORTS

Young adults in this study made a number of recommendations for services that would better meet the needs of children and young people during and after leaving care. They wanted child-centred care; less formal service settings; services that were more sensitive to their level of need at different times; and they strongly expressed the need for therapeutic continuity even if placements changed. Professionals echoed these views. Child-centred care – as mandated by multiple policies including the 'whole child' perspective of the National Children's Strategy (DoHC, 2000b) – is only possible where a comprehensively integrated inter-agency system of working is developed (Owens, 2010), and we therefore return to this issue in the next section. Where less formal service settings are concerned, the Jigsaw model developed by Headstrong in Ireland has been very successful for providing short-term mental health provision for young people in the community.

Many specific models of care and treatment for vulnerable children and young people have been developed. Most recognise that needs are best addressed from a 'whole person' perspective.

MODELS OF CARE

IN-HOME CARE

A fostering model for children at risk of multiple placements or secure/ youth justice placement is **Treatment Foster Care** (TFC), tailored foster care where only one child is placed in a home and foster parents receive training, on-going supervision and 24-hour support. A statement of measurable goals, means of achieving them, and an agreed process for evaluating outcomes, are developed. A systematic review of randomised controlled trials (RCTs) found clinically meaningful decreases in anti-social behaviour; days absconding from placement; criminal referrals; time spent in locked settings; and improvements in school attendance, homework completion and engagement with employment (MacDonald & Turner, 2007). Compared to regular foster care, TFC showed improved behaviour and less likelihood to run away from home or be incarcerated (Clark et al., 1994). TFC appears to be most effective at improving placement stability

and social skills and less so at reducing mental health and behavioural problems (Reddy & Pfeiffer, 1997).

Wrap-around care (also known as intensive case management or 'systems of care') for emotionally disturbed and/or maltreated youth provides individualised coordinated services across agencies and organisations, allowing the child to remain in the community. It has been found to be improve placement permanency (Clark et al., 1994) and behavioural problems (Bruns, Burchard, & Yoe, 1995). Compared with TFC, wrap-around was as effective, and substantially less expensive (Evans, Armstrong & Kuppinger, 1996).

Multi-Dimensional Treatment Foster Care (MTFC) was developed in America for adolescents with complex needs and challenging behaviour and was introduced in Ireland by the Daughters of Charity Child and Family Service in partnership with HSE North Dublin in 2008. MTFC aims to assist young people so they can live successfully in families, rather than in group or institutional settings, by providing them with a constant reinforcing environment, daily structure and close supervision. The system also helps them to avoid negative influences and build positive peer relationships. Intensive, co-ordinated, multi-method interventions are conducted with supervisors trained in social learning principles and developmental psychopathology. Foster parents are screened, trained and supported throughout the process, with 24-hour support. Studies have found MTFC to be a more effective solution than group home care for adolescents with histories of chronic behavioural problems; in particular, MTFC has proven successful at limiting the number of days a young person spends in a locked setting and reducing the likelihood of them having a criminal referral (Chamberlain, 2003).

Finally, there is increasing interest and research in the UK into a successful Northern European model for social care, an overarching holistic person-centred approach known as **social pedagogy** (Petrie et al., 2009). Whereas social care places the focus upon the provision of care, social pedagogy places the focus upon providing an opportunity to enhance relationships and learning, with the intent of improving self-efficacy and self-agency. The focus is on social learning "based on the belief that you can decisively influence social circumstances through education" (Hamalainen, 2003, p. 71). A recent cross-cultural comparative study from the Thomas Coram Research Unit at the Institute of Education at the University of London found that children in Denmark and Germany who were in care in social pedagogy contexts had a better quality of life and outcomes when compared to the UK children in care (Petrie, Boddy, Cameron, Simon & Wigfall, 2006); pilot studies and evaluations are ongoing.

MODELS OF CARE FOR YOUNG OFFENDERS

Some models of care apply specifically to secure settings for children and young people who have offended. It should be noted that challenging or delinquent behaviours that cause entry to the youth justice system may have developed as a result of untreated mental health problems (Skowyra & Cocozza, 2006; Shufelt, Cocozza & Skowyra, 2010). Within the justice

system, however, treatment of mental health difficulties is often not given unless children and young people present with the "most severe, serious, and persistent disorder" (Grisso, 2010, p. 6). This section focuses specifically on interventions developed for children and young people in the justice system.

In the UK, **Youth Justice Liaison and Diversion** (YJLD) Pilots were developed to screen and facilitate access to support for children and young people with mental health and developmental problems, speech and communication difficulties, learning disabilities and other similar vulnerabilities at the earliest opportunity after they enter the youth justice system. An independent evaluation found significant reductions in overall need, levels of depression and levels of self-harm and a significant association between improvements and the amount of YJLD contact. This suggests the benefits of diversion could not only improve mental health, but also delay and possibly reduce the likelihood of re-offending (Haines et al., 2012). This finding suggests early implementation of diversion programmes may be most effective as they may lead to less offending in the medium- and longer-term through their impact on participants' psychological well-being. International research on diversion programmes has traditionally reported little success on re-offending rates (Gensheimer, Mayer, Gottschalk & Davidson, 1986; Schwalbe, Gearing, Mackenzie, Brewer & Ibrahim, 2011; Haines et al., 2012). However, McAra & McKie (2010) note that such studies have typically been limited by their use of crude measures of re-offending such as reconviction rates. McAra and McKie further note that the findings of the Edinburgh Youth Transitions and Crime study give strong support for maximum implementation of meaningful diversion.

Family Integrated Transitions (FIT) (Aos et al., 2011) is designed for juvenile offenders with co-occurring mental illness and chemical dependency who are entering the community after being detained. The young person receives intensive family and community-based treatment, targeted at the multiple determinants of serious anti-social behaviour. The programme strives to promote behavioural change in the home environment, emphasising the systemic strengths of family, peers, school and neighbourhoods to facilitate the change. FIT also focuses on tackling dynamic risk factors – substance abuse, mental health issues and community re-entry from residential placement.

AN EVIDENCE BASE

THE NEED FOR AN EVIDENCE BASE

Despite the range of approaches, it is not possible to identify models of mental health care and intervention that best support the complex psychological needs of children and young people in the care and youth justice systems from the research literature. There is a consensus among clinicians that interventions designed for children in the general population – psychological and pharmacological – appear less effective for particularly vulnerable children (Tarren-Sweeney, 2010a), although there is almost no research assessing this (Landsverk, Burns, Stambaugh & Reutz, 2009). However, where therapeutic interventions are designed specifically for children in care, their effectiveness is uncertain. Researchers and

clinicians highlight the need for further evidence (Grisso, 2010; Tarrren-Sweeney, 2010a, 2010b); as there are indications that some interventions may be preferable, this area is under-researched and there is currently little evidence indicating 'what works' with vulnerable young people.

The implication of such conclusions is not that nothing works, but rather that a convincing evidence base for therapeutic interventions does not yet exist. This is exacerbated by differences among clinicians, policy makers and researchers about the nature of the best available evidence. This restricts the basis from which understanding can be developed, because current hierarchies of evidence do not allow for the "reality of assisting children with complex difficulties in real-world clinical settings" (Tarren-Sweeney, 2013c, p. 4). Such hierarchies of evidence, which privilege RCTs and guide Cochrane and other systematic reviews, exclude valuable studies in this field. These include case reports; explorations of the therapeutic process (rather than outcomes); contextual factors; harmful effects of therapies; children's experience of therapies; and long-term alteration of developmental pathways. Tarren-Sweeney (2013c) argues that existing hierarchies of evidence must be replaced with a requirement for multiple kinds of evidence; and also notes that RCTs of therapeutic interventions, despite being considered the gold standard, suffer from limitations and must be made more robust by using more clinically relevant treatment metrics, employing realistic developmental timeframes for evaluation, integrating them with effectiveness studies and (as discussed above regarding assessment) identifying valid constructs to assess.

THERAPEUTIC GUIDELINES

Given the current absence of good quality evidence for particular therapeutic approaches, general guidelines for therapeutic interventions with children who are in care were developed by the Children's Act Advisory Board (CAAB) (2009b) in Ireland. A therapeutic intervention is defined by the CAAB (2009b) as "an intentional interaction(s) or event(s) which is expected to contribute to a positive outcome for a child, which is selected on the basis of her/his identified needs, and which is underpinned by an informed understanding of the potential impact and value of the interaction/event involved" (p. 10). This broad definition therefore covers many approaches, including carer behaviours with therapeutic intent; individual and group therapy; and establishing an overall therapeutic environment.

The CAAB identified 12 features that interventions should have in order to be effective. These are: a clear purpose; a clear theoretical base; appropriate consultancy; clear boundaries; safeguards; timescales for intervention; clear management; carer training; supervision and support; partnerships; children's rights; care planning; and added value. They also note the importance of timing and relevance of the intervention. Finally, the CAAB guidelines emphasise that residential centres should clearly stipulate their model of intervention in their statement of purpose and care and the importance of placement plan agreement with foster carers. They also emphasise the importance of ongoing consultation with carers and feedback from them for the duration of an intervention.

In terms of mental health interventions for young people with contact with the justice system, Kinscherff (2012) argues strongly for the recognition of the role of trauma exposure in young people's symptoms and misconduct and incorporation of this into intervention. He suggests critical developmental disruptions must be addressed, including reduced capacity for attachment, relationships and empathy, profound emotional dysregulation, and increased risk-taking and aggression among others. A trauma-informed approach recognises that young people are not responsible for the experiences they have had, but that they must learn to manage the consequent acute responses or maladaptive attitudes and behaviours. Such an approach is therefore skills- and strengths-based rather than punitive, and also relies on supportive adult relationships as critical to recovery (Griffin et al., 2012; Kinscherff, 2012).

SUPPORTING ADULTS' CAPACITY TO CARE

Finally, we noted above that relationships with caring adults are critically important for the psychological well-being of children in the care and youth justice systems. However, the research literature consistently identifies concerns about conditions under which adults' capacity to care for these young people is limited. These concerns relate to mental health, social care and youth justice professionals as well as foster carers, and they centre on issues of adequate support; workload; and transference and vicarious traumatisation. We summarise aspects of these here.

In Ireland, the CAAB (2009b) noted that carers in residential units have expressed concerns to inspectors about feeling overwhelmed by the challenging behaviour and complexity of needs of some children in their care. The chairperson of the inter-agency Ballymun Network also noted that, despite aspirations to focus on helping young people, instead their case deliberations were absorbed by:

> **discussions about the fears and anxieties of professionals and agencies over procedural issues such as confidentiality, protocols, roles, competencies, boundaries, and training which, at best, are tangential to the helping relationship. (youngballymun, 2010, p. 47)**

This suggests that under certain circumstances, professionals find it difficult to help children and young people and to form effective therapeutic relationships with them. The report suggests that "radically reflective" processes, training and supports need to be put in place for professionals working in care and justice settings (youngballymun, 2010, p. 47).

For foster parents, Morgan and Baron (2011) in the UK found that children's challenging behaviour affects parenting capacity, strain and placement breakdown and that skills, training and supports are needed for foster parents. In a study of 58 foster carers working for an independent fostering agency (19% response rate), they examined children's challenging behaviours and foster parents' efficacy, stress, anxiety and depression. They found three-quarters of the children (77%; mean age 14.2 years) had borderline or clinical emotional and behavioural difficulties; half the foster parents (54%) had borderline or clinical parenting stress. Importantly, while children's challenging behaviour predicted poorer foster carer well-

being, parental self-efficacy partially mediated this relationship. Parenting efficacy (having appropriate skills and feeling a sense of mastery in the role) is therefore an important factor in placement stability. Morgan and Baron (2011) suggest that foster parents should receive skills training in behavioural techniques for managing challenging behaviour; that the attachment implications of children's histories should be explored; and finally, that recognising small changes is important for carers' confidence, mastery and efficacy. This finding highlights the need for effective supports and training for all foster carers so they may provide nurturing care.

For social workers in particular, challenges to their capacity to care are further compounded by high workloads and inadequate supports. The authors of the ICDRG Report observed from their review of files that, while child and adolescent mental health services and child psychiatry professionals were involved with less severe cases, inexperienced social workers were working unsupported with the most serious cases: the most complex children and parents were therefore not being dealt with by the appropriately qualified professionals (Shannon & Gibbons, 2012). There is evidence to suggest that, compared with international counterparts, Irish social workers have high caseloads (Burns & McCarthy, 2012). In case studies of three Irish social work teams, Burns and McCarthy (2012) found that two teams had an average of 33 children per whole-time equivalent (WTE) post on their caseload and the third team had 23 children per WTE post, compared to averages of 24 - 31 in the USA, and maximums of 15 in Australia and 12 in the UK. An overemphasis on crisis intervention results in the neglect of many children in Irish social workers' caseloads – who in turn only receive attention when they reach a crisis. This work practice, according to Burns and McCarthy, results in a further stress, a "stress of conscience" (p. 32) for the social worker, affecting their efficacy.

A further issue affecting capacity to care is less overt but can have powerful effects on professionals and their relationships with one another. This is because the trauma experienced by children can transfer to professionals and to the system as a whole, if it is not recognised and managed. Psychodynamic explanations clarify how disturbance in children can disturb a system, and how the system can then create further disturbance in the child. For some decades, research has applied psychodynamic concepts to organisations; for example, it has been found that professionals dealing with child sexual abuse can replicate the dynamics of abuse in inter-professional working relationships (Furniss, 1995). Conway (2009) highlights that professionals working with children in the care system need to understand that the trauma experienced by children in their care can be re-enacted in their own professional relationships: "Professionals and services working with such disturbed but understandable patterns of communication may find themselves affected by these powerful emotional processes, which interfere with clear and rational thinking" (p. 21). Conway focuses on the psychological defence mechanisms of projection and splitting. Where projection takes place, traumatised children unconsciously project their uncontained and uncontainable (Bentovim, 1995) feelings into their carers. Such feelings leave carers feeling inadequate and overwhelmed, often leading to placement breakdown. When splitting is enacted, the child attempts to maintain psychological equilibrium by dividing the world between the good

and the bad – including professionals. This dynamic, if it is not recognised and processed, then reappears in inter-professional relationships. Thus, conflicts between professions, which on the surface appear to be about the best interests of the child, may in reality be a re-enactment of the child's internal distress; and breakdown of caring relationships may be the result of unprocessed projected feelings (Conway, 2009).

Finally, **vicarious traumatisation** (VT) (McCann & Pearlmann, 1990) refers to the impact that working with traumatised people can have on therapists and other caring professionals. Symptoms include avoidance, emotional numbing and flooding, intrusive thoughts and feelings, suspiciousness, anxiety, depression, increased feelings of personal vulnerability and somatic symptoms (O'Connor & McQuaid, 2013). Strategies to avert vicarious traumatisation are available and these include having a balanced workload, peer support, and education and training. Organisations should therefore ensure these are in place, along with training for professionals in personal coping strategies. O'Connor and McQuaid (2013) argue that organisations are obliged to prepare and support those who are working with people with a history of trauma, and that they must foster a work environment where vicarious traumatisation is considered natural, acceptable and even expected. Therefore, where workloads are realistic, staff and foster parents are adequately supported, and environments are created where projections and other psychodynamic features of working with traumatised children can be discussed and accepted, professionals' capacity to focus on their primary task of caring for vulnerable children is supported.

AN INTER-AGENCY APPROACH

INTER-AGENCY COLLABORATION

Having considered central issues relating to children's and professionals' needs, we now turn to key systemic issues identified in the consultations. The importance of co-operation across agencies was highlighted in the consultations for this study. Young adults noted difficulties both during and after care of accessing services in multiple locations and not having someone to fight for services for them; professionals expressed considerable frustration at limited co-operation and understanding across agencies and professions. This section outlines Irish and international researchers' views of benefits and barriers relating to inter-agency working and gives some examples of inter-agency practice from care and youth justice systems. There is considerable confusion regarding usage and meaning of terms in this area (Duggan & Corrigan, 2009; Owens, 2010), so here we use the term 'inter-agency' to refer generally to planned collaborative working across agencies.

BENEFITS AND CHALLENGES OF INTER-AGENCY WORKING

Sloper (2004), exploring the needs of children in care and with mental health challenges, noted that a lack of inter-agency collaboration results in children and families dealing with many different professionals and agencies; receiving conflicting advice; and falling between gaps in services. The UK White Paper **Care Matters: Time for Change** (Department for Education and Skills, 2007) argues that stability for children in care will

not be achieved without effective inter-agency working. Researchers have noted that where agencies engaging with children and their families do not co-ordinate or collaborate, this leads to inefficiencies, poor support and compounds client difficulties. Outcomes include failure to engage families; lost prevention opportunities; failure to recognise the impact of trauma on behaviour; failure to refer children for assessments or services; high thresholds for access to services; lack of engagement with and from legal, education, health and mental health services; ineffective service delivery; poor attention to permanency; poor transition planning for 16- and 17-year-olds and poor transitioning into adulthood (Herz et al., 2012; Newman et al., 2010; The Health and Social Care Advisory Service, 2008).

Dedicated, specialist inter-agency services for children in care are recommended by some clinicians (e.g., Golding, 2010), who argue this will lead to improved communication and information-sharing; interventions tailored to children's specific and complex needs; and interventions tailored to a holistic and comprehensive understanding of the child, carer and the wider system. Reviews of relevant literature have been carried out that provide the evidence base for inter-agency collaboration and give examples of evaluations where relevant (Duggan & Corrigan, 2009; Stratham et al., 2011). For children and young people in the justice system, international research indicates that the work of other agencies such as schools, social care and health services are all critical to outcomes (McAra & McKie, 2010; Newman et al., 2012), indicating the importance of inter-agency work in this system as well.

Benefits also accrue to staff from inter-agency systems. Advantages of inter-agency work for frontline staff in the Ballymun Network included reduced stress as a result of having more people to consult or discuss issues with; enhanced ability to confront a young client as a result of having better and more information about them or of being associated with the authority of the Network; and the opportunity to reinforce services by drawing in parallel interventions (youngballymun, 2010).

The necessity and potential benefits for inter-agency working are therefore well-established. Indeed, inter-agency working is now a key concept in services for children and families in Ireland, underpinned by social policy initiatives and some statutory obligations (Owens, 2010). It is focal in Irish policy in the National Children's Strategy, **Our Children, Their Lives** (Department of Health and Children, 2000b), **Agenda for Children's Services: A Policy Handbook** (Office of the Minister for Children, 2007) and the national agreement, **Towards 2016** (Department of the Taoiseach, 2006). It was also recommended in the **National Guidelines for the Protection and Welfare of Children** (2009), the **National Development Plan** (Department of the Taoiseach, 2007), and the **Implementation Plan for** the **Commission to Inquire into Child Abuse** (OMCYA, 2009). Better inter-agency collaboration was also recommended by the ICDRG (Shannon & Gibbons, 2012).

However, despite repeated exhortations for inter-agency work and consistent indications from researchers that it brings benefits, poor inter-agency collaboration and poor information-sharing were identified in a 2008 review of compliance with **Children First** in Ireland; and there is

"consensus that inter-agency collaboration in the delivery of services to children and families is still poor" (youngballymun, 2010, p. 35). There is no national policy on inter-agency collaboration in the area of the mental health of vulnerable children and young people. Research and reports consistently note that inter-agency work is remarkably challenging to implement. The UK Department for Education and Skills (2007) noted that difficulties stem from poor understanding of roles, responsibilities, and language that may lead to poor communication and misunderstandings. In Ireland, an informative review of a recent model of inter-agency working in Dublin is found in an external evaluation of the Ballymun Network (youngballymun, 2010). The evaluation noted that despite some positive developments in building trust between agencies, not all participating agencies appeared to consider the Network to be relevant. In addition, work done for the Network was not always recognised by management of individual agencies, who "do not seem to include inter-agency work in assessing staff or agency performance, even where this is stated to be part of their ethos and corporate plan" (youngballymun, 2010, p. 45). Various challenges were identified in the evaluation, including the lack of an effective mechanism to address poor agency performance or lack of information-sharing, and lack of clarity about responsibility for observing inter-agency protocols. In addition, some agencies expressed concerns about other agencies' performance and commitment; they highlighted sub-optimum participation in case meetings; information withholding; and a need for training in running meetings.

Furthermore, even where inter-agency work is explicitly the goal, reviewers have indicated that fully integrated, child-centred services are not being aimed for. Owens (2010) in a review of inter-agency terms and initiatives, commissioned by the DCYA for inter-agency Children's Services Committees (CSCs), considered the different types of inter-agency collaboration available. She defined 'integrated working' as the most comprehensive and child-centred, which is achieved through formalised collaboration of all agencies and services at all levels, including information and efficient data sharing; common delivery tools; and a lead professional (Owens, 2010). Owens indicated that, despite some aspirations to integrated working, the goals of CSCs largely encapsulate lower-level inter-agency working, i.e., formal working in parallel, but without combining systems, processes and teams.

STRATEGIES TO ACHIEVE INTER-AGENCY COLLABORATION

Research into inter-agency working has generally focused less on optimal models for implementation than on obstacles to it, and there has been little systematic evaluation of which inter-agency practices contribute to success. Indeed, the authors of a recent review of inter-agency work focusing on children's services conducted for CAAB note that good inter-agency practice could not be identified from the available literature (Duggan & Corrigan, 2009). However, some authors have identified strategies. In this section, some examples of models of collaboration between various systems such as youth justice, child welfare and mental health in Ireland and elsewhere are outlined.

At the level of government, strategic commitment to integrated practice is essential (Golding, 2010; Tarren-Sweeney, 2010a). In addition, concisely

articulated beliefs in the benefits of joint working and common goals that speak to each agency's mission are needed; and commitment to joint working in every agency is crucial (Shufelt et al., 2010; UK Department for Education and Skills, 2007). Senior management can support a culture of optimism and realism and should provide resources to support this way of working (Golding, 2010). At the planning level, incorporating collaborative processes in written policies and procedures; conducting applications for joint funding; inter-agency service planning; facilitated strategic planning; guidelines for embedding inter-agency working within participating agencies including mechanisms to respond to agency under-performance and clarity of where responsibility lies for observing protocols have been identified (Department for Education and Skills, 2007; Shufelt et al., 2010; The Health And Social Care Advisory Service, 2008; youngballymun, 2010). From a structural perspective, the co-location of staff contributes to the success of multi-agency working (The Health and Social Care Advisory Service, 2008). On the ground, clear understanding of roles and expertise is central (Department for Education and Skills, 2007). Finally, joint training has also been identified as an essential element of multi-agency working (Department for Education and Skills, 2007, Shufelt et al., 2010). Joint training can address differences in language and communication. It can also counteract staff resistance if goals, processes and procedures are addressed, along with sharing of positive results; and it can facilitate the development of programme manuals and other written materials (Schufelt et al., 2010).

EXAMPLES OF INTER-AGENCY WORKING

Some authors have explored inter-agency work between youth justice and mental health systems in particular, and Skowyra and Cocozza (2006) propose the following are necessary: a co-ordinating body with representatives from all interested parties, including clients, family members and advocates; a strong leader with good communication skills and a good understanding of formal and informal systems; common, clear objectives and strategies for meeting these; strategic planning aimed at achieving immediate and sustainable outcomes; political support from community leaders including judges and legislators; and an effective finance plan including funding opportunities at local and governmental levels.

Internationally, some models of collaboration have been developed for the child welfare and juvenile justice systems; this is supported or required by legislation in some United States jurisdictions since 2002. The **Systems Integration Initiative** (SII) in the US (Herz et al., 2012) involves four phases: mobilisation and advocacy (establishing structural foundations and identifying goals and outcomes); study and analysis (data development, legal and policy analysis and information-sharing and developing an inventory of resources, best practices, assessment, and training); action strategy development; and implementation. The **Crossover Youth Practice Model** (CYPM; Herz et al., 2012) works from a strengths-based perspective and focuses on practice improvements: ensuring greater uniformity in the mission and vision of child welfare and juvenile justice agencies; developing specific policies and practices for dually-involved youth; improving inter-agency engagement in case management; increasing

inter-agency data to track population trends and inform decision making on all levels of involved agencies; conducting inter-agency training to improve agency knowledge about other agency functions and process; and creating a mechanism that provides continuous quality improvement across the two systems.

In the UK, **Youth Offending Teams** (YOTs) are multi-agency teams established to facilitate holistic service provision within the youth justice system, and there is a statutory requirement for health authorities to contribute staffing resources to them (Newman et al., 2012). The Centre for Mental Health Services, in its study of mental health workers in YOTs surveyed a wide variety of such models in the UK and concluded that health provision works best when there is a regular and systemic presence of mental health workers within YOTs, which allows access to consultation and advice and facilitates confident management of cases (Khan & Wilson, 2010); having very strong links to a broad range of local mainstream services was also considered important. In addition to providing direct support to YOTs, staff with expertise in mental health played a vital role in raising awareness of mental health issues among youth justice staff, police and court staff, which increased their capacity to recognise and work more effectively with young offenders with mental health problems (Newman et al,. 2012).

Finally, a further inter-agency issue involves the education system. In the consultations for this study, professionals consistently emphasised the protective effect that attending and engaging in school has for the psychological well-being and positive development of children and young people in State care and the youth justice system. The young adults in the consultation also stressed their disappointment when placement instability or mental health issues had disrupted their own school attendance. Research from most western countries indicates that children in out-of-home care have low school achievement levels and typically enter adulthood with low education levels (O'Sullivan & Westerman, 2007). The Social Exclusion Unit (2003) in the UK reports that the gap between the school achievements of children in State care and those of their peers tends to widen with age: when compared with their peers, about half of children in State care achieve a similar standard at seven years; at 11 years, a third achieve this standard; a quarter do so at 14 and just one in ten does at 16 years. A further factor to consider is that school exclusion has a negative impact on young offenders' conviction trajectories (McAra & McKie, 2010).

It is therefore essential that inter-agency assessments, contacts, supports and training incorporate the education system as well. This is because coping with school presents considerable challenges to children who are particularly vulnerable or who have experienced trauma. Disruption, disorganisation and lack of stability affect emotions, behaviours, attention and readiness to learn (Archer, 2004); and their histories can interfere with school progress even when they are in stable placement (Comfort, 2007). Children may also display hyper-vigilant, violent or fearful behaviours; teachers should develop strategies to help adjustment and minimise change where possible, as transition points are particularly challenging. Comfort notes that "Simply understanding their behaviour is probably

more helpful than any other tool in beginning to deal with and manage them in the classroom and avoiding the need for punitive measures and exclusions. Knowing that substance misuse, physical abuse, neglect, violence, poverty and separation trauma can result in neurological and emotional effects that create obstacles to learning may enable teachers and parents to approach the child with a different kind of sensitivity" (2007, p. 32).

School professionals therefore play an important role in identifying, understanding and supporting not just the educational needs of children and young people in care and youth justice but also needs relating to their psychological well-being. Moran (2007) and Newman (2004) point to six resilience domains that schools can support: a sense of belonging, education, friendships, self-esteem, empathy and self-efficacy. Children in care can be provided with positive experiences in school through trusting relationships with teachers; positive experiences in sports, arts and other extra-curricular activities; and friendships, mentors and role models (Gilligan, 2007; Moran, 2007).

In Ireland, Brierley (2010) recommended improved inter-agency coordination between social work and education agencies (DCYA, HSE and DES and education agencies such as the NEWB, National Council for Special Education, and NEPS) including holistic assessments and service responses. It was also recommended that the HSE routinely monitor school non-attendance in its care and protection systems and share this information with DCYA and relevant education agencies (Brierley, 2010). It is also notable that recent HIQA inspections of foster care, summarised in chapter six, consistenly note that children's educational outcomes are not being systematically recorded in order to allow local health authorities to improve these.

Finally, the Ombudsman for Children's Office has suggested that there needs to be an explicit public policy commitment to promoting all possible educational opportunities (including access, participation, and attainment in education) for children in care and that a joint action plan for children in care needs to be developed by relevant government departments, statutory agencies, and NGOs with responsibility for children in care (OCO, 2013). The OCO has stressed the importance of a commitment to combating stigma and negative stereotyping in all communications about children in care. Furthermore to improve the educational experience of children in care, they and their carers, should be given opportunities to engage in decision-making processes and to express their views on matters affecting them, including issues relating to children's education, future pathways, and in the context of care planning and review (OCO, 2013).

FOCUSING ON OUTCOMES

A key concern voiced by professionals in this study was the fact that intra-agency Key Performance Indicators detracted from their capacity to work collaboratively with other professionals and to develop a 'whole child' care and treatment perspective. Where inter-agency working is the goal, it is particularly important that the focus is on child-centred outcomes rather than on structural and agency-specific ones, and a focus on articulating

outcomes, allied to specific indicators, can reorient agencies to achieve this (Owens, 2010). For indicators to be useful, they should be measurable, precise, consistent and sensitive and they can be set at multiple levels (individual, community or population). Once specific outcomes and indicators have been delineated, meaningful and systematic process and outcome evaluations can be implemented (Owens, 2010).

THE NEED FOR SYSTEMIC CHANGE

This study's consultations with young adults and professionals, and the research literature, all point to the fact that many of the complex mental health needs of children and young people in care and in contact with the youth justice system in Ireland are not currently being met, for many different reasons. However, such complex mental health needs present a challenge to service providers across the world. Internationally, clinicians echo the findings from this study's consultation with professionals: the manner in which services are structured and delivered can further traumatise children and young people, impacting further on their psychological well-being. This can occur through the provision of multiple placements, poor service availability, poor inter-agency communication, lack of advocacy, low expectations and acceptance of challenging behaviour in the care system (DeJong, 2010; Golding, 2010) and through excessively punitive systems in youth justice that fail to understand the psychological and developmental origins of challenging behaviours (Kinscherff, 2012).

Indeed one key international clinician, working with looked-after children in New Zealand, argues that "no western jurisdiction has yet developed an integrated model of clinical practice" to address these needs; achievements to date have been "largely piecemeal, initiated ... by a small number of visionary clinicians... governments have generally underestimated the extent of change required, as evidenced by attempts to make existing service systems and professional practice models fit the needs of children in care" (Tarren-Sweeney, 2010b, p. 614). This account fits well with the picture of care and youth justice services portrayed in the Irish literature and also reflects the findings of our consultation with professionals. The importance of addressing such needs in a holistic manner is underlined by research findings that, in the case of young people, measures of vulnerability and offending are closely intertwined (McAra & McKie, 2010).

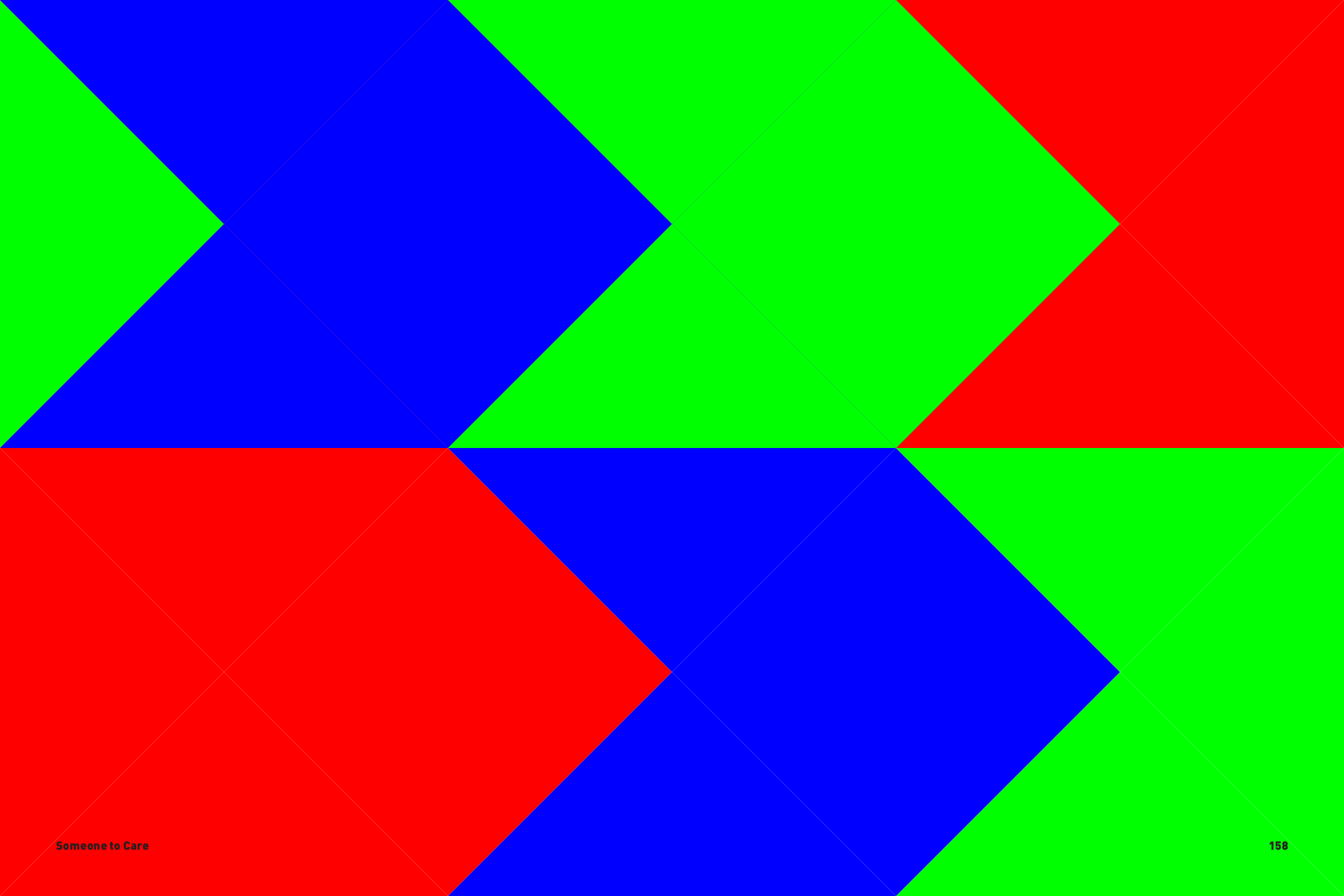
To avoid ineffective, piecemeal approaches, Tarren-Sweeney (2010b) argues that integrated mental health services are required at three levels: specialised practice, service models and civil society. Tarren-Sweeney proposes a set of principles for these integrated services, which echo many key points made by professionals in our consultation. First, at the practice level, Tarren-Sweeney argues that clinicians require specialised knowledge and skills. In addition, clinicians need to relinquish traditional clinical formulations and adopt psychosocial-developmental frameworks. They must also adopt better conceptualisations of the complex symptom profiles in vulnerable children, relating to the attachment- and trauma-related difficulties they experience; and develop a detailed understanding of the family and systemic factors that may affect these children. These issues also apply to young people in the youth justice system (Kinscherff,

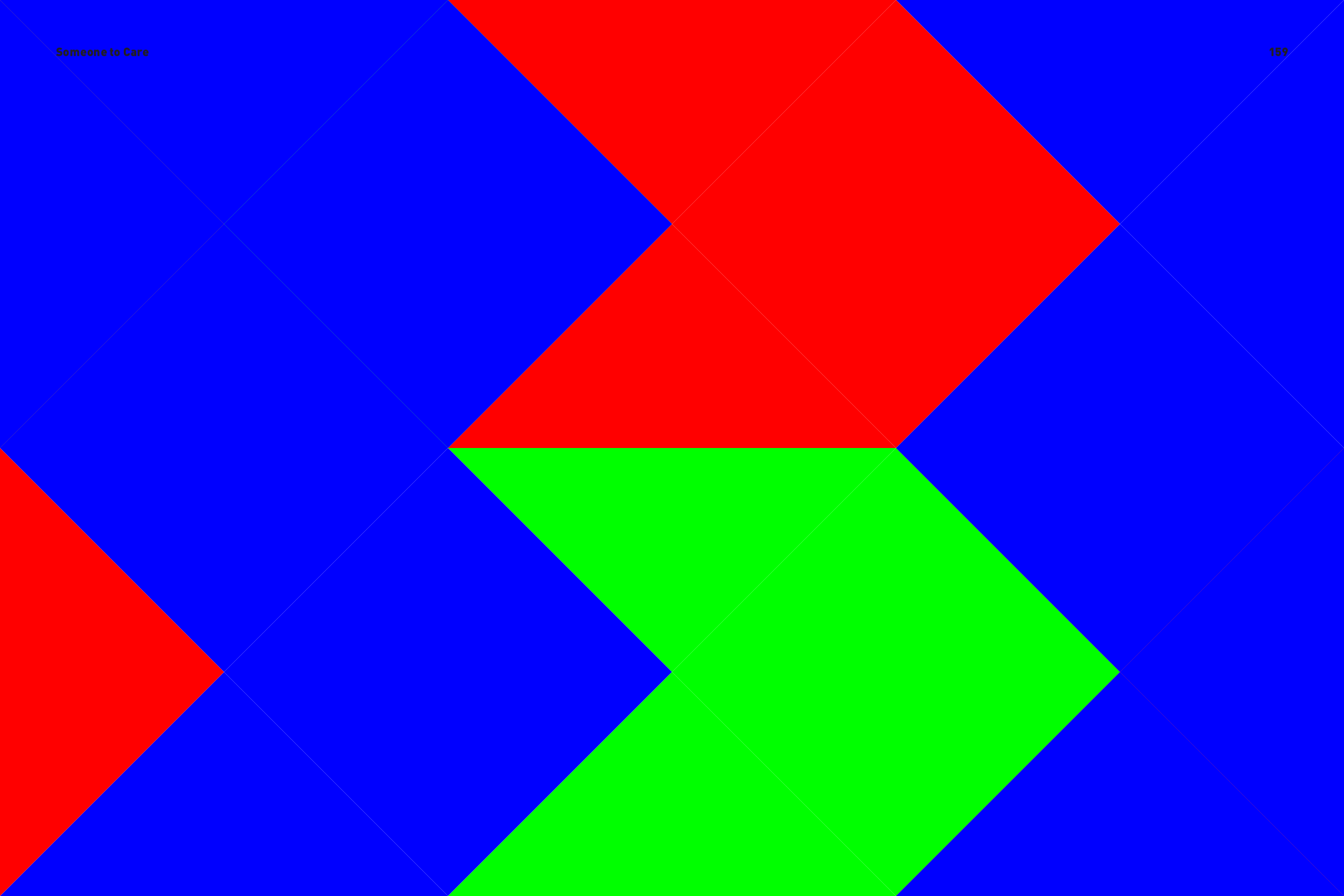
2012). At this practice level, Tarren-Sweeney (2010b) also recommends that clinicians should advocate strongly for children who do not have placement stability.

At the service level, Tarren-Sweeney proposes six specific strategies to support specialised practice. These are: better alignment of services; integration of mental health supports within the social care environment; comprehensive assessments for all who enter the care system; emphasis on preventative, long-term monitoring and engagement rather than acute care; emphasis on active engagement with clients; and normalisation strategies so that children and young people perceive services as a source of comfort rather than alienation. Again, these issues all apply to young people in the justice system, although it is likely that the last of these would be more challenging in that context. Finally, at the civil society level, Tarren-Sweeney argues that government policy must support a shift away from thinking about vulnerable children as solely the responsibility of social care agencies, and promote 'whole of government' accountability for these most vulnerable children in society. This links to policies outlining the need for a 'whole child' perspective, such as the National Children's Strategy (DoHC, 2000b) and fully integrated services (Owens, 2010). This can only be achieved through co-operation and systemic change across departments, if whole of government responsibility for a whole child approach is to be successfully implemented.

SUMMARY OF LITERATURE REVIEW

Drawing on major themes highlighted in the study's consultations with young adults and professionals, this review of Irish and international literature explored issues concerning the mental health and psychological well-being in the care and youth justice systems. These issues include accurate assessment of need; some examples have been identified. Features contributing to good care have been explored, including the vital need for placement and therapeutic stability, and the need for services to take account of the effects that children's trauma can have on professionals and on the system itself. The critical necessity of inter-agency co-operation has been noted, as this is repeatedly cited as a means to ensure better service provision. Overall, however, systemic issues preventing good inter-agency and multi-disciplinary planning and service provision have been repeatedly identified in the literature in Ireland and worldwide. It is important to note that piecemeal changes are unlikely to achieve the goal of supporting the psychological well-being of children and young people for whom the State is responsible: systemic change is required.





CHAPTER 7
ECONOMIC ANALYSIS

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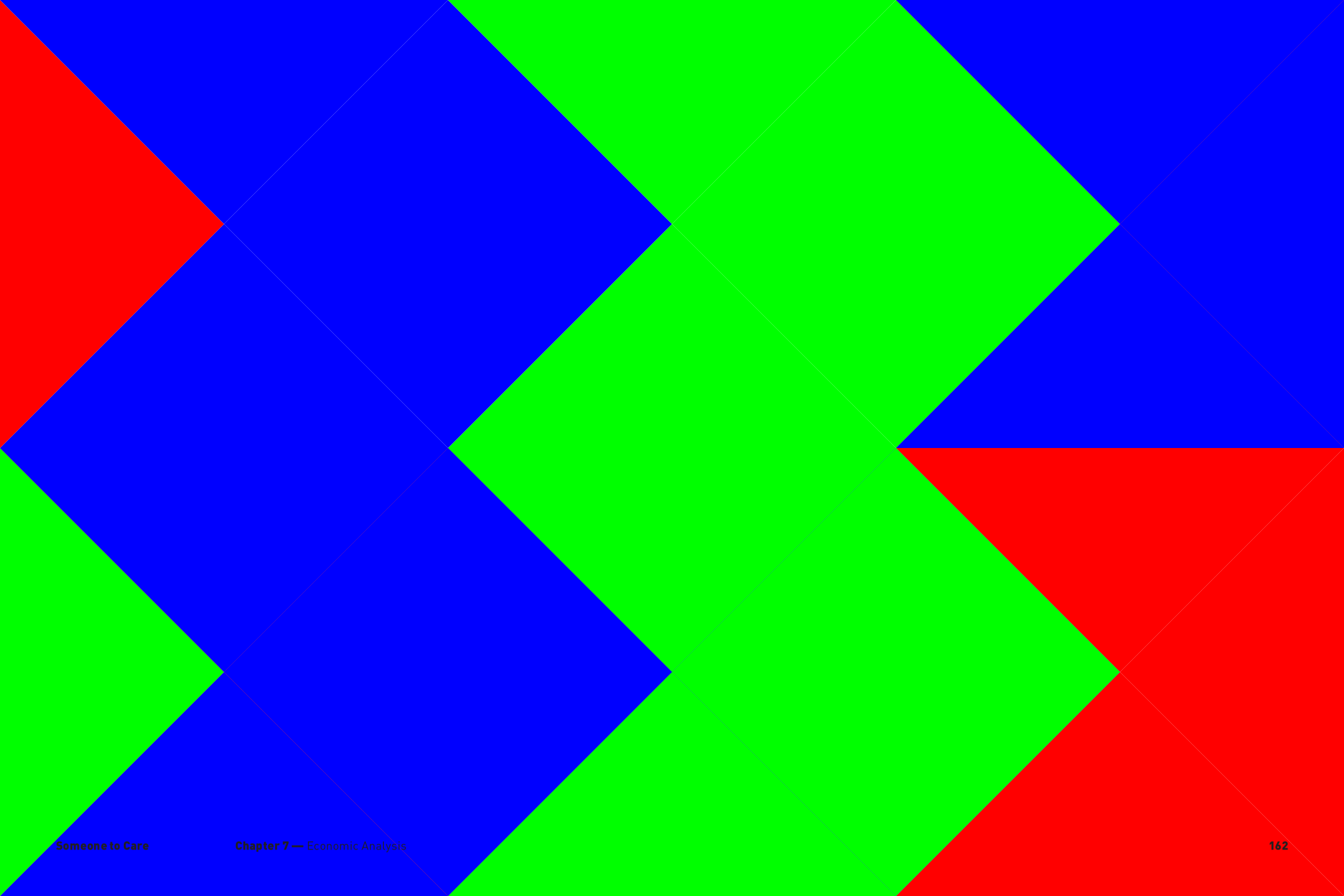

INTRODUCTION

Recent years have seen the emergence of a new value-for-money agenda in public service delivery across Europe. The drive for greater public sector efficiencies in Ireland began in earnest with the tightening of fiscal budgets following the financial and debt crises in 2007. Demonstrating value for money should help to allay concerns, widespread in many countries, about wastage and lack of accountability with respect to how public funds are distributed, but only where it is understood as the optimum use of resources, rather than cost-cutting.

The Irish government has identified value for money as a key consideration in deciding how public money should be spent (Department of Public Expenditure and Reform, 2012). To this end, it has developed a set of principles that should underpin any economic appraisal. Although it falls short of providing guidance on how value for money studies should be conducted, it is a first step in acknowledging the importance of research and evidence, leading to better policy-making and greater accountability. When value for money is measured holistically, it should improve outcomes by diverting resources towards policies that work well, thereby ensuring that limited public funds achieve more.

This chapter attempts to capture the extent of State spending on the care and youth justice systems, and on mental health services for children within these systems. The opening section describes a number of forms of economic analysis before providing a brief review of examples of economic analysis in the field of mental health.

FORMS OF ECONOMIC ANALYSIS

Value for money is conceptualised and applied in a number of ways in policy analysis. Most involve comparison between the costs and benefits of some action, but the nature of the costs and benefits included can sometimes vary considerably. Cost-Benefit Analysis (CBA) seeks to compare the value of the outcomes from an intervention with the costs of implementation. This is distinct from cost-effectiveness analysis, comparing the relative costs and outcomes of two or more courses of action; from cost-utility analysis which estimates the ratio between the cost of a health-related intervention and the benefit it produces in terms of the number of years lived in full health by the beneficiaries; and from Social Return on Investment (SORI), which is described in more detail below.

CBA is really an extension of an outcomes study, so unless an intervention has a robust measure of outcomes, it is usually very difficult to do such an analysis. The quality of the study will depend therefore on the rigour of the research on which the calculations are based, as well as the quality of the cost data that have been applied to it (Welsh & Farrington, 2000). For example, in order to know the cost-effectiveness of a mental health intervention, it is necessary first to know what the magnitude of improvement in mental health was and then to compare it to the costs of the intervention. Even where a study seeks to simply compare input costs with cost reductions, for example through reduced service use, it is

necessary to measure the extent to which the service reduction has taken place.

Identifying the most cost-beneficial interventions is an inherently challenging task because of the difficulty in comparing the results of evaluations, and because of the paucity of economic data. A systematic review in the mental health field found only 14 published economic evaluations, some of rather poor quality (Romeo, Byford, & Knapp, 2005). As Byford et al. (1999) point out, to be able to accurately demonstrate cost savings to the State, it is necessary to compare patterns of service utilisation of health, education, social care and voluntary sector services before and after the intervention. Few studies have such a wide scope, with many simply including criminal justice costs, for example, and the probability of re-offending.

SROI is a broader framework for understanding, measuring, and managing the outcomes of an organisation or policy area. It is particularly useful where an organisation has impacts across a 'triple bottom line', that is, social, economic and environmental impacts, or where many stakeholder groups are affected. It was originally developed in America from social accounting and cost-benefit analysis, and has a lot in common with other outcomes approaches. However, SROI is distinct from these methodologies in that it includes benefits to all relevant stakeholder groups, not just those that accrue to the State, or 'the economy'. It places a monetary value on all outcomes, including non-traded outcomes, so that they can be compared with the investment made. This results in a ratio of total investments to total benefits, that is, the sum of the value of all the outcomes. For example, an organisation might have a ratio of €4 of social value created for every €1 spent on its activities. The ratio aims therefore for a holistic representation of value. While the ratio is important, SROI is about much more than this. A good analysis combines qualitative, quantitative and participative methods of evaluation and presents narrative and financial information that tells a story of change. The information should also help organisations focus on those activities that create the most social value (see Nicholls, Lawlor, Neitzert, & Goodspeed, 2009).

Based on these criteria, CBA or SROI demand a range of valid and reliable data on costs and outcomes, data which are not always available to researchers. The next section details examples of studies of mental health interventions in the care and youth justice systems.

EXAMPLES OF ECONOMIC ANALYSIS

In the literature on the care and youth justice systems, most of the emphasis is on interventions aimed at keeping families together and preventing the circumstances that lead to care orders being made (see for example Aos et al., 2011). This is not least because costs can be extremely high once children enter these systems and one of the easiest ways of demonstrating savings in the short-term is to keep them out of State care. This does not mean that good quality interventions do not exist but may explain why there are fewer that make a persuasive economic case relative to more preventative approaches. For example, Multi-Systemic Therapy has been evaluated in terms of economic returns and showed a net present

value of $131,918 per participant, which is equivalent to a benefit-to cost ratio of $28.33 for every dollar spent (Aos et al., 2011). In the short-term, savings came from spending fewer days out of school and in hospital and in out-of-home placements (Shepperd et al., 2009). This is particularly the case in the crime-related field where the public service costs are high (Romeo et al., 2005). Romeo, Knapp, and Scott (2006) found that for children with persistent anti-social behaviour only 5% of the cost was carried by health departments with other costs attributed to social care agencies, voluntary organisations, families and welfare. In addition, this does not include the social costs of criminal justice, substance misuse or unemployment. For example, the new economics foundation has calculated that the annual cost to the State in the UK of a 'career criminal' is £80,000, rising to £335,000 when wider social costs are taken into account (Knuutila, 2010).

Looking to care placements, there may be occasions where an appropriate, high-quality care placement could lead to long-term savings, not just to the individual involved but to wider society. For example, it has been estimated that the average life-time resource cost of a young person not being in employment, education or training at 16 is £104,300 (€120,000), or as high as €2 million if the young person is also offending (Coles, Godfrey, Keung, Parrott & Bradshaw, 2010). Although care interventions are often associated with poorer outcomes for children, this reflects the fact that most research on outcomes takes place when children are in, or leaving care. For example, a retrospective study of care leavers in adulthood in the UK found that care leavers did better educationally over the long term than 'in difficulty' groups who had no history of accommodation in public care (Cameron, Bennett, Simon & Wigfall, 2007). Similarly, a University of York study using a composite measure of progress found that three-quarters of young adults leaving care were making progress towards, or had achieved, positive outcomes (Dixon, Wade, Byford, Weatherly & Lee, 2006). Looking simply at whether a care order was deemed necessary or not at a particular time is not necessarily a measure of success, in spite of potential short-term cost savings. Collecting proper baseline data when children enter care would enable better measurement of the effect of any care intervention.

Ward, Holmes, and Soper (2008) have developed a methodology for fully costing care placements for children in the UK. Their research has found that postponing service provision only reduced short-term costs; in the long term more costly services and placements were required increasing the overall cost of the care episode. They also found that kinship carers received minimal financial support but that this might prove to be a false economy as it might jeopardise the stability of the placement. Furthermore, they found that the outcomes were least favourable and the costs highest for children who displayed either emotional or behavioural difficulties and were also committing criminal offences. These children were the most likely to be excluded from school and were the least likely to access either routine health or psychotherapeutic support, often because they refused input (Holmes, 2003). Accurate costing of services could be linked to outcome data to facilitate comparisons of cost effectiveness.

A number of reviews of the economics literature on crime and child and adolescent mental health have been carried out. These generally

conclude that there are too few evaluations and the ones that exist are often context specific and narrow in perspective (Patel & Knapp, 1998; Romeo et al., 2005; Knapp, McDaid, & Parsonage, 2011). In a review of economic evaluations of mental health interventions, Byford, McCrone, and Barrett (2003) found only six studies that took a cost perspective close to being societal; that is, including an assessment of patient and family costs, non-healthcare costs or productivity losses. They concluded that although economic evaluations were improving with time, there were still inadequate numbers of such evaluations to inform resource allocation decisions (Byford et al., 2003). In addition, the comparability of cost-benefit results will often be low. Researchers use different methods, include different approaches to valuation (such as marginal vs. average costs), and build in different assumptions (such as discount rates). This has led Welsh and Farrington (2000) to conclude that finding the most economically efficient programme by comparing results is all but impossible. Zechmeister, Reinhold, and McDaid (2008) conclude that robust evidence on cost-effectiveness is still limited to a very small number of interventions with restricted scope for generalisation and transferability, with the most favourable results relating to early childhood development programmes. This review has also found that certain programmes are more amenable to economic analysis than others. Results that are quantitative or include controlled studies lend themselves more easily to calculating benefit cost ratios. In addition, it is more difficult to measure positive mental health interventions, such as community-based preventative programmes. This does not mean that they are less valuable however, which is one of the dangers of focusing policy exclusively on those areas where economic efficiency can be clearly demonstrated.

The application of economic analysis to the field of children's and young people's mental health is relatively under-developed, with no emerging consensus on the parameters of the analysis. There are some studies that show a clear return on investment, and they demonstrate that CBA is a viable method of analysis in this area. The next challenge for the present study was to investigate whether the data required for reliable analysis are available in Ireland.

ECONOMIC ANALYSIS OF IRELAND'S CARE AND YOUTH JUSTICE SYSTEMS

Owing to the absence of agreed measurable outcomes, only cost estimation is reported in this chapter. The methodology used was to identify the most important sources of direct costs in relation to children in care and secure care. The relevant government departments were then contacted to access these data. Gaps that emerged were filled through additional secondary research, including reports from the HSE and Child and Adolescent Mental Health Services (CAMHS). A final step was to attempt to compare some of the unit costs with those from other countries. The HSE and the Department for Children and Youth Affairs supplied most of the data. However, where gaps emerged some estimates had to be made, so the results should be treated with according caution. The reliability of costs varied depending on the quality of the data and the level of extrapolation required.

The cost to the State of providing homes for children in care is €233.2 million. The cost of detention is at least €61.3 million, although figures for 16- and 17-year-olds at St Patrick's Institution were unavailable. The cost of providing mental health services is €11.1 million. Taken together these estimates give a total cost of almost €300 million (see Table 1). This equates to an annual cost per child in care or detention of about €63,000. This average masks huge variability in the costs. A child in detention with mental health needs will cost far more than this, whereas a child with low needs in foster care will cost much less. In addition, this is likely to be a very narrow perspective on the total costs over the long run. By way of comparison, it is worth noting that the annual cost of mainstream education per child is less than €4,000 (Department of Education and Skills, 2011).

Of particular note is the steep gradient in costs if a child's case is escalated from foster care, the least costly option, through residential care at more than five times the cost, to Special Care at 16 times the cost of foster care per year. Likewise, the contrast between the costs of the Garda Diversion Programme, at €2,000 per child per annum, and the cost of detention, at almost €300,000 per child, is considerable.

It is difficult to put these figures in context by comparing them with other jurisdictions, as the way costs are calculated are likely to vary. Costs in England and Wales and Scotland are quite similar to one another. The average costs of residential placements are about £143,000 (€166,000) and £156,000 (€181,000) respectively. What is not clear is whether these figures incorporate the costs of high support and Special Care unit equivalents, as these push up the average placement cost in Ireland substantially. More would need to be known about what service is provided in these types of homes to enable a comparison. The costs of youth detention in Ireland seem high by UK standards. According to the Youth Justice Board, the cost of a bed in a Youth Offending Institution was on average £55,018 (€64,000) in 2007 to 2008. At the other end of the range, a placement to a Secure Children's Home (SCH) costs £206,184 (€240,000). Even at the highest end of the UK estimate, the cost is 25% higher in Ireland.

The HSE has stated that it is not currently possible to extrapolate spending on CAMHS in relation to either inpatient facilities or community mental health teams from the general mental health budget. Existing community mental health teams is at 38% (HSE, 2012b) of what is recommended in **A Vision for Change**. In the last budget €7 million was provided for 150 additional posts in existing child and adolescent community mental health teams and the HSE has stated that recruitment for these posts is ongoing. However, the HSE could not provide figures for what is required to bring these teams up to their full staff complement as recommended in A Vision for Change (verbal communication from the HSE, 13 June 2013). Greater clarity in relation to spending on CAMHS services is required to ensure accountability and transparency but also to ensure proper planning, provision and co-ordination of services. It is recommended that under the new HSE Mental Health Directorate, accurate data on current spending on CAMHS and projections in terms of bringing spending in line with A Vision for Change recommendations be provided as a matter of public policy and priority.

SUMMARY OF ECONOMIC ANALYSIS

The analysis presented here is one side of a cost-benefit analysis, giving a detail breakdown of costs in the care and youth justice systems. With no consistent information on outcomes, it is difficult to put these figures into context and drawing even tentative conclusions from the figures, even where they seem high, should be avoided because there is insufficient information on what each line of the costs actually covers. While the UK is a good comparator in many ways, it is more than 10 times the size of Ireland. This makes it easier for the UK to achieve economies of scale and to provide specialist services more cost-effectively. It is highly likely that, although the costs of sending children abroad or buying in assessments from abroad are high, they are potentially lower than providing them in-country. However, when viewed more holistically, the long-run costs of sending children abroad may be greater if it is not a good decision for the child e.g. if it leads to a breakdown in sibling relationships.

It is only by measuring the outcomes from different types of provision that value-for-money assessments can be made. Short-term cost savings, where they are detrimental to outcomes, are likely to result in false economies because the long-run costs of allowing problems to develop or exacerbate will always be higher, both economically and socially, than the costs of intervening. This could be, for example, in cases where children develop conduct disorders, are long-term unemployed or develop complex mental health problems. What is clear from the figures presented is that any measure that avoids the escalation of a care or youth justice case is likely to save money. Furthermore, a case could be made for diverting additional spending to activities that could prevent such escalation.

TABLE 1
COST OF IRELAND'S CARE AND YOUTH JUSTICE SYSTEMS

TYPE OF CARE
Special care units
Out-of-state placement
High support units
Standard residential
HSE foster care
Private foster care
Day fostering
Kinship care
Social work costs
TOTAL

DETENTION
Child detention schools
St Patrick's Institution
Garda diversion programme
Forensic assessments UK
TOTAL

MENTAL HEALTH
CAMHS
Mental health assessments
TOTAL

NO. OF CHILDREN	€ COST	BASIS	YEAR	€ TOTAL
20	457,178	per child per annum	2011	10,413,000
11	313,488	per child per annum	2011	3,448,368
61	281,156	per child per annum	2011	17,150,531
351	140,400	per child per annum	2011	49,280,400
3776	27,960	per child per annum	2011	121,285,120
	36,280	per child per annum	2011	
				unavailable
				unavailable
6160	5,140	per child per annum	2011	31,662,400
				233,239,819
122	299,000	per child per annum	2011	36,478,000
				unavailable
5673	2,000	per child per annum	2011	11,346,000
10	4,000	per assessment	2011	40,000
				47,864,000
	10,948,000	per annum	2011	10,948,000
44	2,795	per assessment	2011	122,980
				11,070,980

CHAPTER 8
CONCLUSIONS AND RECOMMENDATIONS

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CONCLUSIONS

The mental health needs of children and young people in the care and youth justice systems are the focus of this research report. Notably, many of the young adults consulted for this study spoke very positively about some of their experiences of the care system. They recalled positive relationships they enjoyed with care staff, social workers, psychologists and other professionals, some of which continue to the present day. Each young adult was able to identify one key person who had made a positive difference in their lives. One young adult viewed her experience in care as the best thing that ever happened to her. Others spoke of their strong sense of belonging, of having a home and being part of a family while in the care system. Some spoke of the pleasure of moving to their own homes after their care experiences and the supports they continue to avail of from professionals. In different ways, they all demonstrated considerable resilience in the face of exceptionally challenging life experiences.

However, the young adults interviewed also described profound struggles and these are a stark reminder of the many significant flaws in our care system. Young adults described how multiple placements undermined their sense of stability, detrimentally affected their ability to form relationships with peers and professionals, interfered with their schooling and clearly contributed to ongoing psychological difficulties in their everyday lives. Other struggles they described included difficulties in maintaining contact with their biological families, stigma associated with being in care, the experience of leaving care and feeling unprepared for this transition, challenges in adapting to adulthood and independent living, and the need for ongoing support in early adulthood. The research and analysis presented in this report have identified a broad range of issues at different levels of service provision for children and young people in the care and youth justice systems. This chapter highlights the most critical points which, if left unchanged, risk repeating past failures in the child welfare and protection, and youth justice systems.

One issue identified in this study was professionals' views of the care and justice systems as traumatised and traumatising. Young people who need care and youth justice interventions are usually traumatised and psychologically vulnerable; the complexity of their needs is acknowledged both in the consultations with professionals and young adults and also in the international literature. This is clearly a very challenging field of work. The inadequacy of responses to such challenging difficulties can result in professionals also being traumatised and systems responding in a chaotic, fragmented manner. Such inadequate responses can also traumatise further young people who are most vulnerable and most in need. It is clearly of the utmost importance how professionals in youth justice and care, foster parents, and all those who come into contact with vulnerable young people in these systems are selected and supported. It is also imperative that we strive to find effective ways of responding to young people's needs that are based on appropriate evidence bases.

A primary issue identified by young adults in this study was their need to be understood and to be able to develop trusting relationships with key individuals in these systems. Many spoke of the strong and enduring bonds

they formed with professionals and foster parents and the positive impact that such relationships have had on them, as they now meet the challenges of independent living. Professionals, however, spoke about the challenges in building trusting relationships with some young people who have experienced trauma, often of a relational nature; the need to find ways of engaging these young people so that they can access the help they need; the struggle of working with those presenting with challenging behaviour, of seeing beyond the anti-social behaviour to the child who is still developing and the additional training that is needed to be able to respond to such children in their time of need. Professionals spoke of the need for early intervention for mental health issues, and for connecting with young people to guide them away from a pathway of crime. Young adults also described the difficulty of engaging with professionals and the importance of getting the right response at the right time.

Several factors contributing to this concept of traumatised and traumatising systems were identified. These include the lack of a child-centred ethos in services; the need for earlier intervention to support the mental health needs of young people; a lack of equitable access to services; poor inter-agency co-operation and lack of mutual understanding of the skills, roles and responsibilities of professionals involved with children and young people; a lack of training in psychological well-being for professionals and all those involved with children in the care and youth justice systems; professionals' need for support from specialised services; and the lack of legislative support for access to services.

A second key issue identified in this study is the lack of a shared understanding of mental health in responding to children's and young people's mental health difficulties. Mental health was often seen as associated only with mental illness and diagnosable psychiatric disorders, which has led to an over-emphasis on assessments that seek to endorse or rule out a psychiatric diagnosis, and has dictated to a large extent how services are structured and how referral pathways are managed. The dominance of the bio-medical model in assessment, intervention and service developments was an issue of concern for both young adults and professionals, and this concern is echoed internationally in the current discourse on the limitations of the proposed DSM 5 classification system of the American Psychiatric Association. The failure to appreciate the prevalence of mental health difficulties in young people in contact with the youth justice system was seen as an issue requiring urgent attention. Professionals spoke of some young people in these systems being over-assessed, yet having inadequate follow through of services. Difficulties with labelling and stigma for those who were able to access services were highlighted.

For those who are diagnosed with a disorder, the focus appears to be on the elimination of symptoms. It would be preferable to focus on a comprehensive biopsychosocial response, taking account of the difficulties in a child's or young person's life that contributed to the development of the mental health issue, and on the need for a continuum of interventions and services, drawing on a broad range of resources both in the community and within statutory and voluntary agencies. For other young people who do not meet the criteria for psychiatric diagnosis, needs remain

unidentified and unaddressed. For those whose needs are 'sub-clinical', adequate support services do not appear to be in place and thus many young people are not able to receive the help they need. The focus on assessments that seek to determine whether a child or young person has a diagnosable psychiatric mental health problem therefore does not appear to be an adequate response to identifying and meeting their psychological well-being needs. Furthermore, while specialised services in the form of Child and Adolescent Mental Health Services (CAMHS), are available, the extent to which such services provide support and consultation to frontline workers appears to fall short of what is needed.

It is evident from this study that there is a need to provide a broad range of services that represent primary, secondary and tertiary level interventions that are designed to meet the varying needs of children at different stages of their time in the care or youth justice system. In addition, front line professionals spoke of the need to access consultation and support from professionals in more specialised services who have more expertise in dealing with complex difficulties. The international literature also discusses the need to make specialist consultations available to frontline professionals and those working with young people on a daily basis. Specialised services with particular expertise in mental health need to be developed as an advisory and consultation resource for frontline services, in line with the proposed ACTS model, but further extended to include the broad range of healthcare and youth justice personnel who interact with young people in the care and the youth justice systems.

A third issue for young people in the care and youth justice systems highlighted by this study is the critical importance of stability. This refers to the places where they live, the services they use, and the professionals who work with them. In the care system, placement stability is consistently identified as an important factor in supporting positive mental health. The young adults in the consultation repeatedly expressed their frustration when trying to build relationships because of the high turnover of staff for those who were placed in residential care. Professionals were also frustrated that they were often unable to build therapeutic relationships due to frequent placement moves, which HIQA foster care reports identify as a continuing issue for a number of children in the care of the State for whom matching with appropriate carers has not been achieved. Furthermore, many young people involved in the youth justice system have experienced considerable instability in their lives. Continuity in supportive and therapeutic relationships is therefore key to promoting intrinsic, positive esteem and self-efficacy, and to developing positive coping strategies.

A fourth issue emerging from the study was the clear need for inter-agency collaboration in providing comprehensive services to children and young people in the care and youth justice systems – and also the challenges to inter-agency working. In the consultation with professionals, the absence of inter-agency structures and protocols, and of clear referral pathways between agencies, was evident. In some agencies, the emphasis on Key Performance Indicators does not facilitate inter-agency working, where contact with other professionals and services is not valued as an integral part of service delivery. Professionals spoke of the challenges of working

with other disciplines whose understanding and priorities differ from their own, but also of the respect they had for other professionals.

It is also evident from the literature describing services in Ireland that a common language is needed to facilitate not only inter-agency collaboration but also access to services. The NEPS documentation refers to 'behavioural and emotional' difficulties rather than 'mental health difficulties'. Such distinctions can have implications for service provision, and indeed can have further repercussions that lead to misinformed court processes where framing an issue as a mental health difficulty may invite a different response than one framed as a behavioural disturbance. Finally, reduced opportunities to attend training events with professionals from other disciplines due to resource cutbacks has been a feature of many services and this deprives professionals of opportunities to connect, establish relationships and learn from each other.

Finally, a gap was identified at the level of community-based services that deliver appropriate and effective mainstream mental health services in the care and justice systems. Services need to be made available to all who need them in the community and not just those who are engaged with the care or justice systems. For many young people in the youth justice system, their offending behaviour has resulted from, or been contributed to by, unmet mental health needs. Such needs must therefore be met in the community as a means to prevent young people becoming involved in criminal activity; preventive care needs to be viewed as an alternative to justice based interventions.

A range of services is needed to address the need for community-based services. Young adults themselves could see the need for informal services, like one suggested by a young adult in the consultation – 'Chat If You Want' – or a confidential telephone line. At present, Jigsaw projects operate at this level, but on a geographically-limited basis only, while specialist services such as CAMHS and ACTS only accept referrals of those who have experienced mental health difficulties at the more severe end of the spectrum. The potential for using CAMHS as consultative support services appears to be under-utilised. In the youth justice system, although Garda Youth Diversion Projects operate at the community level, they do not have a mental health remit. The difficulty that many young people have in accessing psychological support across the spectrum of need was strongly emphasised by young adults and professionals in this consultation.

In conclusion, this study has identified areas for improvement in services and supports for the psychological well-being of the most vulnerable young people in society: children and young people who are in the care and youth justice systems. Structural and procedural changes to the current systems could diminish the likelihood of further traumatising these young people and the professionals who work with them. Cost benefit analyses of care systems demonstrate some value for money, but reliable comparisons cannot be made without detailed cost breakdowns; furthermore, value-for-money assessments can only be made by consistently measuring outcomes and comparing different types of provisions. What is clear is that any measure that avoids escalation of a care or youth justice issue is likely to save money. Systemic change to services is required, based on clearly defined and measurable outcomes.

Ireland has human rights obligations under European and international instruments to support the highest attainable standard of mental health of the children and young people in care of State services. This report makes a number of recommendations that could facilitate meeting those obligations.

RECOMMENDATIONS

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1 LISTEN TO THE VOICE OF THE CHILD: INVOLVE YOUNG PEOPLE IN PLANNING SERVICE DEVELOPMENTS, EDUCATION AND CONSULTATION

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Young people and young adults with experience of the care and youth justice system are best placed to contribute to the developing knowledge base on young people's mental health needs and how best to meet these needs. For service design, there should be extensive consultation with those currently in, and with recent experience of, the care and justice systems. A system of peer advocacy should be established for children and young people in care and for young adults after care. In addition, anti-stigmatising education is needed for young people in general, about positive mental health and well-being, and about emotional literacy.

Key principles of the UN Convention on the Rights of the Child should be incorporated into relevant legislation. The principles of best interests, the voice of the child, and non-discrimination should be incorporated into the Child Care Act 1991, the Children Act 2001, the Mental Health Act 2001, and all other relevant legislation. These principles should also be reflected in regulations, standards, and inspections in relation to children in care, children in the youth justice system, particularly in detention, and children in mental health facilities.

2 ISSUE A POLICY STATEMENT AND NATIONAL STRATEGY TO ADDRESS THE MENTAL HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE IN THE CARE OF THE STATE

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A national strategy is needed to inform practice and policy in this area. Such a strategy should adopt a common definition of mental health, going beyond a narrow focus on psychiatric disorders to address the pressing issue of psychological well-being. It should require shared responsibility across agencies for psychological well-being, identify inter-agency roles, outline best practice in policies and procedures, and update **A Vision for Change** to address the needs of this vulnerable group in Irish society. A systematic review is needed to inform the development of such a strategy. The review should identify appropriate assessment models of practice that take account of the biopsychosocial needs of the child and acknowledge the impact of early traumatic experiences. The review should also identify appropriate models of intervention for the Irish context, should go beyond meta-analytic reviews of randomised controlled trials, as these are inherently limited in their capacity to address the complex, contextual challenges of policy making in the social world. The review should incorporate mixed methods of research in order to establish not just 'what works' but also 'for whom, in what context, in what circumstances, and why'.

3 ESTABLISH A COMMON ASSESSMENT FRAMEWORK AND ONGOING MONITORING OF CHILDREN'S AND YOUNG PEOPLE'S MENTAL HEALTH NEEDS

An agreed assessment framework on entry to care or youth justice is required, as is ongoing monitoring and evaluation of progress as well as an assessment of need for all children currently in the systems. "Specialised assessment of these children requires a shift from a relatively narrow, 'mechanical' focus on identifying children's symptoms and disorders – to seeking a comprehensive understanding of their felt experience, their relationships, family / placement processes, and systemic and care-related pressures on their development" (Tarren-Sweeney, 2013b). This information should be held centrally to avoid multiple assessments and to inform service development. Information from assessments should be shared across agencies in a timely manner, holding the child's best interests as the central guiding principle.

It is critical that the care and youth justice systems clearly identify what they require from mental health services, and that processes are established to ensure that these expectations are consistently met. All legislation, regulations, and standards relating to foster care, residential care, and Special Care should be amended, to ensure that there is a requirement to identify any mental health needs a child or young person may have, and to address mental health needs in the care plan, including access to services where appropriate. Outcome measures should be agreed and consistently collected, in order to ensure that the relative costs and benefits of services can be compared. It is essential that these are analysed for all children in care and with youth justice engagement, to identify mental health needs; the extent to which they are engaged with mental health services; and whether this engagement goes beyond an assessment of need to include the provision of necessary mental health supports.

4 PROVIDE STABILITY FOR CHILDREN AND YOUNG PEOPLE IN THE CARE AND IN YOUTH JUSTICE SYSTEMS

Placement stability is the most fundamental need for children and young people in care. A suitable placement should be provided from the outset; excessive staff turnover in residential settings should be addressed; and suitable stable, long-term placements should be provided for those with high levels of need. The stability of the therapeutic relationship should be protected wherever possible. This includes facilitating therapeutic continuity if a placement breaks down.

5 PROVIDE ADEQUATE, EQUITABLE ACCESS TO SERVICES

Person-centred services are a basic requirement. Services should be structured to match children's and young people's levels of need at different times in life. Equality of access is a pressing issue of social justice and many factors are involved in creating

inequalities. Age, location and financial circumstances all affect children's access to mental health supports. Many necessary therapies, such as speech and language therapy, are currently not provided for many children who need them – leading to a 'cascade effect' of resulting educational, mental health and other problems. The issues of waiting lists and access for 16- and 17-year-olds need to be addressed urgently, to facilitate timely access to services. It is essential that every child in care have a social worker, and all efforts should be made to ensure continuity of social workers, to facilitate stability for children and young people.

Supports for foster carers are required. These should be similar to those provided by private fostering agencies, such as 24-hour emergency care and access to therapies and supports as identified in a needs assessment. In addition, there must be a link worker for every carer, and regular inspection of foster homes, with foster children interviewed separately.

Children and young people who offend have multiple and complex needs and these are frequently rooted in mental health challenges. Gardaí and the courts should have timely access to youth justice liaison and diversion schemes that are tailored to mental health needs and other vulnerabilities. Detention or custody is never appropriate for children and young people with mental health problems; a welfare approach should be taken instead. These children should not enter the youth justice system but rather they should be diverted and alternative means found to address underlying mental health needs.

Services should be child- and youth-friendly and could provide, for example, a dedicated helpline, and Jigsaw-style relaxed settings. Co-location of services should be incorporated in service planning. Finally, structures and supports are required for whole-school mental health provision.

6 ESTABLISH MANDATORY PROTOCOLS FOR INTER-AGENCY WORK

In order to provide child-centred care, inter-agency collaboration is essential. Information sharing must be mandatory and agency Key Performance Indicators must incorporate communication between professionals across all services for children in care and youth justice, including education. Across social care/work, psychological, psychiatric, justice and educational services, cross-professional understanding is needed, of interpretations of psychological well-being and behaviour.

In addition, referral pathways between agencies must be established and points of contact identified. Children's Services Committees could play a role in co-ordinating referrals. Social workers require support in providing 'joined-up services' in the care system for children and young people and their families. Within youth justice, there is a need to ensure that any mental health problems children experience are identified and addressed

within probation and diversion, and co-ordinated links are needed with CAMHS and ACTS, who should provide outreach consultation to a broad range of professionals working with young people.

7 DEVELOP TRAINING PROGRAMMES IN IDENTIFYING AND UNDERSTANDING PSYCHOLOGICAL WELL-BEING ISSUES, AS AN INTEGRAL PART OF PROFESSIONAL DEVELOPMENT FOR ALL PROFESSIONALS

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The lack of awareness of mental health issues and stigma relating to these issues must be addressed. Specific professional training and support in recognising children's and young people's mental health needs and challenges, for all professionals in care, justice, and education are required. There needs to be careful selection of professionals working in the care and youth justice system. Training needs include understanding the underlying dynamics of challenging behaviour for individual children, addressing professionals' own prejudices and biases in relation to the challenging and sometimes criminal behaviour of those in their charge, and addressing the need to reduce stigma about mental health needs and supports. Training is needed to support professionals in adopting constructive attitudes to young people, particularly those with challenging behaviours. All agencies need to educate and support staff in relation to vicarious traumatisation, transference and projection. Such psychological processes can significantly impact on professionals and on their capacity to care and to interact with other professionals. Finally, training and support is required for foster parents, during the selection process and on an on-going basis. To encourage attendance at relevant training, this could be a requirement of the foster carer contract.

8 PROVIDE LEGISLATIVE PROTECTION FOR CHILDREN AND YOUNG ADULTS LEAVING CARE OR THE YOUTH JUSTICE SYSTEM, AND FOR CHILDREN WHO ARE HOMELESS

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Under Section 5 of the Child Care Act 1991, all children who are homeless should have an allocated social worker and a care plan. Finally, a statutory right to after-care should be introduced, including the extension of foster care up to the age of 21, or 24 if in full-time education, for those young people who choose to remain with their foster families. Such a legislative provision should be accompanied by regulations that assign clear responsibilities and duties to ensure implementation.

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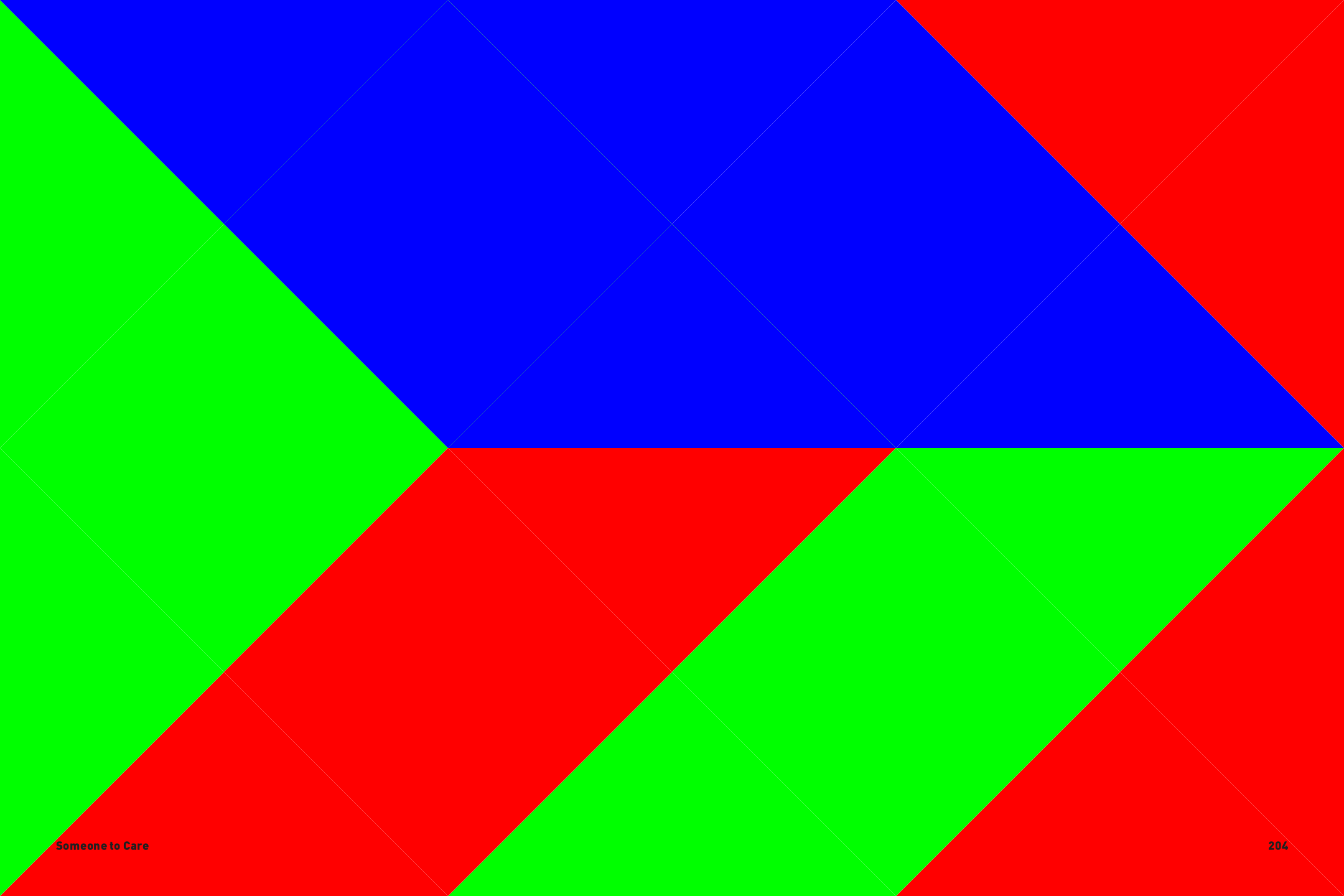
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