Tracing and Tracking of Children Subject to a Special Care Application

An Bord Comhairleach um Achtanna na Leanaí
Children Acts Advisory Board

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TRACING AND TRACKING OF CHILDREN SUBJECT TO A SPECIAL CARE APPLICATION

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SOCIAL INFORMATION SYSTEMS LTD

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FOREWORD

Given the genesis of special care in Ireland it cannot be surprising that we have limited understanding of its effectiveness or otherwise. Since the establishment of the first unit in 1995 there is little evidence that any formal evaluation of outcome has been undertaken. This report, for the first time, endeavours to improve our understanding of what happens to children who have been referred to special care. In setting out the parameters of the study we were particularly keen to consider the outcomes not only for those who entered special care but also to explore what happened to those children who were not considered to have met the admission criteria.

This study is not an end in itself, but rather contributes significantly to the debate which needs to be held about the future shape of child care services in Ireland. We cannot assume that the current system is 'good enough'. It is over ten years since an alternative approach to special care and high support was recommended by the group who established Rath na nÓg. It is only now that this approach is about to be advanced. But even this may not be the right way. Alongside the development of services it is critical that an ongoing process of evaluation of effectiveness is introduced. The system needs to be clear about what it expects from its different services and to establish processes to ensure that those expectations are being met consistently.

The drive in recent years has been to reduce occupancy and use of specialist residential services and to see these services, specifically detention, as services of last resort. There is sufficient material emerging from this report to give cause to at least reconsidering this strategy. Our success in keeping the numbers down in special care may be negated by other statistics e.g. youth homelessness. Particular attention needs to be shown towards ethnic minorities.

On behalf of the Board of the CAAB I would like to particularly thank the young people and their families who assisted us with this study. Their insights are hugely valuable. I must also thank those professionals who work with troubled children both in the community and in the special care units for their ongoing dedication and for their assistance with this study.

Particular thanks to Mark Brierley of SIS for an exceptional report produced in a very demanding timeframe and to Finbarr O'Leary, Deputy Chief Executive and Gráinne McGill, Advisory Officer for ensuring that all of the CAAB's objectives were met in the process.

Aidan Browne,

Chief Executive

RESEARCH QUALITY

Two important elements of the Children Acts Advisory Board's research quality assurance are the use of a Steering Committee to 'guide' a project and using and independent peer review process – see below.

Membership of the Research Steering Committee

Grainne McGill, Advisory Officer, CAAB (Chair)

Robert Murphy, Head of Research and Information, CAAB

Finbarr O' Leary, Deputy Chief Executive, CAAB

Liam Hickey, Director, St. Joseph's School, Ferryhouse, HSE

Michelle Clear, Director of Services for Children and Families, HSE

Fergal Conlon, Assistant Principal, Office of the Minister for Children and Youth Affairs

Peer Reviewer

Dr Gary O'Reilly is senior lecturer and Deputy Director, Doctoral Programme in Clinical Psychology, University College Dublin. He has a part time appointment as a principal clinical psychologist at the Children's University Hospital, Temple Street, Dublin. He has co-edited a number of books including The Handbook of Intellectual Disability and Clinical Psychology Practice (2007) and The Handbook of Clinical Intervention and Young People who Sexually Abuse (2004). He has co-researched (with Dr. Jennifer Hayes, UCD), a report on 'Emotional Intelligence, Mental Health and Juvenile Delinquency' (2007) – the first time that researchers, anywhere in the world, have examined whether young people in detention for criminality have deficits in emotional intelligence.

Acknowledgements

This report was delivered within a tight timetable, and that could not have been achieved without support from members of the Steering Group for this research, the Children Acts Advisory Board who acted in a co-ordinating role, and the responsiveness from all people who were interviewed.

It is usual within acknowledgements to thank people for their co-operation with the research. I would like to add, from a personal perspective, that it has been a privilege to meet with so many genuinely caring and dedicated people during this process, and I hope that this report can help shed some light on special care in Ireland, to the benefit of the children involved.

The Children Acts Advisory Board would like to thank the HSE social workers and management, the young people and their families and the Research Steering Committee who assisted the researchers SIS Ltd.

EXECUTIVE SUMMARY

Introduction

This report provides an overview of the applications for admission to special care made by Health Service Executive (HSE) Local Health Offices in 2007 and traces and tracks outcomes for the children who were subject of those applications up to November 2009. This research has been undertaken by Mark Brierley of **Social Information Systems (SIS)** and was commissioned by the Children Acts Advisory Board (CAAB). In addition to the CAAB, the Steering Group for the work included representation from the HSE and the Office of the Minister for Children and Youth Affairs (OMCYA). The report is based on scrutiny of anonymised special care applications and their supporting documents, interviews with social workers, children, parents/carers, staff from the special care units, guardians *ad litem* and solicitors. SIS had previously researched the application process and case characteristics for applications for special care made between January and June 2007 (SIS 2008).

The terms of reference for this work posed five broad questions:

1. What was the profile of applicants to special care?
2. What was the previous service/intervention history of applicants (e.g. social care, educational, juvenile justice)?
3. What services/interventions have been provided since each special care application was made?
4. Where did the children go to and where are they now?
5. What are the views of stakeholders on benefits and services/interventions?

The main body of the report is structured into several chapters that address these issues as follows:

- **Characteristics of cases subject to an application for special care.** This chapter looks in detail at the demographic profile of the children subject to the applications, the risk factors present in the applications according to the criteria for special care, previous placement history, and other case characteristics such as offending, education and health. It also matches these characteristics to whether or not the application led to an admission to special care, was withdrawn by the applicant, or was refused admission. There were 70 applications in the 2007 cohort: the researcher examined anonymised documentation that supported these applications and supplemented this with interviews with the representatives of the social work department that made the application. One limitation of this approach is that it depends on the extent to which social work departments gathered information from partner agencies around such issues as

health, education and offending behaviour. This chapter of the report addresses questions 1 and 2 above.

- **The application process**. Issues in relation to the application process had been considered in SIS's previous report (SIS 2008) for around half of the applications. SIS were therefore able to expand this to the whole cohort, looking at issues around decision making in the social work department, family welfare conferences, the robustness of the onward placement planned for when the child left special care, and the decision making of the CAAB and the HSE's National Special Care Admission and Discharge Committee (NSCADC) with regards to whether they supported the application or not. This is relevant to question 2 on the previous services and interventions. This chapter was based on information from the CAAB and the NSCADC about their decision making, the application documentation, and interviews with the representatives of the social work department that made the application.
- **Outcomes by November 2009**. SIS interviewed representatives of the social work departments to ascertain whether, overall, they believed that there had been a change to the risk factors that had been present when the application was made in 2007. Questions were also asked about changes to individual risk factors, placement history since the application, and issues relating to offending, education and health. Interviewees were also invited to comment on protective factors i.e. those factors that had helped to promote positive change. Analysis within this section is based on 59 *individuals*[1] rather than 70 *applications* as some children were subject to more than one application in 2007. This chapter addresses questions 3, 4 and 5 above.
- **Interviewee views on the impact of special care**. SIS interviewed a small number of children, parents/carers, representatives of the special care units and social workers to gather their views on special care. This explored issues that were relevant to the circumstances of each individual child in the study and also sought more general comments about special care within the overall context of care and community resources available. This chapter addresses question 5 above in particular.
- The final two chapters summarise **key findings** and **recommendations**.

Within the key findings sections of both the Executive Summary and the main report, the researchers have brought together findings under key emergent themes rather than the strict order of the questions above. So, for example, when considering age, this enables commentary to be provided in one place on demographic profile, differences in terms of admissions to special care or risk profiles, and perceived outcomes by November 2009.

[1] There were actually 61 children in total but two have been excluded from the tracing and tracking exercise, with the agreement of the commissioners, for a variety of reasons that will not be recorded in this report in order to preserve anonymity.

With regards to numbers, it is important to note that, because there were 70 *applications* and 59 *individuals,* the former is generally used for process issues (i.e. profile of applications and whether or not they led to an admission to special care) whereas the latter is generally used to trace and track where individuals were by November 2009. The relatively small number of cases prevents meaningful statistical analyses being performed for most of the emergent data, but the patterns that are present are nevertheless interesting and hopefully informative. Special care, as an option of last resort, will always involve small numbers. As a result, some of the recommendations in this report are deliberately written with an element of caution, highlighting emergent issues that need to be considered rather than stating them to be definitive positions.

Key Findings

Special care in 2007 was operating in an evolving environment. The HSE had only come into existence as a single national structure in 2005; the CAAB was subject to change during the research period (changing its name from the Special Residential Services Board and extending its remit to deal with both welfare and juvenile justice); the infrastructural arrangements were all new; in summer 2007 and early 2008 there were a number of High Court rulings that would influence the criteria for special care. More recently, provisions within the Child Care (Amendment) Bill, 2009, should they be enacted, will also influence the future shape of special care.

Applications, Admissions and Outcomes

In 2007, there were 70 applications for special care in Ireland, for 61 children. 46% (n=32) of the applications led to an admission to special care, 41% (n=29) were refused admission, and 13% (n=9) were withdrawn.

By November 2009, 46% of the individuals (n=27 out of 59) who had been subject to one or more applications in 2007 had overall risk factors that were perceived by social workers to have improved, 19% (n=11) had mixed fortunes (the perception being that some risks improved, some stayed the same or worsened), 14% (n=8) had the same level of overall risk, and 22% (n=13) had worsened. For both those who were admitted to special care and those whose application was withdrawn, 75% had overall risk factors that improved or had mixed fortunes (n= 21 out of 28 for those admitted, six out of eight for those withdrawn), while only 48% of those who were not admitted had improved or mixed fortunes (n=11 out of 23) and 30% of this same group had risk factors that actually worsened (n=7).

General Views on the Impact of Special Care

Of those children admitted to special care in 2007, social workers felt that special care had a positive effect for 54% (n=15 out of 28), with it providing a place of safety only for another 21% (n=6) (for many of the social workers a place of safety was all that they wanted and expected). For 18% of the children (n=5) special care was perceived by social workers to have had a negative effect. Those who

had been admitted to Gleann Alainn at some stage of their life had a higher likelihood of overall risk factors that improved or had mixed fortunes than those admitted to Ballydowd, Coovagh House, or not admitted at all. The children who were interviewed who had experienced both Gleann Alainn and Ballydowd (n=3) were also more positive about Gleann Alainn.

Some 42% of social work interviewees (n=25 out of 59) felt that special care was an effective model and 29% (n=17) felt that it was reasonably effective. Nevertheless, 24% felt it needed reshaping significantly (n=8) or was totally ineffective (n=6). Three had mixed views.

Social work interviewees, guardian *ad litem*/solicitor discussion groups, and some of the parents/carers were unhappy about the 'therapies' available in special care. By this, they primarily meant the availability of psychiatric and psychological support. In 2007 Ballydowd had psychiatric support, Gleann Alainn and Coovagh House had psychological support, but none had both. Nineteen social work interviewees made comments on the 'therapies' available in special care and this was a contributory factor to some thinking that special care needed to be reshaped.

Eleven social work interviewees also felt that the model in Ireland places too little emphasis on a managed step-down process: more is said on this later but it was again one of the themes noted by those who were dissatisfied with the model.

Gender Variations

Special care appears to cater more for the needs of females than the needs of males. Females were more likely to be the subject of applications (59%, n=41), and their applications were also more likely to lead to an admission (61% [n=25] admitted compared to 24% [n=7] of males). Females with the same 'real and substantial risks to self' as males (one of the criteria for admission to special care) were much more likely to be admitted to special care. Males were more likely to be at risk of, or engaging in, criminal activity (72%) than females (39%) and females were more likely to have one or more of the three sexual behaviour risk features (83%) than males (24%). This raises questions about whether the same sexual behaviour risks are tolerated more in males than in females.

Only 31% (n=9) of the males had no involvement with the criminal justice system at the time of the application compared to 59% of the females (n=24). The interpretation given to the judgement of Judge MacMenamin in HSE (Southern Area) v. S (S) (A Minor), and more recently Judge Sheehan's judgement in DT (A Minor Suing by his Guardian Ad Litem Breda Buckley) – and – The National Special Care Admissions and Discharge Committee and the HSE – and – ET and MT, (2008) was that where there were criminal matters before a district court, these needed to reach a conclusion before a child could be considered for special care. This therefore is a substantial part of the reason why fewer males were admitted than females in 2007. The Child Care (Amendment) Bill, 2009, if

enacted, will clarify this situation so that 'generally, unless a child has been remanded in custody or received a custodial sentence, the HSE can apply for a special care order'. (Oireachtas 2009, p14)

Age Variations

Children aged 12–14 were the subject for 33% of the applications (n=23), 15 year-olds were the subject for 43% (n=30), and 16–17 year-olds were the subject for 24% (n=17). Younger children were more likely to be admitted to special care than older children and were also more likely to experience improvements in overall risk factors. 33% of those aged 16–17 had risk factors that actually worsened (n=4 out of 12). Given that 16–17 year-olds also are least likely to be admitted to special care, this raises a question about whether the needs of 16–17 year-olds exhibiting behavioural difficulties are being effectively addressed, not just within special care but within the services provided by the HSE in general and its partner agencies. The positive impact on younger children led some interviewees to think that either special care should be used at a younger age and/or that there should be some form of special care aimed specifically at younger children.

Variations by Ethnicity

Some 74% of the applications (n=52) were for children whose ethnicity (using the definitions in the Census incorporated into the special care application form) was White Irish and 14% were Irish Travellers (n=10). 40% of Irish Travellers were admitted to special care (n=4, compared to 48%, n=25, of those whose ethnicity was White Irish) and 63% of the Irish Travellers had overall risk factors that worsened or stayed the same (n=5 out of 8) compared to 36% for White Irish (n=16 out of 44). Although numbers are small, this raises questions about whether Traveller-oriented services are sufficiently accessible and available nationally, whether social work staff are sufficiently trained to deal with cultural issues, or whether the presenting needs of Irish Travellers are not being treated the same way by the system.

HSE Area Making the Application

The HSE South area had the highest percentage of applications not admitted (57%, n=8 out of 14). There appears to be two reasons for this. First, the children for these applications had never experienced anything more intensive than a mainstream residential or community/family placement, implying that the applicants may have been deemed to have not fully explored alternative placements. Second, applications from the HSE South area were less likely to have an onward placement secured at the point of the application.

Youth Homelessness

Only 38% of the applications for children at risk from youth homelessness were admitted to special care (n=5 out of 13). By November 2009, of the 16 individuals who had either been at risk from youth homelessness at the point of the application or who had acquired that risk factor in the intervening

period, 56% (n=9) had overall risk factors that worsened or were a new feature. Twelve experienced homelessness after the application. This suggests that the needs of children who are at acute risk who have experienced homelessness are not being addressed adequately. These issues are more pertinent in Dublin Mid-Leinster and Dublin North East, given that 38% of the individuals from Dublin Mid-Leinster (n=8/21) experienced homelessness after the application, and 27% of those from Dublin North East (n=4/15).

Placement History Prior to the 2007 Application

The likelihood of an application succeeding had some relationship to the child's placement at the time the application was made. 73% of children in high support (n=8 out of 11) and 67% of children in an emergency placement were admitted to special care (n=2 out of 3). Only 23% of those remanded in custody (n=3 out of 13) were admitted (mainly applications made before Judge MacMenamin's SS judgement).

Children who had only experienced between one and four previous care placements were not likely to be admitted to special care (21%, n=3 out of 14) except where the situation was regarded as an emergency (in simple terms, this was where the social work department deemed there to be an immediate and acute risk to the child's welfare, often to their life, and this view was usually shared and supported by both the CAAB and the NSCADC).

Children who had been admitted to special care in the past for less than nine months in total were more likely to be admitted to special care (67%, n=4 out of 6) than those who had previously been in special care for a total of nine months or more (14%, n=1 out of 7). By November 2009, overall risk factors were most likely to have improved for those who had spent 7–9 months of their life in special care (83%, n=5 out of 6) or less than six months (71%, n=10 out of 14), compared to those who were never admitted to special care (65%, n=15 out of 23) or who were admitted for 10–12 months (38%, n=3 out of 8). This would appear to support the maximum period of nine months (three consecutive sets of three months) contained within the Child Care (Amendment) Bill, 2009 although it also suggests that nine months in total out of a child's life should be the maximum period in special care.

Discharge from Special Care[2]

Only 51% of applications (n=36) had an onward placement that was specified and secured at the point of the application, with mainstream residential units most likely to be secured (64%, n=16 out of 25) and high support units least likely (30%, n=9 out of 30). While 56% of the applications with the onward placement secured were admitted (n=20 out of 36), this was the case for only 35% of those where it was not secured (n=12 out of 34). Interviewees from social work departments commented on

[2] Note that at the time that this report was being written, the CAAB was soon to publish criteria for discharge from special care. An extract from this document is shown as Appendix C.

how difficult it can be to secure an onward placement when making the application. They often felt that they had been pushed to discharge a child from special care before a robust onward placement had been identified and had experienced difficulties finding onward placements for almost a third of the children who were placed in special care.

Given that so many applications specified high support as the discharge option without being able to secure that placement, and that a smaller proportion were discharged to high support than was planned in the applications, this does raise questions about whether more co-ordination of admissions and discharges between special care units and high support units is required. Several social work interviewees felt that more co-ordination was required. On the other hand, research has suggested that the current shape of high support in Ireland does not differ substantially from mainstream residential care (Laxton 2008).

As already noted, many interviewees who were least satisfied with special care felt that the model needed reshaping by linking high support units directly to the special care units, with a shared management structure, or even having them on the same sites as the special care units. Several had sourced these types of arrangements abroad. They felt that the provision of a step-down unit on the same site would enable a child to move in and out of special care over the three month period of their order as needs and levels of engagement changed. Eleven social work interviewees made comments on this subject.

The difficulty of accessing mainstream residential placements was a recurrent theme within the research, with some social workers feeling that units have too much power to block an admission or to end a placement unilaterally. Both social work interviewees and the special care units gave examples of children who stayed in special care for longer than was deemed necessary because of difficulties in identifying and securing an onward placement. This is an extremely important issue. Effectively, children have been deprived of their liberty when the professionals involved felt that there was no justification to do so. Difficulty in obtaining placements from local admission and discharge committees, and the power of individual units to refuse admission, were usually cited as the reasons why a mainstream placement could not be accessed: four children were discharged home when this was not the preferred option of the social work department because a mainstream placement could not be found.

Placement History Since the 2007 Application

While social work interviewees felt that 26% of children settled down into improved behaviour soon after leaving special care (n=8 out of 31), 39% were perceived to have immediately reverted to their risk taking behaviour or their behaviour became even worse (n=12). A further 25% (n=8) were perceived to be unstable for a while then settled down, while around 9% (n=3) were felt to have

settled for a while then reverted to their previous risk taking behaviours. Interviews with the children, their parents/carers and social workers suggested that sometimes the immediate effect of discharge can be that the child 'runs amok' before reflection on the lessons learnt in special care are remembered and assist them to more controlled behaviour.

By November 2009, 46% (n=17 out of 37) of those who were still children were in residential care (mainstream, high support, special care) and 38% (n=14) were either at home, in independent/supported living arrangements or foster care. The remainder were accessing homeless services (n=3) or detained in the justice system (n=3). However a third of those who were adults by November 2009 were either accessing homeless services (14%, n=3 out of 22) or in detention (18%, n=4), with 45% either at home, in independent/supported living arrangements or foster care (n=10), 14% were in residential care (n=3), and the whereabouts of 9% was unknown (n=2).

Some 49% (n=29 out of 59) of the individuals went home at some stage after the application but for only 34% (n=10) was this the preferred choice of the social work department, with 48% (n=14) of the children refusing any other placement and 14% (n=4) going home because mainstream placements would not accept them. These placements were much more likely to be successful where placement at home had been the preferred choice of the social work department.

Offending and the Criminal Justice System

Given that 56% of the males (n=15 out of 27) were detained by the criminal justice system at some point after the application to special care in 2007 compared to just 29% (n=6 out of 32) of the females, it would seem that, while males are struggling to access special care, they are more likely than females to end up in juvenile criminal detention. Several interviewees were concerned about the slow speed of the justice system, saying that significant delays led to children not seeing the consequences of their actions. Some social workers also noted that, where a child received a custodial sentence but was immediately released pending an appeal, that child was again not seeing any consequences for their behaviours, resulting in those behaviours worsening. There was little evidence of a joined-up approach between justice and child protection/welfare systems to assess and act on a multi-disciplinary basis where children in care were at risk of offending: several social workers noted that children were either in one system or the other.

For eight of the individuals, part of the reason for the application for special care was to separate them from a known individual(s), usually an adult male. Applications for five of these individuals were successful, two were not, and one was withdrawn. Injunctions and barring orders were taking against some of the men involved and some were cautioned: a few of those injunctions were taken in parallel with the application for special care although this detail was not included in the application documentation. In a small number of these cases, the social work departments described situations

that had arisen that suggested there was a need to put in place an information sharing protocol between An Garda Síochána and the HSE, including appropriate pathways within each agency for escalating concerns. A joint protocol between An Garda Síochána and the HSE is now in place for 'children missing from care' but that was not the specific concern for these cases.

Education and Learning Disabilities

Some 76% of applications (n=53 out of 70) were for children who had been school non-attenders in the previous 12 months. By November 2009, 47% of the individuals were engaged in education (n=28 out of 59), many of whom were involved in education outside school settings, Youthreach or FÁS. Of those for whom significant concerns about their education had been recorded against the criterion for 'real and substantial risks to self' a similar proportion (46%, n=21) were engaged in education by November 2009.

Some 25% of those with a low/mild/borderline learning disability (n=5 out of 20) were detained in the justice system at some point after the 2007 application compared to only 6% (n=2) of those with no learning disability. As a result, some 30% of individuals with learning disabilities (n=6 out of 20) were felt to have had risk factors that had worsened.

Note that our understanding is that the HSE is currently working with the National Educational Welfare Board to develop joint working protocols.

Health Related Factors

Some 79% of the applications (n=55) identified alcohol and/or substance misuse as a risk factor for the children, although the nature of this misuse was often unclear in the application documentation. Through a mixture of the application documentation and interviews with social workers, the researcher was able to establish that alcohol was a concern for 45 of the applications and cannabis for 34. For almost all of the substances, proportionally more females were misusing them than males (cannabis being the exception). Nine of the females were misusing heroin, of whom a third were admitted to special care (n=3). Some 57% of those who misused heroin experienced homelessness after the application (n=4 out of 7) compared to only 32% of those who had misused cannabis (n=9 out of 28) and 26% of those who had misused alcohol (n=10 out of 39). However, risk factors were as likely to worsen for those who had no history of substance abuse (33%, n=4 out of 12) as for solvents (33%, n=1 out of 3), prescriptions drugs (30%, n=3 out of 10) or heroin (29%, n=2 out of 7).

Eight children in the study were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)[3], of whom only 25% (n=2) were admitted to special care. 63% of the children with ADHD (n=5) had risk factors that worsened. Numbers are small but this may be significant.

Some 24% (n=17 out of 70) of the applications were for children who were in receipt of psychiatric services at the point of application, of whom only 35% (n=6) were admitted to special care. Given that special care is not intended to provide acute psychiatric interventions, this may not be surprising. However, a substantial number of applications were for children who appeared to have received some form of psychiatric assessment or intervention in the past. The research did not explore in detail the nature of psychiatric interventions received.

Application Process

At the time of the application to special care in 2007, family welfare conferences had not been held for 70% of the applications. Only 24% (n=12 out of 50 who expressed a view) of social work interviewees felt that family welfare conferences have a positive role to play within the special care application process. 50% opposed the requirement to hold a family welfare conference or consult with the family welfare conference service (n=25). 26% (n=13) gave mixed or neutral views. Eighteen of the respondents said that they found family welfare conferences useful in other contexts (i.e. at an earlier stage of intervention), but believed that, as special care was a measure of last resort, all options within the family and extended family would normally have been exhausted by this stage. The role of family welfare conferences within the special care process is therefore of questionable value.

Some interviewees wished to see increased transparency in the operation of the NSCADC. In particular, they said that membership of the committee needed to be published officially. The NSCADC feels that there has been much publicity in this area but it may be that a refresher is required to address this perception amongst some of a lack of transparency: this may be the result of changes in staff at local level.

[3] The current application form does not specifically ask if the child has a diagnosis of ADHD, so it is possible that this figure was under-reported.

Recommendations

Recommendations for the HSE at National Level and Policy Makers

	Recommendation	Relevant findings
1	The HSE and policy makers should review whether variations in patterns of applications, admissions and outcomes between males and females are acceptable and in the best interests of the children. If this is not the case, the implications in terms of the configuration of special care provision and guidance to staff will need to be considered.	Females are much more likely than males to be the subject of special care applications, be admitted to special care, and have better outcomes.
2	The HSE and policy makers should review whether the current low levels of admission to special care and poor outcomes for children aged 16–17 (who were subject to a special care application) are acceptable and in the best interests of the children, or whether service reconfiguration in the HSE and in partner agencies may be required to better meet the needs of this group.	Only 24% of children aged 16–17 at the point of application were admitted to special care. In addition, 16–17 year-olds were much more likely than other age groups to have risk factors that worsened by November 2009. Children of this age may well be more likely to have entrenched behaviours (and therefore less capacity to change) and, approaching adulthood may also have greater expectations about living independently than younger children. There needs to be a debate about whether special care and associated services (from HSE and partner agencies) are appropriate to this age group.
3	The HSE and policy makers should review whether the current low levels of admission and poor outcomes for children at risk of youth homelessness (who were the subject of a special care application) are acceptable and in the best interests of the children, or whether special care and/or other HSE services need to be reconfigured to better address and prioritise the needs of this group of children.	Children subject to a special care application who have experienced homelessness are amongst those least likely to be admitted to special care and most likely to have poor outcomes in terms of changes to risk factors. 20% of the children experienced homelessness since the 2007 application. Numbers are small but the pattern is distinct.
4	The HSE should consider whether low levels of admission and poorer outcomes for Irish Travellers are acceptable and in the best interests of the children, and whether this has any implications in terms of training for social work staff and/or reconfiguration/accessibility of Traveller services.	Irish Travellers were less likely to be admitted to special care than children whose ethnicity was White Irish. They were also almost twice as likely to have overall risk factors that worsened by November 2009. Although numbers are small, this raises questions about whether Traveller-oriented services are sufficiently accessible and available nationally, whether social work staff are sufficiently trained to deal

	Recommendation	Relevant findings
		with cultural issues, or whether the presenting needs of Irish Travellers are not being treated as effectively by the system.
5	The HSE should ensure that admissions and discharges from and between special care units and high support units are better co-ordinated. This might be achieved through centralised national structures and/or processes. In addition, with the imminent closure of Ballydowd, the HSE should consider opportunities to increase the co-location and joint management of special care units and high support units.	High support was frequently identified in the application as the preferred onward placement on discharge from special care but only 30% of these onward placements were secured and fewer children still were actually discharged to a high support unit. Although previous research has questioned whether the current shape of high support differs substantially from mainstream residential care (Laxton 2008), there appears to be scope to improve the co-ordinated response to applications for both special care and high support to ensure that high support is used more often as a 'step-down' from special care. In addition, several interviewees sourced placements abroad where the management of special care and high support arrangements was directly linked, enabling children to move between secure and less secure environments in a co-ordinated manner as their behaviours changed. These interviewees were generally negative about the model for special care in Ireland.
6	The HSE should consider developing increased consistency in the models of special care offered by the special care units. Each unit should have the same access to psychiatric and psychological support (as required by the needs of the child).	In 2007, the national structure was still new, the units were reported to be operating different models and had different capacities. Nineteen of the social work interviewees made comments on the 'therapies' available in special care, the primary comment being that the pattern of psychiatric and psychological input was uneven between the units and this was perceived to be a weakness. Those who had negative views of special care often cited this. As the national approach to special care becomes more consolidated, this should be reviewed.
7	The HSE should consider if there should be a separate special care facility for younger children.	Several social work interviewees felt that special care should be aimed more towards younger children and some felt that the provision of a facility for younger age groups would be beneficial, given that their maturity and expectations may be very different from 16 and 17 year-olds. Such a facility might be for 12–13 year-olds, with some 14 year-olds and possibly on occasion some 15 year-olds,

	Recommendation	Relevant findings
		depending on levels of maturity, understanding and vulnerability. On the other hand when considering the above issue it is important to also take into account that children aged 12–14 who entered special care in 2007 seemed to have generally positive outcomes by November 2009.
8	The OMYCA should take into account the findings in this report related to the length of time children spend in special care when developing future policy for special care. The court, HSE and guardians *ad litem* should also be mindful of these findings when considering the best interests of the child.	Although numbers are small, children who had previously been admitted to special care for nine months or less were much more likely to gain a further admission to special care than those who had spent more than nine months there. Outcomes in terms of changes to risks were also better for children who had spent less than nine months in total in special care by November 2009. This certainly supports the proposals within the Child Care (Amendment) Bill, 2009 that children may only be placed in special care for a maximum of three consecutive three month periods; but the recommendation made here goes further by suggesting a working presumption that a child should spend no more nine months of their life in special care, consecutive or otherwise.

Recommendations to Support Inter-agency Working

	Recommendation	Relevant findings
9	Where a child is deemed to be at risk from specific, known adults, protocols need to be developed between the HSE and An Garda Síochána on actions to be taken, information sharing, escalation of concerns, and processes to monitor the effectiveness of the above.	In a small number of cases where the child was deemed to be at risk from a known adult(s), the social work departments described situations that had arisen that suggested there was a need to put in place an information sharing protocol between An Garda Síochána and the HSE, including appropriate pathways within each agency for escalating concerns. A joint protocol between An Garda Síochána and the HSE is now in place for 'children missing from care' but that was not the specific concern for these cases.
10	There are opportunities to increase the integrated assessment of children's needs: **a.** The OMCYA, HSE and Department of Justice, Equality and Law Reform should consider whether any measures should be put in place to increase the integrated assessment of risks and needs (offending and child protection/welfare) for children in care who offend. **b.** The OMCYA, HSE and Department of Education and Science and education agencies (e.g. the National Educational Welfare Board, the National Council for Special Education, the National Educational Psychological Service), need to consider whether levels of poor school attendance for children who become the subject of a special care application are acceptable and in the best interests of the children, and whether this should have any implications in terms of future policies and monitoring arrangements. There may be scope for: ■ improved co-ordination and delivery of holistic assessments and service responses between social work and education agencies; ■ the HSE to routinely monitor how many	Numerous interviewees 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. Within the cohort, males were more likely to have offended than females and by November 2009 were also more likely to end up in the juvenile detention system than females. A more holistic approach might help to improve outcomes for the children. Some 76% of applications were for children who had been school non-attenders in the previous 12 months. This suggests that children whose behaviour leads to concerns in terms of their social care needs are also coming to the attention of education agencies. Responses to those needs do not at present appear to be co-ordinated and holistic, with little evidence of joined-up assessments or information exchange, again suggesting the possibility of social care and education agencies operating in isolation.

	Recommendation	Relevant findings
	children in its care and protection systems have problems with school non-attendance every year and share this information with the OMCYA and the relevant education agencies. This issue should be considered in the ongoing work between the HSE and the National Educational Welfare Board to develop joint working protocols.	
11	The OMCYA, HSE and Department of Justice, Equality and Law Reform and Courts Service should consider if any measures should be put in place to speed up the administration of justice for children in care who offend, to benefit the holistic welfare of the child.	Several social work interviewees felt that the time taken for the administration of justice can be too slow. Those who raised this issue said that this contributed to deteriorating behaviour, as the child was perceived to have never seen any consequences for their behaviour. In other jurisdictions, priority has been given to speeding up the administration of justice for children. When considering these issues it is important to note that it may well be that the perceptions of the social workers were misplaced (as it was not within the remit of this research to consult with the Department of Justice, Equality and Law Reform, these perceptions are unverified). It should also be borne in mind that the interpretation of the *SS* and *DT* judgements in the research period meant that, where there were ongoing criminal proceedings in the district court , children were not being admitted to special care, with the potential negative impact on their welfare. This emphasises further the need for swift administration of justice.

Recommendations for Practice and Processes

	Recommendation	Relevant findings
12	Within practice, social work professionals need to be mindful of whether and in what circumstances they respond differently to the same types of risk-taking behaviour shown by females and males, particularly in relation to sexual risks and risks of involvement in the criminal justice system.	Females are more likely to be subject to a special care application and those applications are much more likely to be successful. There are distinct differences between the genders with regards to sexual risks and risks of involvement in the criminal justice system.
13	The guidance for special care should be amended to state that where a child has had fewer than five previous care placements, they are unlikely to be admitted to special care, except in cases of emergency, on the grounds that not all options have been exhausted.	Only three out of 14 applications made where the child had a maximum of between one and four previous care placements were admitted to special care. This would serve as a reminder to applicants that they must make every effort to ensure that all options have been exhausted before applying for special care.
14	Discharge from special care: **a.** The HSE should refresh understanding of its staff, particular at senior level and within local admission and discharge committees, of the importance of securing an onward placement when a special care application is made. **b.** Local admissions and discharge committees should support and prioritise children who are the subject of special care applications in allocating placements. **c.** The HSE should take action to ensure that all relevant staff are briefed and trained in the recently published *Special Care Discharge Criteria* (CAAB 2010).	It is regarded as good practice for the onward placement to be identified at the outset, both to prevent drift in the case and to provide the child her/himself with an idea of what will happen next. Applications with an onward placement secured are much more likely to be successful. Some social work interviewees also felt that the discharge options for children in special care were not being prioritised by their local admissions and discharge committees. For example, in four cases the child was discharged home from special care, despite this not being the preferred option of the social worker, because a mainstream residential placement could not be found.

Recommendations for Monitoring and Research

	Recommendation	Relevant findings
15	The HSE should report annually on special care and the operations of the NSCADC, including a statement of the NSCADC's terms of reference and criteria, its membership, the number of applications it considered, the outcomes of the applications, and the demographic profile of the applications. Given the findings in this research, it may be useful to report: **a.** the pattern of applications and admissions by gender; **b.** the pattern of applications and admissions by age; **c.** the pattern of applications and admissions by ethnicity; **d.** the pattern of applications and admissions where the application suggests that the child is at risk from youth homelessness; **e.** the pattern of applications and admissions by learning disability and by whether the child has had chronic school non-attendance during the previous 12 months; **f.** the pattern of applications and admissions of children with ADHD; **g.** for all children admitted to special care in a year, the total time that such children have spent in special care in the past or in custody.	Special care is an area of interest to policy makers, social workers, guardians *ad litem* and solicitors alike, as well as to the general public. Some perceptions of lack of transparency might be easily addressed by publicly providing on an annual basis a report containing the recommended information. There are also a number of emergent patterns contained within this report, some of which had substantial data behind them (e.g. gender variations) but some of which were based on very small numbers (e.g. children with ADHD) that would benefit from ongoing monitoring and public reporting.
16	The application form for special care should be amended: **a.** to prompt the applicant to state whether the child has previously experienced homelessness, is regarded as being at risk of youth homelessness, and any actions taken to reduce this risk; **b.** so that where risks identified relate to alcohol and substance misuse the applicant must specify what substances are involved and what actions are being taken, or have been taken, to manage the harm from this abuse; **c.** to ensure that, where a child subject to a special care application is deemed to be at	The recommendations here are based on information that the researcher found difficult to obtain directly from the application form and supporting documentation but which may be useful to draw out explicitly from those making an application for special care.

	Recommendation	Relevant findings
	risk from specific, known adults, information is recorded on any actions taken or planned against that adult by the social work department; **d.** to ensure that, where a child 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; **e.** to establish whether a guardian *ad litem* is already appointed for the child, and, if so, by what court and when; **f.** to ensure that it is clear whether the planned onward placement has been secured or not.	
17	Future research into special care outcomes should identify in detail: **a.** the subsequent placements of children, in particular the number of children who go home at any stage, the range of supports offered if they go home, and the effectiveness of those supports; **b.** 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 those supports; **c.** processes for accessing education supports for children subject to a special care application and the effectiveness of those supports.	The three topics identified in this recommendation were areas in which the researcher feels that more in-depth investigation than was achievable within this research would be beneficial. These are all substantial topics in their own right. The comments relating to the subsequent placements of children focus particularly on supports provided if the child goes home. Twenty-nine of the 59 individuals in the study went home at some stage after the 2007 application, only ten of which were the planned, preferred choices of the social work department. The research touched on how many went home, whether this was planned and how successful it was, but not on the supports offered to maintain those placements and their effectiveness in promoting better outcomes. Almost all of the children were receiving psychiatric interventions or had received a psychiatric assessment/intervention in the past. 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 research examined whether the children who were subject to a special care application

	Recommendation	Relevant findings
		were accessing education, training or employment by November 2009. There was also an attempt to ascertain social work views of the effectiveness of education agencies in assisting with engaging children into education, training or employment, with limited success. Given that we understand the HSE and the NEWB are working on developing protocols for joint working, it may be useful in the future to examine the effectiveness of those protocols for children who have accessed special care.
18	Further research should be conducted into whether the requirement to hold a family welfare conference should be a component part of the application process for special care.	Some 50% of social work interviewees (n=25 out of 50 who expressed a view) opposed the requirement to have a family welfare conference for special care, 24% (n=12) found it useful and 26% (n=13) did not have a strong view. At the time of the application, family welfare conferences had not been held for 70% of the applications. Social workers supported family welfare conferences in other contexts, but many felt that the requirement to hold one for special care came much too late, given that, as a measure of last resort, all family/extended family options would normally have been exhausted. They often saw it as an unnecessary bureaucratic burden. Previous research (SIS 2008) also indicated that family welfare conference co-ordinators had some doubts about the usefulness of family welfare conferences for special care applications.
19	Further research should be conducted into future cohorts of children who were subject to special care applications, using findings in this current report as a comparative baseline.	This current research has produced findings that are hopefully of benefit and interest to policy makers and practitioners. It is based on 70 applications and 59 individuals so some of the emergent patterns, while interesting and informative, have a narrow evidence base. Further research would widen this evidence base.

INTRODUCTION

1. This report provides an overview of the applications for admission to special care made by Health Service Executive (HSE) Local Health Offices in 2007 and traces and tracks outcomes for the children who were subject of those applications up to November 2009. This research has been undertaken by Mark Brierley of Social Information Systems (SIS) and was commissioned by the Children Acts Advisory Board (CAAB). In addition to the CAAB, the Steering Group for the work included representation from the HSE and the Office of the Minister for Children and Youth Affairs (OMCYA).

2. SIS previously researched the application process and case characteristics for applications for special care made between January and June 2007 (SIS 2008). This current research therefore extends that study to applications in the second half of 2007 and also traces and tracks outcomes for all children subject to an application in that year.

3. Special care in 2007 was operating in an evolving environment. The HSE had only come into existence as a single national structure in 2005; the CAAB was subject to change during the research period (changing its name from the Special Residential Services Board and extending its remit to deal with both welfare and juvenile justice); the infrastructural arrangements were all new; in summer 2007 and early 2008 there were a number of High Court rulings that would influence the criteria for special care. More recently, provisions within the Child Care (Amendment) Bill, 2009, should they be enacted, will also influence the future shape of special care.

Legal Context

Inherent Jurisdiction of the High Court

4. The original provisions of the Child Care Act, 1991 did not permit access to secure treatment accommodation for children and hence detention in a secure facility. Secure detention could only be accessed through a statutory route where the young person had committed a criminal offence. Faced with this gap in the statutory framework, the High Court began exercising its constitutional prerogative to extend its inherent jurisdiction over children to secure their welfare, if necessary, by detention, for the purposes of treatment[4].

> *'…the courts have found that the constitutional rights of certain children can only be vindicated by the provision of facilities in which they can be detained or*

[4] The European Court of Human Rights has held that such detention in the case of a non-offending child must be in an appropriate 'educational supervisory regime' and not detention per se (DG v Ireland (2002); Caul (2003), Shannon (2004))

contained for the purposes of treatment. Given that the courts have come to this conclusion, it is clear that the State has no option but to provide secure facilities.' (Durcan 1997)

The Child Care Act, 1991 (as inserted by s.16 Children Act, 2001)

5. The Child Care Act, 1991 (as inserted by s.16 Children Act, 2001) provided for a statutory special care scheme where a court can make a special care order (s.23A) or an interim special care order (s.23C), if it is satisfied that the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare, and the child requires special care or protection which he or she is unlikely to receive unless the court makes such an order. The order of the court involves the detention and secure placement of a child in a special care unit (s.23K) which is under the management of the HSE. Within such accommodation the HSE is authorised to provide appropriate care, education and treatment for the child (s.23 (B) (2)). In so doing, the HSE is empowered to take such steps as are reasonably necessary to prevent a child in special care causing injury to themselves or others or from absconding from the unit (s.23 (B) (3))[5].

6. The specific objectives of special care are to:

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

[5] Note this provision was never fully operationalised.

7. The provision of special care units by the HSE is subject to approval and certification by the Minister (s. 23K), following inspection[6]. Special care units are secure placements for children who are in need of special care or protection with the explicit objective of providing a stabilising period of short-term care which will enable a child to return to less secure care as soon as possible. The three special care units operational in Ireland in 2007 were:

Ballydowd Young People's Centre – a mixed gender unit in County Dublin with a maximum capacity of 15. (Note that at the time that this report as being written, Ballydowd was due to be closed and its capacity redistributed to other HSE units).

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

Coovagh House Special Care Unit – a mixed gender unit in County Limerick, with a maximum capacity of five, which was re-opened in early 2007. In practice, capacity never exceeded three.

8. Sections in the Child Care Act, 1991 (as amended) which provided for the district court to hear applications for special care were not operationalised due to the need for revised regulations (see section in this report on the Child Care (Amendment) Bill, 2009). Thus, throughout 2007, applications were made by the HSE to the High Court for an order of detention of a child to be placed in a special care unit, with the High Court continuing to use its inherent jurisdiction for the welfare of the child with the provision of educative and therapeutic services.

High Court Judgements

9. In 2007 and early 2008, there were four significant judgements in the area of special care delivered by the High Court:

- *Health Service Executive (Southern Area) v. S (S) (A Minor)* represented by his Guardian *Ad Litem* and Next Friend ML, and MS, SC and The Special Residential Services Board (Notice Parties) (2007) IEHC 189, unreported MacMenamin J.
- *Health Service Executive v. DK, a* minor represented by his solicitor and next friend Rosemary Gantly and OK-D, 18th July 2007 unreported, MacMenamin J.
- *Health Service Executive (South Eastern Area) v. WR (a minor)* represented by his solicitor and LR and The Special Residential Services Board (Notice Parties) 18th July 2007 unreported, MacMenamin J.

[6] Note this provision was never fully operationalised.

- *DT (A Minor Suing by his* Guardian *Ad Litem, Breda Buckley) – and - The National Special Care Admissions and Discharge Committee and the Health Service Executive – and – ET and MT,* 17th January 2008.

10. The relevance of the three former of these judgements will be noted at relevant points in this report, as they coincided with the period being researched. The judgements also led to an amendment of the criteria for special care in September 2008, the central point being to clarify that placement for special care was not deemed appropriate where criminal matters were before a district court:

> *'(a) A previous criminal conviction does not itself preclude an application for special care;*
>
> *(b) A special care order cannot be made in situations where the child/young person is subject to criminal charges (and is before the courts), and where these charges have not been dealt with or decided by the courts.' (CAAB/HSE 2008)*

Child Care (Amendment) Bill, 2009

11. Several proposals are contained within the Child Care (Amendment) Bill, 2009.

12. Section 23.f.8. of this Bill states that the HSE will apply to the High Court for a special care order. This means that special care orders would be within the ordinary jurisdiction of the High Court only, not the District Courts.

13. Section 23 (n) of the Children Act, 2001 (as amended) stated that: 'a child on being found guilty of an offence may not be ordered to be placed or detained in a special care unit'. 'This could be read in two ways, one that special care units could not be used as an alternative to juvenile criminal detention facilities and secondly that a criminal conviction excluded a child from entry into a special care unit' (Oireachtas 2009, p14). The Bill seeks to clarify this:

> *'A child convicted of a criminal offence may be placed in a special care unit where s/he has not been sentenced to a custodial sentence which would take effect at the same time as the special care order. Conviction of an offence is not the defining issue; rather it is the type of sentence received.*
>
> *'Generally, unless a child has been remanded in custody or received a custodial sentence the HSE can apply for a special care order or an extension of the original order and continue to detain a child in a special care unit. Where a child is remanded in custody or given a custodial sentence the HSE can withdraw its application or apply to have the special care order discharged immediately.*

> *'The HSE can apply for a special care order for a child who has: been charged with an offence, convicted of an offence and given a suspended sentence, a deferred children detention order, or a Children Act Order'. (Oireachtas 2009, p14)*

14. Under the Child Care Act, 1991 (as amended), an order would be made for 'a period which is not less than three months or more than six months,' and the court could 'extend the period of validity if and so often as the court was satisfied that the grounds for making the order' continued to exist. The Bill proposes to limit special care orders so that they cannot exceed a three month period. 'However, an application for an extension of up to another three months can be made, and a further application for another three months can also be made. Applications for extensions are made on the basis that the HSE is satisfied that the child is benefiting from special care, the risk of harm to the child posed by his or her behaviour continues to exist and that the child requires the continuation of special care. Therefore in some situations a child could be in special care for a maximum of nine months consecutively, on the basis of the original care order and two sequential extensions'. (Oireachtas 2009, p15).

15. The Bill also seeks to introduce a new system of statutory review by the High Court of special care orders. Section 23 (i) states that the High Court will carry out a review 'in each four week period'. The purpose of the review is to ascertain whether the child continues to require special care and will have regard to an assessment carried out by the HSE.

16. Provisions of the Bill relating to the role of the CAAB and the criteria for special care will be commented on later in this introductory chapter.

Operational Context

17. In 2005 the HSE came into existence as a national structure, replacing the existing ten independent Health Boards and the Eastern Regional Health Authority. A National Special Care Admission and Discharge Committee (NSCADC) was established at the beginning of 2007, comprising the former chairs of the admissions committees for the three special care units, the managers of the three special care units, and an independent Chair. In addition, in November 2006 the HSE also employed a National Manager for Special Care and High Support.

18. Provisions of the Children Act, 2001 introduced a role for the Special Residential Services Board in offering a view to the court on each application for special care. The Board was also given a remit for research in the area of special care. During 2008, the Act was amended and as a result the name of the Board changed to the Children Acts Advisory Board, the name

that is used throughout this report. The amendments also added to the remit of the Board a responsibility for publishing the criteria for admission to and discharge from special care, in consultation with the HSE. Provisions of the Child Care (Amendment) Bill, 2009 will change this: Part 5 of the Bill will abolish the CAAB and subsume some of its functions into the OMCYA on an administrative basis.

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

20. It was expected that the full provisions of the Children Act, 2001 with regards to special care would be implemented from January 2007. In anticipation for this, substantial infrastructural changes were made. The criteria for special care were modified through discussion between the HSE and the CAAB and a single Special Care Information and Application Pack (SRSB/HSE 2006) was developed. This pack included the criteria, guidance on key parts of the process, a national application form, and forms to support family welfare conferences held as part of the application process. During 2006 briefing sessions were undertaken throughout the country, by what was then known as the HSE National Special Care and Children Act Committee (set up for the purpose of planning implementation of the relevant sections of the Children Act, 2001), to introduce the revised process to HSE social work staff. The CAAB also held a networking event to provide information on issues relating to special care in early 2007. The National Special Care Admissions and Discharges Committee was established at the beginning of 2007. The full provisions were not implemented in January 2007 due to the need for revised regulations but this report nevertheless covers a period of change, with the introduction of new infrastructural arrangements.

Criteria for Special Care

21. The criteria for admission to special care that were operational in 2007 (SRSB/HSE 2006) were as follows:

1. The young person is 11 – 17 at admission[7].
2. The behaviour of the young person is such that it poses a real and substantial risk to his/her health, safety, development or welfare unless placed in a special care unit, and/or on 'an objective basis' is likely to endanger the safety of others.

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

3. The young person will present with a history of impaired socialisation and impaired impulse control, and may also have an established history of absconding which places them at serious risk.
4. If placed in any other form of care, the young person is likely to cause self injury or injury to other persons.
5. Consideration has been given to placement history and the elimination of **all other** non-special care options, **based on the child's needs.**
6. It is clear that a less secure structured environment would not meet the young person's needs at this particular time.
    a. As a general rule, the criteria must be met in determining the appropriateness of placement in a special care unit.
    b. Any exceptions must meet the overriding majority of criteria.
    c. All applications will be reviewed by an Admissions and Discharge Committee of the HSE.
7. Applications for placement in special care units should be based on a comprehensive needs assessment including the following:
    a. A comprehensive and up to date social history.
    b. A detailed care placement history outlining all social services and other interventions.
    c. A care plan that supports the aims and objectives of this placement based on the identified ongoing needs of the young person.
    d. A discharge plan, identifying the subsequent less secure placement or alternative, and identifying agency personnel with responsibility for actioning the plan.
    e. Up-to-date psychological and educational reports which comment upon the grounds for seeking admission to a special care unit.
    f. Where there are concerns regarding a young person's mental health, a psychiatric report may be appropriate. Should a young person decline to participate in such a referral, the psychiatrist may report, having reviewed the young person's file.
8. The HSE should co-ordinate the sharing of these intensive facilities within and across regional areas. While it is preferable that the young person resides in a specific regional area to facilitate family and community contact and reintegration, given the secure nature of these units and the care obligation, the number of units should be strictly limited.

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

22. Situations where a placement was not appropriate were where the primary reason for seeking placement was:

1. The young person has a moderate[8], severe or profound general learning disability.
2. The young person requires medically supervised detoxification for drug misuse.
3. The young person has an acute psychiatric or medical illness requiring intensive medical intervention.

23. The amended criteria in 2008 took into account the MacMenamin judgements of 2007 by adding a fourth exclusion:

> *'(a) A previous criminal conviction does not of itself preclude an application for special care;*
>
> *(b) A special care order cannot be made in situations where the child/young person is subject to criminal charges (and is before the courts), and where these charges have not been dealt with or decided by the courts.'*

24. The above criteria were based on Section 23.B.2 of the Children Act, 2001 which stated:

> *'A special care order shall commit the child to the care of the health board concerned for so long as the order remains in force and shall authorise it to provide appropriate care, education and treatment for the child in a special care unit provided by or on behalf of the health board'.*

25. The provisions of the Child Care (Amendment) Bill, 2009, will change this if enacted. Section 23 (c) defines special care as a means of provision to a child in 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;*
>
> *(ii) his or her care requirements, and includes medical and psychiatric assessment, examination and treatment and educational supervision in a special care unit, and requires a special care order (made by the High Court) directing the HSE to detain the child in such a unit and may include the release of the child from the unit during the period of the order.*

26. Criteria for admission to special care may therefore be amended slightly in the future in the light of the above and it is important for the reader to understand the criteria that were in operation in 2007.

[8] *according to the W.H.O. classification, young people with this disability would typically have an IQ less than 50*

Methodology

27. Note that the term 'children' is used throughout this report rather than 'young people' or 'adolescents' as only the former term is used in Irish legislation. The exception to this is the chapter on Outcomes by November 2009, where 'individuals' is the term preferred, reflecting the fact that many of the children were adults by that date. The fieldwork for the research was conducted between September and December 2009. Seventy applications were made for special care in 2007, for 61 children, with nine of those children being the subject of more than one application.

28. Data for the research derived from several sources:

The application paperwork. Social work departments making applications for special care were required to send to the CAAB and the HSE's National Special Care Admissions and Discharge Committee copies of several key documents, including: the national application form; a comprehensive and up-to-date social history; an up-to-date statutory care plan; an up-to-date discharge plan (often addressed in the application form rather than provided as a separate document); an up-to-date psychological report; an educational report; and, where appropriate, a psychiatric report. Seven of the applications were not on the correct application form (several used the previous application form for Ballydowd); seven did not include a care plan or included a care plan that was more than six months old; six did not include a comprehensive and up-to-date social history. SIS was sent all copies of the supporting paperwork by the CAAB, with the names of children and their families removed to preserve anonymity. Towards the end of the research, five additional applications were identified where the paperwork had been sent to the NSCADC alone, and the NSCADC provided copies of these document for the CAAB to anonymise and pass on to SIS. Throughout the research process Gráinne McGill of the CAAB provided a co-ordinating role between SIS and the various interviewees: because of the requirement to preserve anonymity, all discussion on applications between SIS and the CAAB used the CAAB's case referencing system, so SIS relied on the CAAB to match these numbers to names for the social work departments so that, for example, on discussing 'Case 81' the social work department would know which child was the focus. One limitation of the above is that it depends on the extent to which social work departments gathered information from partner agencies around such issues as health, education and offending behaviour.

Interviews with the applicants. SIS conducted semi-structured interviews with those workers in the HSE Local Health Office social work departments who were currently the caseholders for the child (or who were the most recent caseholders if the child was not in care). The CAAB contacted all the social work departments to confirm the most appropriate person to contact. The purpose of the interviews was three-fold: to clarify information contained in the application paperwork; to gain

the applicants' perceptions of the process; and, most importantly, to trace and track the history of the children since 2007. Ideally, the interview was to be conducted with both the social worker and their team leader together, but this was not always possible (staff turnover, maternity leave, or last minute calls to court). On some occasions, the interviewee was the applicant for more than one application. A total of 83 people from social work departments were interviewed in both this and the previous research (SIS 2008):

- Principal social workers (n=3): one was involved in both phases of the research, one in the previous research only, one in the current research only.
- Team leaders (n=38): 11 were involved in both phases of research, 12 in the first phase only, 15 in the second phase only.
- Social workers (n=41); nine were involved in both phases, 12 in the first phase only, 20 in the second phase only.
- Names of the interviewees are not recorded in this report to further protect the anonymity of the children. Interviews were possible for 68 of the 70 applications. Two cases needed to be excluded (with agreement of the commissioners for this research) for a variety of reasons which will not be stated here in order to preserve anonymity.

Interviews with children and their families. A target of ten interviews with children and their families was set for the research, felt to be realistic given the nature of the research. SIS has a child protection policy and the researcher from SIS was able to provide the CAAB with a recent Enhanced Criminal Records Bureau check from the UK. SIS worked closely with the CAAB and the Steering Group to define a robust and detailed approach to gaining informed consent within this context. This included an overview agreement about specific steps should an incident occur (e.g. disclosure of abuse). It also involved the development of short forms for children, their parents/carers, and children who were adults by November 2009, explaining the research and asking for their signed consent to participate in the research. Parents/carers had two forms to consider: one for consent for their child to participate, and one for themselves to participate. These were sent out to contacts within social work departments for social workers to discuss with the children/families. All signed consent forms were returned to the CAAB; the CAAB then informed SIS that consent had been received, and SIS made arrangements with the relevant social work departments to conduct interviews without knowing the names of the interviewees. The researcher then explained the purpose of the interview again to the interviewee before beginning and told them that if they were at any time uncomfortable they could stop the interview or not answer a question. Five of the children (some of whom were adults at the time of the interview) took part, and four parents/carers. An appropriate adult was present for the face-to-face interviews with the children.

Interviews with representatives of the Special Care Units. SIS met with representatives of all three special care units to discuss their views on each of the special care applications. Again, the CAAB provided a co-ordinating role to ensure that the special care units knew which children were the focus of the interviews without SIS knowing the name of the child.

Group discussion with guardians *ad litem* and solicitors. SIS held group discussions with guardians *ad litem* and solicitors in both Dublin and Cork for their perspectives on special care. This was arranged by the CAAB and the guardian *ad litem* services in both those areas. Eight guardians *ad litem* and three solicitors participated in these discussions.

Data supplied by the CAAB. This included information on the views of the CAAB in relation to the applications

Data supplied by the NSCADC. This included information on NSADC support or otherwise for the applications.

Discussions with representative of the OMYCA and the Health Information and Quality Authority. These discussions were held prior to interviews with the social work departments and provided important contextual background information for the research.

29. The terms of reference for this work posed five broad questions:

1. What was the profile of applicants to special care?
2. What was the previous service/intervention history of applicants (e.g. social care, educational, juvenile justice)?
3. What services/interventions have been provided since each special care application was made?
4. Where did the children go to and where are they now?
5. What are the views of stakeholders on benefits and services/interventions?

30. The report is structured into several chapters that address the following issues.

- **Characteristics of cases subject to an application for special care:** this chapter looks in detail at the demographic profile of the children subject to the applications, the risk factors present in the applications according to the criteria for special care, previous placement history, and other case characteristics such as offending, education and health. It also matches these characteristics to whether or not the application led to an admission to special care, was withdrawn by the applicant, or was refused admission. This chapter of the report addresses questions 1 and 2 above.
- **The application process:** issues in relation to the application process had been considered in SIS's previous report (SIS 2008) for around half of the applications. SIS were therefore able to expand this to the whole cohort, looking at issues around decision making in the social work department, family welfare conferences, the robustness of the onward placement planned for when the child left special care, and the decision making

of the CAAB and the HSE's National Special Care Admission and Discharge Committee with regards to whether they supported the application or not. This is relevant to question 2 on the previous services and interventions.

- **Outcomes by November 2009.** SIS interviewed representatives of the social work departments to ascertain whether, overall, they believed that there had been a change to the risk factors that had been present when the application was made in 2007. Questions were also asked about changes to individual risk factors, placement history since the application, and issues relating to offending, education and health. Interviewees were also invited to comment on protective factors i.e. those factors that had helped to promote positive change. This chapter addresses questions 3, 4 and 5.
- **Interviewee views on the impact of special care:** SIS interviewed a small number of children, parents/carers, representatives of the special care units and the social workers to gather their views on special care. This explored issues that were relevant to the circumstances of each individual child in the study and also sought more general comments about special care within the overall context of care and community resources available. This chapter addresses question 5 above in particular.
- The final two chapters summarise **key findings** and **recommendations**.

31. Note also that throughout this document, where percentages are used they are rounded to the nearest whole number. As a result, on occasion the sum of the percentages in a table may be 99 or 101% rather than 100%.

CHARACTERISTICS OF CASES SUBJECT TO AN APPLICATION FOR SPECIAL CARE

32. Within this section of the report, the focus is on the case characteristics that were considered in deciding whether the application should lead to an admission to special care. Analysis of the characteristics of the 70 applications is based primarily on the content of the application form and supporting documentation plus information from the NSCADC on whether the child was admitted to special care.

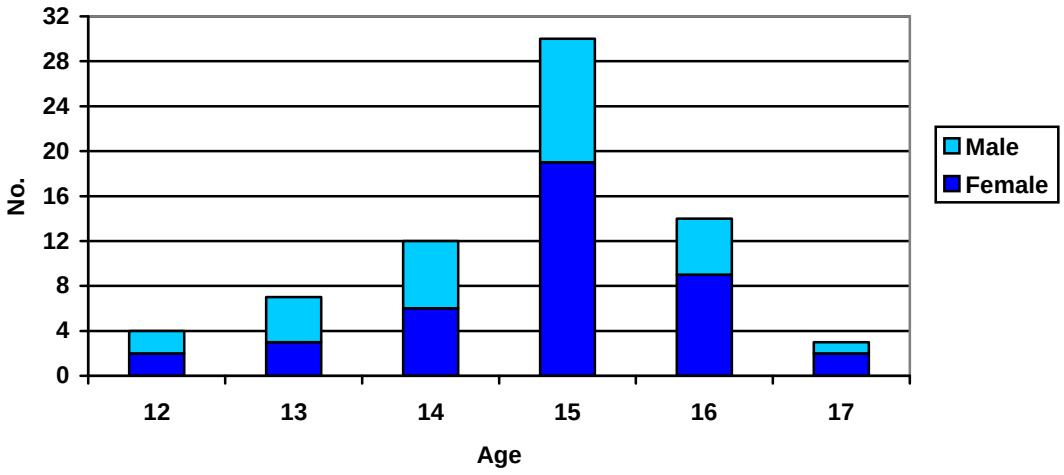
Demographic and Geographic Characteristics

Gender and Age

33. Some 59% (n=41) of the applications were for females and 41% (n=29) were for males, a ratio of 3:2. The Review of Admission Criteria and Processes for Special Care (SIS 2005) noted that, of applications for admission to special care in 2004, 53% were for females and 47% were for males. The gender imbalance was therefore greater in 2007 than it had been three years before. Note, that the most recent figures for applications in 2009 show a more balanced pattern, with 51% of applications (n=28) being for females and 49% (n=27) for males[9].

34. Children aged 12–14 were the subjects for 33% of the applications in 2007 (n=23), 15 year-olds were the subject for 43% (n=30), and 16–17 year-olds were the subject for 24% (n=17).

Figure 1: Age and gender of children for all special care applications in 2007



[9] Information provided to SIS by the CAAB.

Ethnicity of Children Subject to a Special Care Application

35. The application form for special care included a section to record the ethnicity of the children, using categories for ethnicity that were taken from the Census. 74% of the applications were for children who where White Irish (n=52), 14% (n=10) were for Irish Travellers, 7% (n=5) were White Irish/English or White English and in 4% (n=3) of applications ethnicity was not recorded[10]. Six of the Irish Travellers were female, four male (in proportion with the overall balance of females to males in the applications), although the Irish Travellers tended to be older than the general age profile for the cohort (three aged 12–14, two aged 15, and five aged 16–17).

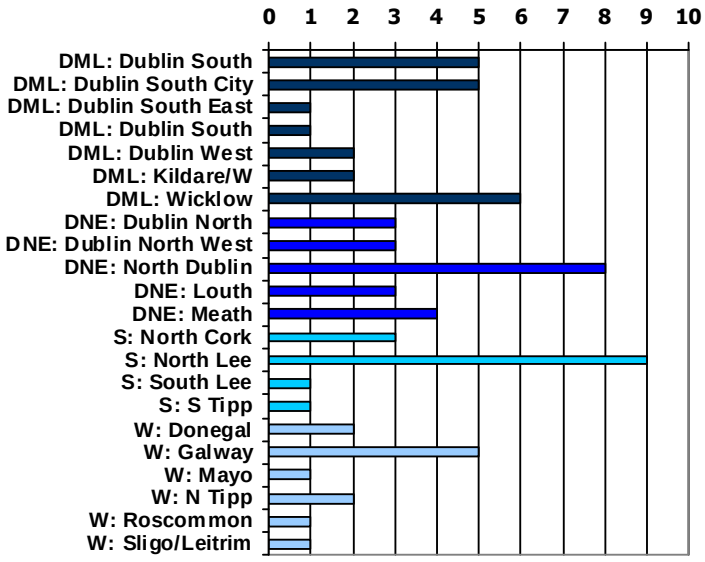
Care Status of Children Subject to a Special Care Application

36. The number of applications for children who were in voluntary care (43%, n=30) slightly exceeded the number for those who were on a full care order (41%, n=29). Seven were on interim care orders, four were not in care at all, and for two the care status was not made clear in the application or its supporting documentation.

HSE Area and Local Health Office

37. There are four regional Areas within the HSE. Around a third of applications came from the Dublin Mid-Leinster HSE Area (33%, n=24), with almost a third coming from Dublin North East (30%, n=21), a fifth from the South (20%, n=14) and less than a fifth from the West (17%, n=12). 72% of Local Health Offices (n= 23 out of 32) made an application within the period, with the highest numbers coming from North Lee, North Dublin and Wicklow.

Figure 2: Applications x Local Health Office



[10] Numbers may not add up to 100% because of effects of rounding.

Application Outcomes by Demographic and Geographic Characteristics

Application Outcomes

38. Slightly under half of the applications resulted in an admission to special care (46%, n=32), almost as many were refused admission (41%, n=29) while a minority were withdrawn (13%, n=9).

Application Outcomes by Gender

39. There was a marked difference in application outcomes by gender. Whereas 61% of the applications for females resulted in an admission to special care (25 out of 41 applications), only 24% of the applications for males had the same result (7 out of 29). The Review of Admission Criteria and Processes for Special Care (SIS 2005) noted that there was a gender difference in terms of children admitted to special care, a ratio of almost 2:1 in favour of females. This current research again reflects that pattern. Applications for males were as likely to be withdrawn by the applicant as actually admitted to special care.

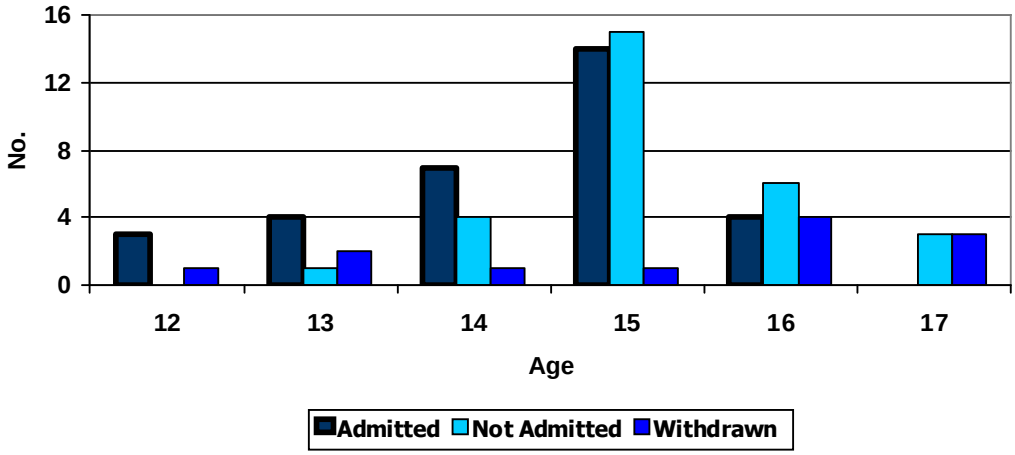
Table 1: Per cent of applications for females and males

	Total	Admission %	Not admitted %	Withdrawn %
Female	100%	61%	34%	5%
Male	100%	24%	52%	24%
Both	**100%**	**46%**	**41%**	**13%**

Application Outcome by Age at Application

40. There were patterns for application outcomes related to the age of the child at the time of the application. 61% (n=14 out of 23) of the applications for children aged 12–14 led to an admission to special care. At age 15, the likelihood of an admission was more evenly balanced, with only 47% (n=14 out of 30) of applications resulting in an admission. By age 16–17, only 24% (n=4 out of 17) of applications resulted in an admission, 52% (n=9) were refused admission, and 24% (n=4) of applications were withdrawn.

Figure 3: Outcomes for all applications to special care x Age at application



41. The pattern is more marked by gender. At all ages, females were more likely to be admitted. All females aged 12–14 were admitted to special care compared to only 25% of the males at that age. At age 16–17, the only children admitted were females.

Table 2: Per cent of applications for females and males at different ages that were admitted to special care

	% Aged 12–14 at time of application who were admitted	% Aged 15 at time of application who were admitted	% Aged 16–17 at time of application who were admitted
Female	100%	53%	36%
Male	25%	36%	0%
Both	**61%**	**47%**	**24%**

Application Outcomes by Ethnicity: Irish Travellers

42. There is also a difference in terms of admissions for Irish Travellers. Of the ten applications for Irish Travellers, only four (40%) resulted in an admission to special care. This partly matches the pattern for age: four of the six who were refused admission were aged 16–17. Numbers are also very small. However, an interview with one person from a special care unit suggested that there were sometimes concerns about the extent to which applicants had addressed fully cultural issues for Travellers prior to making an application – not in all cases, but certainly in some. Note that the CAAB had supported 90% of the applications for Irish Travellers, while the NSCADC only supported the 40% who were admitted.

Application Outcome by Care Status

43. Given that special care is seen as an option of last resort, it may be surprising that only 38% of children (n=11 out of 29) on a full care order were admitted to special care, whereas the proportions were higher for children in voluntary care (53%, n=16 out of 30), on an interim Care Order (60%, n=3 out of 5) or not in care at all (50%, n=2 out of 4). Note that all children who had been in voluntary care for two years or more were admitted (n=11) and 63% of those on a full care order for a similar length of time (n=10 out of 16).

Table 3: Application outcome x Care status at the point of the application for special care

	Total	Admission	Not admitted	Withdrawn	% with this care status who were admitted
Full care order	29	11	15	3	38%
Interim care order	5	3	-	2	60%
Voluntary Care	30	16	10	4	53%
None	4	2	2	-	50%
Not stated	2	-	2	-	0%

Application Outcome by HSE Area and Local Health Office

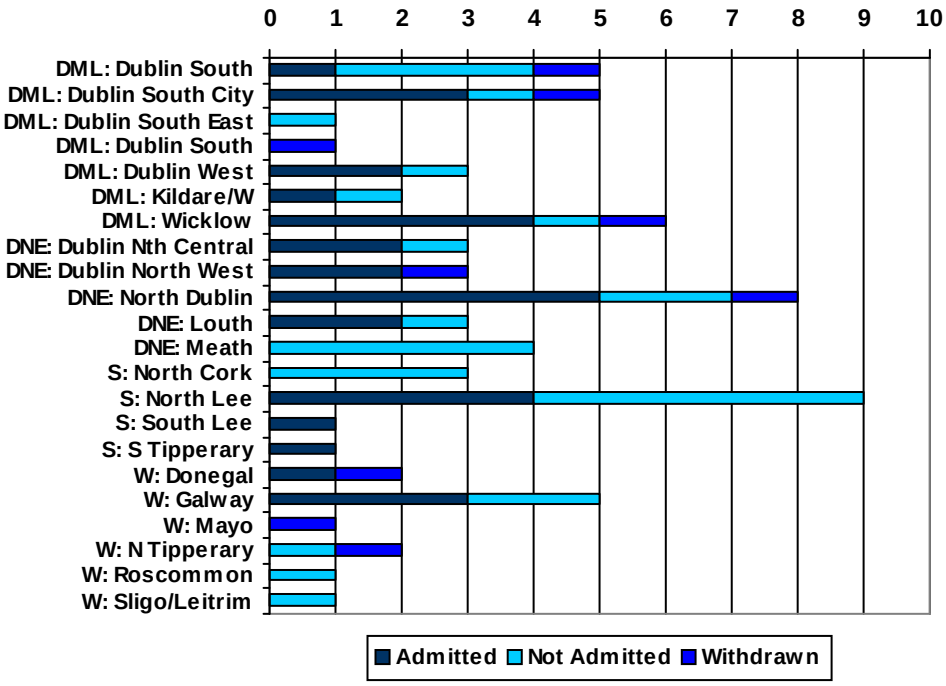
44. Some 52% of applications from Dublin North East resulted in an admission to special care, compared to 48% for Dublin Mid-Leinster, 43% for South and 33% for West. South had by far the highest percentage of applications not admitted (57%) while West had the highest percentage of withdrawn applications (25%). The high percentage of non-admissions for South cannot be explained by gender (57% were female) or age (43% were aged 12–14 and only 14% were aged 16–17). We will return to this issue later.

Table 4: Application outcome x HSE Area

HSE Area	Total	Admission	Not admitted	Withdrawn
Dublin Mid-Leinster	23	11	8	4
Dublin North East	21	11	8	2
South	14	6	8	0
West	12	4	5	3
Total	70	32	29	9
	% of applications in HSE Area			
Dublin Mid-Leinster	100%	48%	35%	17%
Dublin North East	100%	52%	38%	10%
South	100%	43%	57%	0%
West	100%	33%	42%	25%

45. Application outcomes for individual LHOs are shown below.

Figure 4: Application outcome x Local Health Office



Special Care Criteria

46. In this section we consider the features present in each application for special care against each of the criteria for special care that were in operation in 2007 and their relationship with successful or unsuccessful applications.

Age at Admission

Criterion 1. The young person is aged 11–17 at admission[11]

47. All applications were for children who were aged 12–17 when the application was made.

Real and Substantial Risks to Self by Application Outcome[12]

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

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

[12] Note that Criterion 4 'If placed in any other form of care, the young person is likely to cause injury to self or injury to other persons' does not have a separate section on the application form and tends to be considered alongside Criterion 2.

48. Criterion 2 has two alternative elements: real and substantial risks to self (as in bold above), and endangering others. The application form requires the applicant to comment on both elements separately. All 70 applications aimed to secure admission to special care on the basis of perceived risks related to 'real and substantial risks to self'.

Table 5: Real and Substantial Risks x Application Outcome

	Total	Admitted	Not admitted	Withdrawn	% of applications with this risk feature that were admitted
Total risks posed to self (i.e. the list shown immediately below)	**70**	**32**	**29**	**9**	**46%**
Alcohol and/or substance misuse	55	27	21	7	49%
Self-harm	32	14	13	5	44%
Risks to sexual health	27	17	9	1	63%
Suicidal ideation	24	11	9	4	46%
Sexualised behaviour	21	13	6	2	62%
Personal hygiene/self-neglect	4	1	3	0	25%
Failure to take medicines/mixing prescribed medicines with other substances unsafely	4	0	3	1	0%
Management of medical condition being put at serious risk	2	1	1	0	50%
Total risks posed by others (i.e. the list shown immediately below)	**44**	**22**	**17**	**5**	**50%**
Engages with unsafe/inappropriate adults	30	20	9	1	67%
Risk of sexual exploitation/prostitution	26	18	7	1	69%
At risk of aggression/threatened by others/victim of assault	21	11	7	3	52%
Involvement with a negative peer group	14	6	7	1	43%
Significant protection issues with regards to specific contact of the child	10	6	3	1	60%
Total at risk from refusing to engage with services	**42**	**21**	**16**	**5**	**50%**
Significant concerns about education/training	19	9	8	2	47%
Total at risk of, or engaging in, criminal activity	**37**	**13**	**21**	**3**	**35%**
Concerns about unaccounted money	7	4	3		57%
Total at risk from youth homelessness	**13**	**5**	**7**	**1**	**38%**
Total with mental health concerns (includes self-harm, suicidal ideation and general mental health concerns)	**40**	**18**	**14**	**6**	**44%**

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

- risk of sexual exploitation/prostitution (69%);
- engages with unsafe/inappropriate adults (67%t);
- risks to sexual health (63%);
- sexualised behaviour (62%);
- significant protection issues with regards to specific contact of the child (60%).

50. In total 59% of the applications (n=41) had one or more sexual health/behaviour risks. The three categories of risk related to sexual behaviour have been interpreted as follows:

- **Risk of sexual exploitation/prostitution** is used where the application specifically noted these concerns, or it stated concerns relating to (usually) an older or adult boyfriend/man (older or adult girlfriends/women were not mentioned as often in the applications but there were some examples).
- **Risk to sexual health** is used where the application made specific reference to concerns about high risk of sexually transmitted infections (STIs) or risk of pregnancy.
- **Sexualised behaviour** is used where this was explicitly raised as a concern in the application.

51. An admission to special care was less likely where the following were present:

- personal hygiene/self-neglect issues (25%);
- at risk of, or engaging in, criminal activity (35%);
- at risk from youth homelessness (38%);
- involvement with a negative peer group (43%);
- self-harm (45%).

52. The interpretation placed on the SS judgement of Judge MacMenamin in 2007 will explain why criminal activity is on this list. Similarly, special care is not intended to provide an acute psychiatric intervention and some of the applications where self-harm was present would have been borderline with psychiatric services. Much more surprising, however, is the presence on this list of children who are at risk from youth homelessness. Thirteen of the applications were for children regarded as being at risk from youth homelessness. Five of the 13 were aged 16–17, eight were 14–15, so failure to access special care cannot be linked to age for these children. Nine of these applications were supported by the CAAB, four by the NSCADC.

53. When considered according to gender, females with the same 'real and substantial risks to self' as males were much more likely to be admitted to special care. Despite their smaller number, males were more likely to be at risk of, or engaging in, criminal activity: this was true for 72% (n=21 out of 29) of the males compared to 39% (n=16 out of 41) of the females. In addition, females were more likely to have one or more of the three sexual behaviour risk features: this was true for 83% (n= 34 out of 41) females compared to 24% (n=7 out of 29) of the males.

Table 6: Real and Substantial Risks x Application Outcome x Gender

	Total	Females (41)	Females admitted	% of females with this risk feature that were admitted	Males (29)	Males admitted	% of males with this risk feature that were admitted
Total risks posed to self (i.e. the list shown immediately below)	**70**	**41**	**25**	**61%**	**29**	**7**	**24%**
Alcohol and/or substance misuse	55	33	20	61%	22	7	32%
Self-harm	31	20	11	55%	12	3	25%
Risks to sexual health	27	26	16	62%	1	1	100%
Sexualised behaviour	21	13	8	62%	11	3	27%
Suicidal ideation	24	16	12	75%	5	1	20%
Personal hygiene/self-neglect	4	3	1	33%	1	0	0%
Failure to take medicines/mixing prescribed medicines with other substances unsafely	4	3	0	0%	1	0	0%
Management of medical condition being put at serious risk	2	1	0	0%	1	1	100%
Total risks posed by others (i.e. the list shown immediately below)	**44**	**28**	**18**	**64%**	**16**	**4**	**25%**
Engages with unsafe/ inappropriate adults	30	22	16	73%	8	4	50%
Risk of sexual exploitation/ prostitution	26	23	17	74%	3	1	33%
At risk of aggression/ threatened by others /victim of assault	21	14	10	71%	7	1	14%

	Total	Females (41)	Females admitted	% of females with this risk feature that were admitted	Males (29)	Males admitted	% of males with this risk feature that were admitted
Involvement with a negative peer group	14	8	4	50%	6	2	33%
Significant protection issues with regards to specific contact of the child	10	9	5	56%	1	1	100%
Total at risk from refusing to engage with services	**42**	**26**	**15**	**58%**	**16**	**6**	**38%**
Significant concerns about education/training	19	12	7	58%	7	2	29%
Total at risk of, or engaging in, criminal activity	**37**	**16**	**8**	**50%**	**21**	**5**	**24%**
Concerns about unaccounted money	7	4	2	50%	3	2	67%
Total at risk from youth homelessness	**13**	**4**	**2**	**50%**	**9**	**3**	**33%**
Total with mental health concerns (includes self-harm, suicidal ideation and general mental health concerns)	**36**	**25**	**14**	**56%**	**15**	**4**	**27%**

Risk of Endangering Others by Application Outcome

54. The second part of Criterion 2 considers danger posed by the child to others and has its own section for commentary on the application form.

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

55. Thirteen of the applications did not try to make a case for admission to special care on the basis of this part of Criterion 2.

56. As shown in the table below, few categories of risks relating to endangering others seem to have had a more than 50% likelihood of featuring in admissions to special care and where

they do numbers are usually too small to make any meaningful observations. The one risk factor that does stand out is the admission of 75% (n=9 out of 12) who were felt to be inciting other children to criminal, antisocial or risky behaviour.

Table 7: Endangering others x Application outcome

	Total	Admission	Not admitted	Withdrawn	% of applications with this risk feature that were admitted
General concern about risk of endangering others	**7**	**5**	**2**	**-**	**71%**
Endangering care staff	**44**	**19**	**18**	**7**	**43%**
Assaulted care staff	26	12	10	4	46%
Threatening/abusive towards care staff	18	7	8	3	39%
Endangering children	**34**	**15**	**15**	**4**	**44%**
Assaulted other children/young people	10	3	5	2	30%
Fights with other children/young people	6	3	1	2	50%
Threatening/abusive/bullying towards other children/young people	13	5	7	1	38%
Incited other children to criminal/antisocial acts or risky behaviour	12	9	3	-	75%
Sexually inappropriate behaviour towards other children	4	-	4	-	0%
Endangering family/foster carers	**27**	**10**	**14**	**3**	**37%**
Assaulted family	13	3	7	3	23%
Threatening/abusive behaviour towards family	9	6	3	-	67%
Threatening/abusive behaviour towards foster carer(s)	4	1	3	-	25%
Family fears child or company child keeps	3	1	2	-	33%
Weapons	**20**	**7**	**10**	**3**	**35%**
Has carried a weapon	21	6	11	4	29%
Threats with weapons	5	1	2	2	20%
Arson or Damage to Property	**18**	**8**	**8**	**2**	**44%**
Arson	5	2	2	1	40%
Damage to property	20	8	9	3	40%

	Total	Admission	Not admitted	Withdrawn	% of applications with this risk feature that were admitted
Endangering Professionals/Other Adults	**14**	**8**	**4**	**2**	**57%**
Threatening/abusive behaviour other adults	3	2	-	1	67%
Assaulted other adults	3	2	1	-	67%
Assaulted teacher	2	-	1	1	0%
Threatening/abusive towards teacher	3	2	1	-	67%
Threatening/abusive towards other professional	3	2	1	-	67%
Endangering Gardaí	**13**	**4**	**6**	**3**	**31%**
Assaulted Gardaí	8	3	3	2	38%
Threatening/abusive towards Gardaí	6	2	3	1	33%
Endangering social worker	**8**	**2**	**5**	**1**	**25%**
Assaulted social worker	5	3	1	1	60%
Threatening/abusive towards social worker	4	-	4	-	0%

57. Despite their smaller number, males had more of the risk factors relating to endangering others than females. Twenty-three of the 29 males (79%) were regarded as a danger to care staff. Again, females with these risk factors were more likely to be admitted to special care than males: for example 14 of the 21 females who had endangered care staff were admitted compared to only five of the 23 males.

Table 8: Endangering others x Application outcome x Gender

	Total	Females (41)	Females admitted	% of females with this risk feature that were admitted	Males (29)	Males admitted	% of males with this risk feature that were admitted
General concern about risk of endangering others	7	2	2	100%	5	3	60%
Endangering care staff	44	21	14	67%	23	5	22%
Endangering children	34	16	11	69%	18	4	22%
Endangering family/foster carers	27	13	8	62%	14	2	14%

	Total	Females (41)	Females admitted	% of females with this risk feature that were admitted	Males (29)	Males admitted	% of males with this risk feature that were admitted
Weapons	20	6	4	67%	14	3	21%
Arson or damage to property	18	9	5	56%	9	3	33%
Endangering professionals/ other adults	14	8	6	75%	6	2	33%
Endangering gardaí	13	6	3	50%	7	1	14%
Endangering social worker	8	5	2	40%	3	-	0%

Impaired Socialisation / Impulse Control

58. Criterion 3 considers impaired socialisation/impulse control and has a separate section for commentary on the application form.

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

59. Very few of the risk factors related to impaired socialisation/impulse control had a strong relationship to the likelihood of an application resulting in the admission of the child to special care. For example, only 33% of those with a diagnosed conduct disorder were admitted (n=5 out of 15). Ten of those with a diagnosed conduct disorder were male.

Table 9: Impaired socialisation / impulse control x Application outcome

	Total	Admission	Not admitted	Withdrawn	% of applications with this risk feature that were admitted
Total absconding	**65**	**31**	**27**	**75**	**48%**
Currently missing	6	2	4	33	29%
Absconds frequently	56	29	21	6	52%
Absconds occasionally	4		3	1	0%
Goes missing from home frequently	3	2	1		67%
Total with poor anger management / challenging behaviour	**36**	**14**	**18**	**4**	**39%**
Total with risk-taking behaviour	**40**	**21**	**15**	**4**	**53%**

	Total	Admission	Not admitted	Withdrawn	% of applications with this risk feature that were admitted
Cannot judge, impressionable, or seeks out, unsafe/risky situations	22	13	8	1	59%
Vulnerable to predatory individuals	21	11	9	1	52%
Poor insights into risks of current behaviour	17	9	6	2	53%
Over-familiar with new people / poor judge of real friendships	1	1			100%
Total with impaired socialisation	**29**	**12**	**14**	**3**	**41%**
Struggles to form long-lasting/healthy/appropriate relationships with peers	22	10	11	1	45%
Lacks social skills	17	8	8	1	47%
Distances self from adults	3	2	1		67%
Total where challenging boundaries is a significant concern	**26**	**13**	**9**	**4**	**50%**
Will not conform to boundaries	7	5	2		71%
Lack of boundaries and guidelines at home	8	3	4	1	38%
Will not conform to boundaries in care settings	5	2		3	40%
Will not to conform to boundaries in school	4	2	1	1	50%
Total with poor impulse control / quickly drawn into trouble / highly influenced by peers	**24**	**10**	**12**	**2**	**42%**
Poor impulse control / quickly drawn into trouble	22	10	10	2	45%
Highly influenced by peers	5	2	3		40%
Total with lack of remorse / empathy / understanding of impact of own behaviours	**13**	**5**	**5**	**3**	**38%**
Total with diagnosed conduct disorder	**15**	**5**	**7**	**3**	**33%**

60. Most of the children were stated within the application to have a history of absconding (93%, n=65) and only 48% of these children were admitted to special care. The use of special care to break a pattern of absconding was specifically rejected by Judge MacMenamin in *Health Service Executive v. DK, a minor:*

'An order detaining a minor is not legally justified because that child has an established pattern of absconding from the family home, or other out of home placements… The court may only make an order for the detention of a minor where there is clear and convincing evidence as to the underlying reasons for that pattern of absconding and a clear, clinical view as to the anticipated therapeutic value to that child of a short period of detention in a secure unit. Detention in this context cannot be used as a punishment for absconding, or simply a mechanism for the containment of that child.' (paragraph 52).

Placement History

61. Criterion 5 considers the extent to which other placement needs have been considered and has a separate section for commentary on the application form.

Criterion 5: Consideration has been given to placement history and the elimination of *all other* non-special care options, *based on the child's needs.*[13]

62. The table below ranks placement types in terms of an approximate 'degree' of intensity of support (i.e. special care, high support, residential care, community/family). Children who have only ever experienced community or family placements were actually more likely to have been the subject of a successful application than those who had previously been placed in special care or high support. Note that the seven out of the 14 children not admitted to special care from the HSE South had never experienced anything more intensive than a mainstream residential or community/family placement, suggesting that those applications may not have been deemed to have exhausted all options. This may be a significant part of the explanation of why the South has a higher failure rate for applications than other HSE Areas.

Table 10: 'Highest degree' placement type previously experienced x Application outcome

	Total	Admission	Not admitted	Withdrawn	% of applications with this feature that were admitted
Special care highest	22	11	9	2	50%
High support highest	15	6	6	3	40%
Residential highest	22	9	10	3	41%
Community/family placement highest	11	6	4	1	55%

[13] Emphasis as per the special care criteria.

63. When considered by gender, the usual pattern of gender imbalance can be seen.

Table 11: 'Highest degree' placement type previously experienced x Application outcome x Gender

	Total females	Females admitted	% of applications for females with this feature that were admitted	Total males	Males admitted	% of applications for males with this feature that were admitted
Special care highest	18	11	61%	4	-	0%
High support highest	7	4	57%	8	2	25%
Residential highest	10	5	50%	12	4	33%
Community/family placement highest	6	5	83%	5	1	20%

64. The success of applications in relation to the child's placement when the application was made reflects patterns already noted in this report. Where the child was remanded in custody or accessing youth homeless services, they were less likely to be admitted. Eight of those remanded in custody were males, five were female, with no pattern according to HSE Area. The Child Care (Amendment) Bill, 2009, if enacted, will continue to block the admission of children to special care if they are remanded in custody, but not where there are other ongoing proceedings (Oireachtas, 2009, p14). Children whose placement at the time of the application was in a high support unit were those most likely to be admitted to special care.

Table 12: Placement when application was made x Application outcome

	Total	Admission	Not admitted	Withdrawn	% of applications that were admitted
Residential unit	18	9	5	4	50%
Remanded in custody	13	3	9	1	23%
Family/foster care	12	5	4	3	42%
High support unit	11	8	2	1	73%
Missing	6	2	4	-	33%
Youth homeless	6	2	4	-	33%
Emergency placement	3	2	1	-	67%
Special care	1	1	-	-	100%

65. For around half of the applications (49%, n=34) the HSE social work department had been involved with the child for more than five years and only for 9% (n=6) had the social work department been involved for less than 12 months. The length of time the HSE social work

department had been involved with the child had no relationship to the outcome of the application.

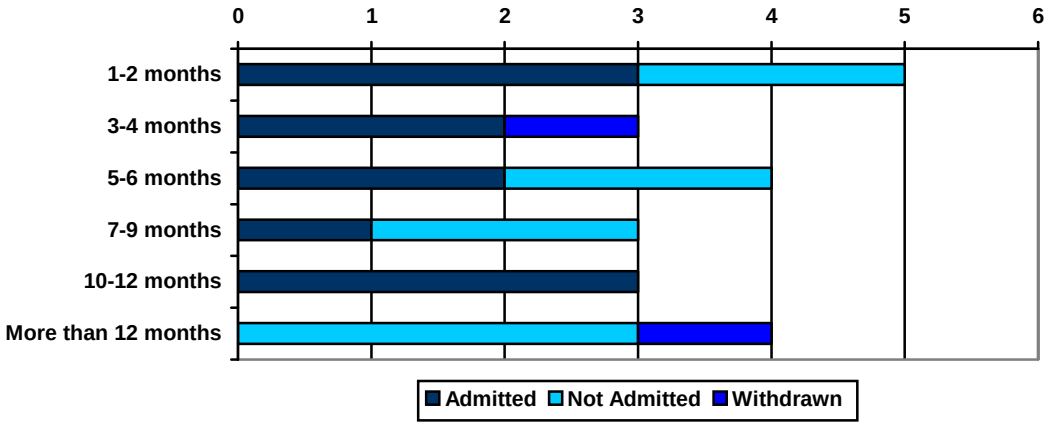
66. In terms of the number of previous care placements, two-thirds of those with no previous care placements were admitted (n=2 out of 3), only one of which was regarded as an emergency at the time. Those with between one and four previous care placements were highly unlikely to be admitted (only 21%, n=3 out of 8), perhaps reflecting a view that not enough options had been tried. Those with between five and nine placements were most likely to be admitted (62%, n=16 out of 26). There is a decline thereafter for those with 10–14 and 15–19 placements (50% of those not admitted with this number of previous care placements were aged 16–17, n=6 out of 12), but then the pattern changes as both children who had 20 or more previous care placements were admitted to special care (one was aged 13, the other 15, both were female).

Table 13: Number of previous care placements x Application outcome

	Total	Admission	Not admitted	Withdrawn	% of applications that were admitted
0	3	2	1	-	67%
1–4	14	3	8	3	21%
5–9	26	16	8	2	62%
10–14	19	8	8	3	42%
15–19	6	1	4	1	17%
20 and over	2	2	-	-	100%

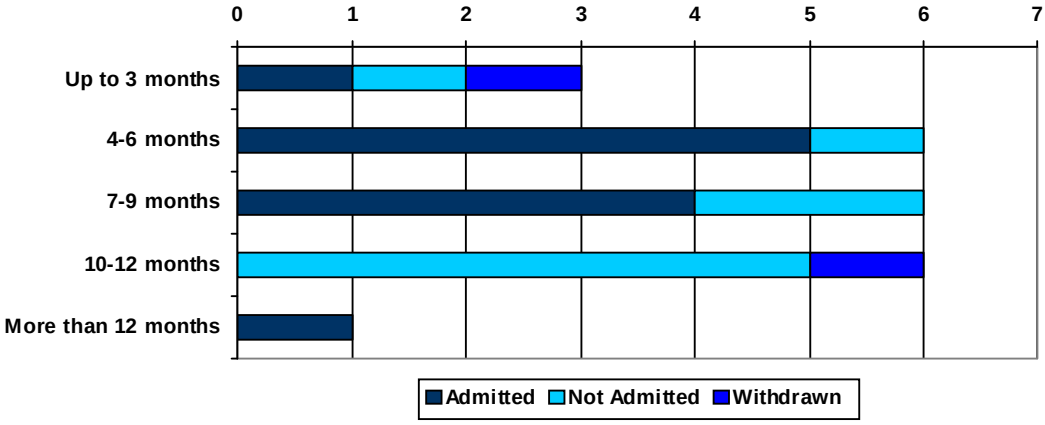
67. As already stated, 22 of the applications were for children who had previously been admitted to special care. Re-applications were much more likely to be successful if there was only one previous admission: 63% of these applications were admitted (n=7 out of 11) compared to only 36% of those who had more than one previous admission (n=4 out of 11). More than a third of the 22 re-applications (36%, n=8) were for children who had been out of special care for less than four months. Numbers were too small to determine whether there was a relationship between the length of time since the child had left special care and the success of the application.

Figure 5: For those previously admitted to special care, how long was it since they had left special care x Application outcome



68. Almost all the children who had previously spent ten months or more in special care (in one or more special care placements) were not admitted during their latest application. Note that the Child Care (Amendment) Bill, 2009 will allow for a maximum of three consecutive three month periods in special care.

Figure 6: Total number of months previously spent in special care x Application outcome



69. For 13 cases, there had previously been an unsuccessful application for special care. Of these, nine were admitted (695) in response to their 2007 application.

Less Secure Structured Environment

70. Criterion 6 considers the extent to which the applicant has demonstrated that a less secure structured environment would not meet the child's needs. It has a separate section for commentary on the application form.

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

71. The *Review of Special Care Applications* (SIS 2008) noted a continuum of needs in terms of what social workers hoped that special care would achieve for the child. Responses to this criterion in the application form tended to fall along this continuum, and the researcher supplemented this by asking interviewees what they hoped special care would achieve for the child.

72. Almost all of the applications (99%, n=69) wanted special care in order to contain the child, especially to stabilise an extreme situation (n=42) or for safety (n=41). 61% (n=43) hoped that special care would help the child to engage with services. Half (n=35) wanted some form of intervention, although very few were specific about what that intervention should be: the highest number (n=9) was for work on positive relationships. 17% (n=12) saw separation from others as something that they felt special care would provide and only 14% (n=10) hoped for some form of assessment in special care.

Table 14: Less secure criteria x Application outcome

	Total	Admission	Not admitted	Withdrawn	% admitted
Containment	**69**	**31**	**29**	**9**	**45%**
stabilise an extreme situation	42	18	20	4	43%
safety	41	18	16	7	44%
needs a high level of structure and boundaries	29	12	16	1	41%
absconding	27	14	9	4	52%
emergency/containment/stabilisation was the primary aim	16	9	7	0	56%
chronic substance misuse	4	2	1	1	50%
concerns about connections to criminal elements	2	1	1	0	50%
secure environment	17	5	9	3	29%
to facilitate an external assessment	1		1		0%
Separation	**12**	**5**	**5**	**2**	**50%**
from influence of negative peer group	5	1	3	1	20%
from adult who is considered a risk	5	3	1	1	60%
from adult relative felt to be putting child at risk	2	1	1	0	50%
Engagement	**43**	**23**	**18**	**2**	**53%**

	Total	Admission	Not admitted	Withdrawn	% admitted
need to re-engage with education	9	6	3	0	67%
refusing to engage with services	22	13	8	1	59%
engages well in a structured environment	12	6	6	0	50%
Assessment	**10**	**4**	**4**	**2**	**40%**
Intervention	**35**	**17**	**15**	**3**	**49%**

73. The application form also has a section to record previous interventions. There are several difficulties in analysing this section of the form. First, recording of the success of the intervention by the applicant was often difficult to interpret: it was not always clear whether the intervention was successful or whether the child had been referred but had not engaged. Second, for many of the children, the 'real and substantial risks to self' section of the form had already identified problems in engaging the child with any services, and, as shown in the previous paragraph, improved engagement was often an aim of the applying social work department. Thus, the table below may over-report interventions that were not really received because of lack of engagement, or under-report some where the lack of engagement led the social work department to believe that a referral would not be productive. Third, some interventions may not be being recorded because they are provided directly by social workers, keyworkers in residential settings, or community support workers, for example around substance misuse awareness, sexual health awareness or relationships. Fourth, given the extent of risk factors related to sexual risks or substance misuse services, it may be surprising that these interventions do not feature more prominently. This may be because those services are either not available locally for children or are seen as acute specialist services. Psychiatric/CAMHS services, on the other hand, are much more prominent, despite most children not having an acute psychiatric need.

Table 15: Previous interventions x Application outcome

	Total	Admission	Not admitted	Withdrawn	% where this had previously been attempted who were admitted
Child guidance/psychiatry / CAMHS / counselling	61	28	24	9	46%
Community supports (e.g. Extern, Youth Advocate Programme	51	26	20	5	51%
Psychological supports	28	14	9	5	50%
Substance misuse services	14	9	3	2	64%
Family therapy/interventions	10	7	3	0	70%
Sexual health	9	6	3	0	67%
Other HSE Services	6	3	2	1	50%
Traveller services	2	0	2	0	0%

Other Case Characteristics

Offending at the Point of Application

74. More than two-thirds of the applications (69%, n=48) involved children who had displayed offending behaviour in the past.

Table 16: Offending at point of application

	Total	%
Remanded in custody	13	19%
Remanded in custody but missing	2	3%
Ongoing proceedings, previous remands/detention	3	4%
Ongoing proceedings, no previous remands/detention	8	11%
No ongoing proceedings but previous remand	5	7%
Garda investigation	11	16%
Juvenile Liaison Officer only	6	9%
No offending behaviour	22	31%

75. There was a significant difference by gender. 31% of the males (n=9) were 'remanded in custody' or 'remanded in custody but missing' (i.e. technically remanded in custody but absconded from the placement, usually when on mobilities outside the remand centre) when the application for special care was made compared to just 15% of the girls (n=6); a further 21% of males (n=6) were subject to ongoing criminal proceedings compared to 12% of the females (n=5). In other words, more than half of the males were remanded in custody or subjects of ongoing proceedings at the time of the application. Of those remanded in custody/remanded but missing, this included 23% of those who were in voluntary care (n=7) but only 14% of those on a full care order (n=4).

Table 17: Offending at point of application x Gender

	Total	Female	% of females	Male	% of males
Not currently involved with the justice system	33	24	59%	9	31%
Garda investigation	11	6	15%	5	17%
Ongoing proceedings	11	5	12%	6	21%
Remanded in custody (two of whom were actually missing at the point of the application, having absconded)	15	6	15%	9	31%
Total	**70**	**41**	**100%**	**29**	**100%**

76. Applications by HSE area showed markedly different patterns with regards to offending history. 33% of the applications from the West involved children who were remanded in custody, a higher proportion than for the other three HSE areas. 33% of applications from Dublin North East involved ongoing proceedings. In contrast, only 21% of applications from Dublin Mid-Leinster involved children who were either currently remanded in custody or subject to ongoing proceedings.

Table 18: Offending at point of application x HSE area

	Total applications	Remanded in custody	Ongoing proceedings
Dublin Mid-Leinster	23	17%	4%
Dublin North East	21	19%	33%
South	14	21%	14%
West	12	33%	8%

77. Some 58% of children who were not involved with the justice system (n=19 out of 33) were admitted to special care. This was much higher than for other offending statuses at the point of the application.

Table 19: Offending x Application outcome

	Total	Admission	Not admitted	Withdrawn	% with this offending status at point of application who were admitted
Not currently involved with the justice system	33	19	10	4	58%
Garda investigation	11	4	4	3	36%
Ongoing proceedings	11	5	5	1	45%
Remanded in custody (two of whom were actually missing at the point of the application, having absconded)	15	4	10	1	27%

78. Given that more than 50% of the males were remanded in custody or subject to ongoing proceedings or Garda investigation, and the interpretation of Judge MacMenamin's SS ruling, it might be assumed that this was a significant factor in why males were less likely to be admitted to special care than females. However, this does not appear to be the case. For example, 50% of females remanded in custody were admitted to special care compared to only 11% of males, and this imbalance is true whatever the offending status of females and males. It does not explain the variation. Note that several interviewees felt that children were remanded in custody for petty offences where the court had concerns about the general welfare of the child.

Table 20: Offending x Application outcome x Gender

Percentage with this offending status who were admitted to special care	All	Female (n=41)	Male (n=29)
Not currently involved with the justice system	58%	67%	33%
Garda investigation	36%	50%	20%
Ongoing proceedings	16%	60%	33%
Remanded in custody	21%	50%	11%

79. Of 23 children who had been detained in the justice system prior to their 2007 application (in Oberstown Girls or Boys, the National Assessment and Remand Service at Finglas, St Joseph's at Clonmel prior to May 2007, Trinity House, St Patrick's), only 26% (n=6) were admitted to special care. All but one of the successful applications was made prior to February 2007, and the one that was successful after this date was originally not supported by the NSCADC.

Education at the Point of Application

80. Some 76% of the applications (n=53) were for children who had been school non-attenders during the previous twelve months. 41% of the applications (n=29) were for children who had a history of frequent school moves, with no patterns by gender and no relationship with the likelihood of the application resulting in an admission to special care. Surprisingly, none of the eight children who had had 15 or more care placement moves appear to have also experienced frequent school moves, and two of these eight also appear to have not had any school attendance problems in the previous 12 months.

Table 21: Frequent school moves x Number of care placements

Number of care placements prior to application	Total applications	Frequent school moves
0	3	3
1–4	14	6
5–9	26	12
10–14	19	8
15–19	6	0
20 and Over	2	0

81. Most of the applications were for children who did not have a learning disability (55%, n = 39), while 31% of the applications (n=22) were for children with a low/mild/borderline learning disability. There were gender differences here. 71% of the females (n=29 out of 41) did not

have a learning disability compared to 34% of the males (n=10 out of 29), whereas only 20% of the females (n=8) had a low/mild/borderline disability compared to 48% (n=14) of the boys. 51% (n=20 out of 39) of those with no learning disability were admitted to special care compared to only 27% (n=6 out of 22) of those who had a low/mild/borderline disability.

Health at the Point of Application

82. Special care units are not intended to deal with children who require medically supervised detoxification for drug misuse. Nevertheless most children who were subject to an application for special care in 2007 had problems in this area. 79% of the applications (n=55) identified alcohol and/or substance misuse as a risk factor, the largest single category against the criteria for 'real and substantial risks to self'. Often, however, there was little elaboration on this in the application documents. This will partly be because for some children the social work department might not have more specific evidence; it might be because some of the children boast about substances that they claim to be taking as part of their attention-seeking behaviour (cocaine in particular was mentioned by three social work interviewees in this context); and it might be because the child was believed to, as several social workers said, 'take anything that was going'. This lack of specific information can cause problems for the special care units: an interviewee in one unit said that, when one child was admitted, the unit had not been informed that the child was on a methadone programme and felt unable to plan for this in advance.

83. Through the application documentation and interviews, the researcher tried to gain a better picture of which substances the children were misusing. Alcohol and cannabis were the two most prominent, while for ten of the applications the child was believed to be using heroin (seven of the heroin users were aged 16–17). Those using heroin were less likely to be admitted to special care than those using other substances, and, indeed, less likely than those using no substances at all. This may suggest that children whose behaviour is concerning but who are also misusing heroin are not receiving a sufficiently joined-up service from the various agencies involved.

Table 22: Alcohol and substances that featured in the applications

Substances	Total	Female	Male
Alcohol	45	28	17
Cannabis	34	19	15
Ecstasy	15	12	3
No substances	15	8	7
Cocaine	13	10	3
Prescription Drugs	13	8	5

Substances	Total	Female	Male
Heroin	10	9	1
Aerosols	9	6	3
Mixture	4	2	2
Solvents	3	1	2
Speed	2	1	1
Other	1	0	1

84. There were some interesting patterns for substance misuse between the genders. For almost all of the substances, proportionally more of the females were misusing them than males, and on occasion the difference was substantial: for example, 24% of the females misused ecstasy compared to 10% of the males; 24% misused cocaine compared to 14% of the males; and 22% misused heroin compared to only 3% of the males. Males only exceeded females with regards to cannabis and no substances at all. Only 33% of the females misusing heroin were admitted (n=3 out of 9).

Table 23: Percent of applications where substances were misused x Gender

	Total	% of females (n=41) who misused this substance	% of males (n = 29) who misused this substance
Aerosols	9	15%	10%
Alcohol	45	68%	62%
Cannabis	34	46%	55%
Cocaine	13	24%	14%
Ecstasy	15	29%	10%
Heroin	10	22%	3%
Other	1	0%	3%
Prescription Drugs	13	20%	17%
Solvents	3	2%	7%
	Total	**% of females (n=41) who misused this substance**	**% of males (n = 29) who misused this substance**
Speed	2	2%	3%
Mixture	4	5%	7%
No substances	15	20%	24%

85. Nine of the applications were for children who had Attention Deficit Hyperactivity Disorder (ADHD), of whom two (22%) were admitted to special care. The current application form does not specifically ask if the child has a diagnosis of ADHD, so it is possible that this figure was under-reported. Seven of the applications were for children who had speech and language needs, of whom three (43%) were admitted to special care.

86. Some 46% of the applications (n=32) were for children who had had an admission to hospital in the 12 months prior to the application that was linked to the risks identified in the application. Of these, 56% (n=18) were admitted to special care, 11 were not admitted and three applications were withdrawn.

Table 24: Hospital admissions reason x Application outcome

	Total	Admission	Not admitted	Withdrawn	% who had been admitted to hospital for this reason who were admitted to special care
Substance misuse	14	9	3	2	64%
Parasuicide	7	4	2	1	57%
Self-harm	6	4	2	0	67%
Injury as victim of assault	5	2	2	1	40%
Injury sustained in a criminal act	3	2	1	0	67%
Psychiatric concerns	2	0	2	0	0%

87. Almost all of the children were receiving psychiatric interventions or had received a psychiatric intervention/assessment in the past. However, only 24% (n=17) were in receipt of psychiatric interventions at the point of the application, and only around a third of these were admitted to special care (35%, n=6). Several interviewees noted that psychiatric services provided little beyond assessment and were difficult to access speedily, so the table below may actually suggest more was going on in this area than actually was. With hindsight, it would have been interesting to explore in more depth the psychiatric services received, both before and after the application and this is a deficit that any future research may benefit from addressing.

Table 25: Psychiatric services – History at point of application

		Total	Admission	Not admitted	Withdrawn	% Admitted
Current service	Currently receiving a psychiatric service	17	6	6	5	35%
Recent activity	Recent referral to CAMHS	5	2	3	0	36%
	Recent assessment	6	2	2	2	
Evidence of previous services	Previous psychiatric intervention, now completed	2	0	1	1	13%
	Counselling only	6	1	5	0	
Failure to engage	Failure to engage with psychiatric services	7	5	2		71%
No evidence of interventions	Psychiatric assessment in past, no evidence of other interventions	9	6	2	1	77%
	Psychiatric assessment without seeing child	3	3	0	0	
	Self-harm and/or suicidal ideation, no evidence of psychiatric interventions	1	1	0	0	
No psychiatric needs	Psychiatric assessment in past, no psychiatric illnesses present	6	3	3	0	43%
	No psychiatric needs or assessment in past	8	3	5	0	

Summary of Case Characteristics Present for Successful Applications

88. The table below shows case characteristics present for successful applications. The middle column shows case characteristics that were present where 60% or more of applications led to an admission to special care. The last column shows case characteristics most likely to be present where the application did not lead to an admission to special care, where only 40% or less of applications were successful.

Table 26: Case characteristics present for successful applications

	60 % or more admitted where	40% or less admitted where
Gender	-	Male (24%)
Age	Age 12–14 (61%)	Age 16–17 (24%) Irish Traveller aged 16–17 (40%) (Irish Traveller of any age – 40%)
Care status	-	full care order (38%)
HSE Areas	-	Applications from West (33%)
Real and substantial risks to self	Female and: ■ suicidal ideation (75%); ■ risk of sexual exploitation/prostitution (74%); ■ engages with unsafe/inappropriate adults (73%); ■ at risk of aggression / threatened by others / victim of assault (71%); ■ risks to sexual health (62% [male 100%]); ■ sexualised behaviour (62%); ■ significant protection issues with regards to a specific contact of the child (60%). Male and concerns about unaccounted money (67%).	Male and: ■ at risk of, or engaging in criminal activity (24%); ■ self-harm (25%); ■ at risk from youth homelessness (33%); ■ involvement with a negative peer group (33%).
Endangering others	Female and: ■ endangered other professionals/adults (75%); ■ endangering other children (69%); ■ endangering care staff (67%); ■ carried weapons (67%); ■ endangering family/foster carers (62%).	Male: ■ endangering family/foster carers (14%); ■ endangering gardaí (14%); ■ carried weapons (21%); ■ endangered social worker (25%).
Impaired socialisation/ impulse control	-	Conduct disorder (33%) Lack of remorse / empathy / understanding of impact of own behaviours (38%) Poor anger management / challenging behaviour (39%)

	60 % or more admitted where	40% or less admitted where
Placement history	In a high support unit at the time of the application (73%) In an emergency placement at time of application (67%) Female and: ■ highest previous placement was community/family (83%); ■ previously been in special care (61%); Between five and nine previous care placements (62%); Been in special care before for less than nine months in total (67%); Previous application for special care was unsuccessful (67%).	Remanded in custody at time of application (23%) Youth homeless at time of application (33%) Missing at time of application (33%) Male and: ■ highest previous placement was community/family (20%); ■ highest previous placement was high support (25%); Between one and four previous care placements (21%); Between 15 and 19 previous care placements (17%); Been in special care before for more than nine months in total (14%).
Offending history	-	Remanded in custody or custodial sentence in past (30%)
Education	-	Low/mild/borderline learning disability (27%)
Health	Believed to be misusing: ■ solvents (67%); ■ ecstasy (60%). Hospital admissions in past 12 months for: ■ self-harm (67%); ■ injury sustained in a criminal act (67%); ■ substance misuse (64%). Some suggestion of psychiatric assessment or problems but no evidence of interventions (77%) Failure to engage with psychiatric services in past (71%)	Believed: ■ not to be misusing alcohol or substances (33%); ■ to be misusing heroin (33%). Hospital admissions in past 12 months as victim of assault (40%) ADHD (22%)

APPLICATION PROCESS

Decision making within the Social Work Department

External Influence

89. During interview, SIS asked the applicants whether there had been any external influence on the social work department to initiate an application for special care. For 95% of the applications (n=56), there was no external influence. 54% (n=7 out of 13) of the applications where there was some external influence were admitted to special care, compared to 43% (n=24 out of 56) where there was not.

Table 27: External Influence x application outcome

	Total	Admission	Not admitted	Withdrawn	% admitted
Not significant	56	24	24	8	43%
Significant and social work department fully agreed	7	4	3	0	57%
Significant and social work department unconvinced at first	5	3	2	0	60%
Significant and social work department disagreed	1	0	0	1	0%

Views of Parents and Children

90. The application form included a question for social workers to complete *on 'What are the parent(s)/primary carer's views on the application for special care?'* 84% (n=59) of applications included the views of the child's parent/carers, and 93% of those parents/carers (n=55) agreed with the application for special care. In five applications, it had not been possible to locate the parents, in one a decision was taken not to alert the parents because of fears that they would collude with the child to prevent admission, and in five more the views of the parents were not recorded.

91. The application form also included a question for the social workers to complete *on 'What are the young person's views on the application for special care?'* As might be anticipated, the views of the children themselves about the special care application were much less supportive than the views of the parents/carers, with only 35% (n=12) expressing any support for the application, albeit reluctantly in some instances. Ten of the children were not made aware of the application and for a further five the views of the children were not recorded, meaning that views were not present for 21% of the applications. Six of these children may

have been difficult to connect to, however: three were missing at the point of the application and three were accessing youth homeless services.

Family Welfare Conferences

92. Section 23 (a) of the Children Act, 2001 stated that 'before applying for a special care order under this part of the Act, the HSE shall arrange for the convening of a family welfare conference'. The HSE's Special Care Information and Application Pack provided two options for complying with this requirement:

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

93. These alternatives recognise that a family welfare conference is not always possible but require that this be explored with the local family welfare conference co-ordinator rather than decided by the social work department alone.

94. Family welfare conferences were held for 30% of applications (20 with the family involved, one without). Family welfare conferences were scheduled or a referral had been made at the time of the application for a further 25% (n=18). For 44% (n=31) no was held.

Table 28: Family Welfare Conferences held

	Number of applications	%
Yes and parents/family involved	20	29%
Yes but parents/family were not involved	1	1%
No but one is scheduled	8	11%
No but referral for family welfare conference has been made	10	14%
No and none is scheduled	31	44%

95. In terms of compliance with this part of the process:

- 59% of the applications (n=41) were fully compliant, having either held a family welfare conference or agreed with the local family welfare conference service that a family welfare conference was not viable;
- 30% of the applications (n=21) were partially compliant. These include the 18 applications where a family welfare conference was scheduled or a referral to the family welfare conference service had been made, plus three applications where this process happened

after the application on the recommendation of the CAAB and/or the NSCADC where the applying social work department had originally answered 'No and none is scheduled';

- 11% of applications (n=8) were non-compliant, failing to hold a for consult with the local family welfare conference service.

96. Reasons why family welfare conferences were not held were:

- family do not want to participate in a family welfare conference: 10;
- no parents or extended family: 8;
- emergency situation: 7;
- family dynamics mean that the process is unlikely to be constructive at this time: 6;
- decision to apply for special care taken at another meeting with family present: 5;
- family had previously agreed to special care and had not changed their view: 4;
- failure of a previous family welfare conference: 3;
- family not engaged with social work department: 3;
- simply not considered: 2.

97. Of those social work interviewees who expressed a view on the role of the family welfare conference within the special care application process, 24% (n=12) felt that they had a valuable role to play, 26% (n=13) had mixed or neutral views, but 50% (n=25) had a negative view of their role. The primary reasons for this negative view were:

- Twenty-three felt that all options were likely to have been exhausted by the time the application was being made.
- Eighteen said that family welfare conferences are useful in other contexts (i.e. at an earlier stage of intervention), but believed that, as special care was a last resort measure, all options within the family and extended family would normally have been exhausted by this stage.
- Sixteen said that the requirement to have a family welfare conference slows down the process and takes up valuable time.
- Five said that where special care is being considered, the family are usually too fractured for a family welfare conference.
- Five commented that family welfare conferences might be useful to support discharge (and some had used them in this way).

98. Some 46% of applications that were fully compliant with the requirements for family welfare conferences (n=19 out of 41) were admitted to special care and 48% of those that were

deemed to be partially compliant (n=10 out of 21). Only three of the eight non-compliant applications were admitted (38%).

Robustness of Onward Placement

99. Special care is intended to be a short-term measure rather than a long-term resource. *The Special Care Information and Application Pack* states:

> *'At the pre-admission stage the young person's discharge plan and a provisional discharge date will be agreed. This plan will be subject to regular review as part of the statutory care plan review process while the young person is in special care.' (SRSB/HSE, 2006)*

100. It is regarded as good practice for the onward placement to be identified at the outset, both to prevent the risk of drift in the case and to provide the children themselves with an idea of what will happen next. It is equally essential, as exemplified above, that the child's needs are reviewed while placed in the special care unit: the extent of progress within the placement, or the issues that may emerge, might lead to a rethink of, and change to, the planned onward placement. This latter point will be explored more fully in the chapter on outcomes by November 2009.

101. High support units and residential units were the planned onward placements for significant numbers of applications. Although high support featured as the most common onward placement planned, it is notable that 57% of applications did not aim to 'step-down' into high support. A third of the applications (33%, n=23) planned for the child to return to same care placement that they were in at the time of the application (13 to residential, seven to high support, three to fostering).

Table 29: Onward placement planned

	Total applications[14]	% of applications
High support	30	43%
Residential unit	25	36%
Home, shared care or fostering	11	16%
Placement abroad	3	4%
No step-down arrangement in evidence	2	3%
Independent/supported living	1	1%
Traveller family care service	1	1%

[14] Note: does not add up to 70 as some applications specified more than one option.

102. For many applications, however, the onward placement that was stated was not robust. Only 51% of applications (n=36) had an onward placement that was specified and secured at the point of the application for special care. Indeed, in only 30% of the applications where high support was defined as the onward placement was that placement secured (n=9 out of 30), much lower than for other placement types. Several interviewees commented on the absence of co-ordination of application and discharge processes between special care units and high support units, making it difficult to secure a discharge placement in a high support unit prior to making a special care application.

Table 30: Onward placement planned x Was the onward placement secured at the time of the application?

	Total[15]	Secured	Not secured	% of placement type secured
High support unit	30	9	21	30%
Residential unit	25	16	9	64%
Home, shared care or fostering	11	6	5	55%
Placement abroad	3	2	1	67%
No step-down arrangement in evidence	2	0	2	0%
Independent/supported living	1	1	0	100%
Traveller family care service	1	0	1	0%

103. Of the HSE areas, applications from Dublin North East were much more likely to have their onward placement secured (67%) compared to Dublin Mid-Leinster (48%), South (43%) and West (42%). There were also gender differences: 68% of applications for females had the onward placement secured (n=28 out of 41) compared to only 28% for males (8 out of 29). The security of the onward placement also seems to reflect offending status at the point of the application, with those remanded in custody least likely to have an onward placement secured.

Table 31: Was the onward placement secured at the time of the application? x Offending status at time of application

	Total	Onward placement secured	% with secured onward placement
Remanded in custody	15	4	27%
Ongoing proceedings	11	6	55%
Garda investigation	11	4	36%
No current involvement with the justice system	33	22	67%

[15] Note: does not add up to 70 as some applications specified more than one option

104. As might be expected there was a relationship between the robustness of the onward placement and the likelihood of gaining admission to special care. 56% of those with onward placements secured (n= 20 out of 36) were admitted to special care, compared to only 35% of those were the onward placement was not secured (n=12 out of 34). Only 25% (n=2 out of 8) of applications from the South with no onward placement secured were admitted to special care, again contributing to the reason why more applications from that HSE Area failed to gain admission.

Views and Recommendations

Emergency Applications

105. Some 19% of applications (n=11) were regarded as 'emergency' by the applying social work department, and 91% (n=10) of these were admitted to special care. The perception of these applications being an 'emergency' was usually shared by both the CAAB and the NSCADC i.e. that the child's behaviour posed an acute/life-threatening risk to itself.

Children Acts Advisory Board (CAAB)

106. Provisions of the Children Act, 2001 introduced a role for the CAAB to offer a view to the court in each application for special care. The views of the CAAB were sought in advance for 87% of the applications (n=61), of which the CAAB supported 75% (n=46), did not support 23% (n=14) and was not required to offer its view for one where the application was withdrawn. For three applications, the views of the CAAB were only sought after the child had been admitted to special care, all of which were emergency applications. For six applications, the views of the CAAB were never sought: two of these were emergency applications (one of which was admitted) but four were not (one admitted, two not admitted, one withdrawn).

107. In terms of compliance with the requirement to seek the views and gain the support of the CAAB:

- forty-one applications were fully compliant (59%) in seeking the CAAB's views in advance and gaining support for application;
- five were partially compliant, all of which sought the views of the CAAB in advance but four of which were only supported with conditions (e.g. being asked to hold a family welfare conference) and one was only supported on appeal;
- twenty-four applications (34%) were not compliant, either through not consulting the CAAB in advance or not gaining the CAAB's support for the application.

National Special Care Admissions and Discharge Committee (NSCADC)

108. The NSCADC offered a view on 61 of the applications: of the rest, one was admitted to special care prior to the NSCADC offering its view and eight were withdrawn while the NSCADC was awaiting the clarification of further details. Of the applications where the NSCADC offered a view, it was much less likely to support the application for special care than the CAAB. The NSCADC supported 52% of applications (n=31) and did not support 48% (n=30). The NSCADC only supported 24% (n=4 out of 17) of the applications where a child was remanded in custody. In total only nine of the children who were remanded in custody or had ongoing proceedings at the time of the application were supported by the NSCADC, and six of these were for applications prior to mid-July 2007, suggesting the impact of Judge MacMenamin's SS ruling on the NSCADC's decision making.

109. Of the 54 applications where both the CAAB and the NSCADC offered a view (i.e. taking out the 16 where either body was not asked for a view or the application was withdrawn), views coincided on only 59% of applications (n=32). Of the 22 where views differed, the NSCADC supported four applications that the CAAB did not; the CAAB supported 18 applications that the NSCADC did not.

110. The table below looks at the case characteristics present where the NSCADC and the CAAB had different views about the application. We have already established that the two bodies disagreed for 41% of the applications where both expressed a view (n=22 out of 54). Where individual case characteristics are present in the same or a higher percentage, they are more likely to be related to the reasons for disagreement on a consistent basis. So, for example, if the application was for a heroin misuser or an Irish Traveller, the two bodies were much more likely to have different views on whether there should be an admission to special care (the CAAB was more prone to support those applications than the NSCADC). Where the child was aged 16–17, had a low/mild/borderline learning disability, or was at risk from youth homelessness at the point of application, the difference in views is at a similar level to the overall level of disagreement, suggesting a possible association. Where percentages are lower, those case characteristics seem to have a weaker association with the differences in view. SIS's previous report (SIS 2008) suggested that ongoing criminal proceedings or previous placements in special care might be being considered more strictly by the NSCADC than by the CAAB as reasons to not support an application but the table below actually suggests this is not a strong association, with disagreement more likely, for example, where the application was for a male than where the child have previously been in special care.

Table 32: Case characteristics where views of the NSCADC and the CAAB differed

Case Characteristic	Number of applications with this characteristic present where views of the NSCADC and the CAAB differed	Total number of applications where this characteristic was present (out of all applications where both the NSCADC and the CAAB offered a view)	% of applications where this characteristic was present where views of the NSCADC and the CAAB differed
Heroin misuser	7	10	70%
Irish Traveller	5	10	50%
All Applications	**22**	**54**	**41%**
Aged 16–17	7	17	41%
Low/mild/borderline learning disability	9	22	41%
At risk from youth homelessness at the point of application	5	13	38%
Risks posed by others	16	44	36%
Periods of youth homelessness in past	6	17	35%
Remanded in custody or subject to ongoing proceedings at the point of application	8	26	31%
Onward placement not secured at point of application	11	36	31%
Highest ‘degree’ previous placement was residential unit of community/family	10	33	30%
Self-harm	9	32	28%
Male	8	29	28%
Endangering care staff	12	44	27%
Had previously been in special care	6	22	27%
Endangering children	8	34	24%
ADHD	2	9	22%
Suicidal ideation	5	24	21%
Conduct disorder	3	15	20%

Appeals and Their Outcome

111. Eighteen applications were the subjects of an appeal where neither of the two bodies supported the application. Sixteen of those appeals were to the NSCADC, four were to the CAAB. Only three of the appeals to the NSCADC were successful and only one of those to the CAAB. For two of the applications where the appeal was unsuccessful, the social work department proceeded to court and secured admission to special care.

Withdrawn Applications

112. Nine of the applications were withdrawn, four because the child stabilised in an existing placement, one because an alternative placement abroad was sourced, one because of enhanced training provided to the current placement which enhanced its capacity to maintain the child. The social workers interviewed were not convinced that special care had ever been the best option for five of these applications (i.e. often the application was made without the support of the individual social worker, under external influence or as a result of direction from someone more senior in the social work department). Two were admitted to special care at a later date and one was subject to a further unsuccessful application at a later date.

OUTCOMES BY NOVEMBER 2009

113. Within this chapter of the report, the focus is on the individuals who were subject to a special care application in 2007 rather than the 70 applications, given that some were the subject for more than one application. Fifty-nine of the 61 individuals are included, with two being excluded for a variety of reasons which will not be recorded in this report in order to preserve anonymity (as agreed with the commissioners for this research). This chapter derives primarily from interviews with the social work departments that made the applications for special care.

114. The core focus of this chapter is on the circumstances of the individuals as of November 2009. Key themes are:

- Overall, compared to the risks that were perceived as being present when the applications were made in 2007, have those risks improved, worsened, stayed the same, or had mixed fortunes (some improved, some worsened)?
- What has been the change to the individual risk factors that were identified in 2007?
- What has happened to the individuals in terms of their placement history, offending history, education/training/employment, and health, and how does this relate to whether risks are perceived to have improved overall?
- What have acted as 'protective factors' to promote positive change?

115. The intention originally was also to track the agencies and services that the individuals have received since the application but this was difficult to achieve for several reasons: the children (and their family) may not have engaged with the service or may have engaged intermittently, so listing those services would have added little to insight; often the social workers will have changed since the application and may have little personal familiarity with this level of detail in the case (if it is now closed), which meant that the study could have placed a significant burden on them to track those resources in addition to the core information being sought (some cases had 30–40 files). However, by focussing on outcomes, on protective factors, and on whether the 'system' (including community resources) needs to be reshaped (see next chapter), the key messages about the availability, accessibility and usefulness of those resources should emerge.

116. Some 71% (n=42) of the social work departments were still in direct contact with the individuals who were subject of the application. Where they were not in contact, the break was usually reasonably recent or the social work interviewee had information from partner agencies on the current position of the individual. It is possible to be confident that the information in this chapter is fairly robust.

Changes in Risks Since 2007

Overall Change in Risks

117. Interviewees from social work departments were asked whether the risks identified at the point of the application in 2007 (or first application for 2007, where there were two applications that year) had:

- improved;
- had mixed fortunes (some risks improved, some worsened);
- stayed the same;
- worsened.

118. Risks had improved for around 46% of the individuals (n=27) and had had mixed fortunes for a further 19% (n=11). So just under two-thirds had experienced either all-round improvement in their risk factors, or some improvement. Nevertheless, just over a fifth (n=13) had worsened, and almost 14% (n=8) had not changed at all.

Table 33: Risks change for each individual subject to a special care application in 2007

Risks Change	No.	%
Improved	27	46%
Mixed	11	19%
Same	8	14%
Worsened	13	22%
Total	**59**	

Overall Change in Risk Factors by Application Outcome

119. Within this section we consider the overall change in risk factors against the application outcome (i.e. whether the child was admitted to special care or not in 2007). Where children were subject to more than one application in a year, they are regarded as having been 'admitted' if any of these applications resulted in an admission to special care.

120. There were significant variations in overall changes in risk factors by the outcome of the application. Outcomes were similar for those who were admitted to special care in 2007, or where the application was withdrawn: risks for 75% of these individuals improved or had mixed fortunes (n=27 out of 36). However, only 48% of those not admitted to special care as a result of their 2007 application (n=11 out of 32) saw overall risks improve, while 30% of these saw overall risks worsen (n=7). At face value, this would appear to suggest that either

special care has the desired effect and causes positive change, or, conversely, that some children who would benefit from special care are not being admitted and their behaviours worsen as a result. However, this needs to be unpicked further and this will be done later in this chapter.

Table 34: Risks change for each individual subject to a special care application in 2007 x application outcome

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Admission	28	15	6	2	5	75%	18%
Not admitted	23	9	2	5	7	48%	30%
Withdrawn	8	3	3	1	1	75%	13%
Total	**59**	**27**	**11**	**8**	**13**	**64%**	**22%**

Overall Change in Risk Factors by Gender

121. Patterns by gender are different. A similar percentage of females and males experienced improvement (47% of females and 44% of males) but more males were likely to have worse outcomes or the same level of overall risks than females, both proportionally and in absolute terms (45% of males, n=12; 28% of females, n=9).

Table 35: Risks change for each individual subject to a special care application in 2007 x Gender

	Total	Female	% of Female	Male	% of Male
Improved	27	15	47%	12	44%
Mixed	11	8	25%	3	11%
Same	8	3	9%	5	19%
Worsened	13	6	19%	7	26%
Total	**59**	**32**		**27**	

Overall Change in Risk Factors by Age

122. There also appear to be patterns by age at the time of application. Improvements were most likely for those aged 12–13 at the time of the application (80% of these 10 improved or had mixed outcomes); 60% of the ten who had been aged 14 improved or had mixed outcomes; 65% of the 26 who had been aged 15 improved or had mixed outcomes; but only 54% of the 13 who were aged 16–17 at the time of the application improved or had mixed outcomes (compared to 33% whose risks worsened at age 16–17). Given that 16–17 year-olds also are least likely to be admitted to special care, this raises a question about whether the needs of 16–17 year-olds exhibiting behavioural difficulties are being effectively addressed, not just

within special care but within the services provided by the HSE in general and its partner agencies.

Table 36: Risks change for each individual subject to a special care application in 2007 x age at application

Age at application	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
12	4	2	1	0	1	} 80%	} 10%
13	6	4	1	1	0		
14	10	4	2	1	3	60%	30%
15	26	12	5	4	5	65%	19%
16	11	4	2	2	3	} 54%	} 33%
17	2	1	0	0	1		

Overall Change in Risk Factors by Ethnicity

123. There was also a pattern according to ethnicity. Only three of the Irish Travellers improved, with 63% (n=5 out of 8) having risk factors that were the same or, more likely, worsened. Three of these five were aged 16–17, however, so age may be the dominant factor, and numbers were also small. Nevertheless, an interviewee from a special care unit suggested that several applications for Irish Travellers were from social work departments that had not fully addressed the cultural issues. This does therefore raise questions about whether Traveller-oriented services are sufficiently accessible and available nationally, whether social work staff is sufficiently trained to deal with cultural issues, or whether the presenting needs of Irish Travellers are not being treated the same way by the system. It is impossible to draw conclusions given the small number of such cases but there is a pattern here that needs to be considered.

Table 37: Risks change for each individual subject to a special care application in 2007 x Ethnicity

	Total	Improved	Mixed	Same	Worsened
White Irish	44	19	9	7	9
Irish Traveller	8	3	0	1	4
White English	3	2	1	0	0
White English/Irish	2	2	0	0	0
Not answered	2	1	1	0	0

Overall Change in Risk Factors by Care Status

124. There was also a pattern according to care status at the point of application. Outcomes were worse for those on a full care order compared to all other types of care status.

Table 38: Risks change for each individual subject to a special care application in 2007 x Care status at point of application

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Full care order	23	5	5	5	8	43%	35%
Interim care order	5	3	1	1	0	80%	0%
Voluntary care	26	16	4	2	4	77%	15%
Not in care	3	2	1	0	0	100%	0%
Not stated	2	1	0	0	1	50%	50%

Overall Change in Risk Factors by HSE Region making Application

125. There were some variations in overall changes in risk factors by HSE Region, with Dublin North East and Dublin Mid-Leinster more likely to have had risk factors worsen.

Table 39: Risks change for each individual subject to a special care application in 2007 x HSE Area making the application

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Dublin Mid-Leinster	21	8	6	2	5	67%	24%
Dublin North East	15	7	2	2	4	60%	27%
South	11	6	1	2	2	64%	18%
West	12	6	2	2	2	67%	17%
Total	**59**	**27**	**11**	**8**	**13**	**64%**	**22%**

Changes to Individual Risk Factors

126. In making their applications for special care, social workers built a case based on the criteria for special care, of which three components related to risks: risk of real and substantial harm to self; risk to others; risks related to impaired socialisation/impulse control. Changes in these individual risks can also be tracked. Again, the focus is on 59 individuals rather than 70 applications in this section, hence the numbers will differ from the previous analysis of these risk factors in the chapter on Characteristics of Cases Subject to a Special Care Application.

Real and Substantial Risks to Self – Changes

127. There are some marked variations in changes in individual risk factors. Most likely to go completely, improve, or have mixed results were: sexualised behaviour (70%); self-harm (59%); significant concerns about a specific contact of the child (56%); significant concerns about education/training (53%).

128. Most likely to worsen were: risks from youth homelessness (56%); unaccounted money (50%); at risk of, or engaging in, criminal activity (41%); alcohol and substance misuse (31%); significant concerns about a specific contact of the child (22%).

129. Most likely to stay the same were: risks to sexual health (52%); suicidal ideation (48%); risk of sexual exploitation/prostitution (45%); at risk of aggression/threatened by others (44%).

130. Thus, although social workers perceived that just under two-thirds of the children had experienced an overall improvement in their risk factors, or some improvement (the 'mixed' category), this does not come through as strongly when individual risk factors are considered. This may be easy to explain. When the application was made, the combination of risk factors was so acute that in many situations the social work department even feared for the child's life (all of the children involved in this study were still alive by November 2009). The child's behaviour was perceived as being out of control. By the time of this research, many of those children had stabilised, their needs were not so acute, but concern that some of those factors might return in the future remained. So, for example, work might have been done to reduce the child's acute sexualised behaviour, they may have had minimal sexual risks at the time of this research, but the social work interviewee might nevertheless regard the individual as potentially vulnerable to sexual exploitation in the future. Where the same level of acute risk was perceived to be present at the time of this research as at the time of the original application, more often than not the interviewee regarded the risk as having worsened.

Table 40: Changes to Real and Substantial Risks to Self

	Total	Gone or Improved	Mixed	Same	Worsened	New	% Gone, Improved or Mixed	% Same	% Worsened or New
Risks to Self	**59**	**31**	**2**	**22**	**4**	**0**	**56%**	**37%**	**7%**
Alcohol and/or substance misuse	49	22	0	12	13	2	45%	24%	31%
Risks to sexual health	21	9	0	11	0	1	43%	52%	5%
Self-harm	29	17	0	9	1	2	59%	31%	10%
Sexualised behaviour	20	14	0	5	0	1	70%	25%	5%
Suicidal ideation	21	9	0	10	1	1	43%	48%	10%
Risks posed by Others	**35**	**21**	**0**	**13**	**1**	**0**	**60%**	**37%**	**3%**
At risk of aggression/ threatened by others/ victim of assault	18	9	0	8	0	1	50%	44%	6%
Engages with unsafe/inappropriate adults	24	11	0	10	2	1	46%	42%	13%
Involvement with a negative peer group	12	6	0	5	0	1	50%	42%	8%
Risk of sexual exploitation/prostitution	20	9	0	9	2	0	45%	45%	10%
Significant protection issues with regards to specific contact of child	9	5	0	2	1	1	56%	22%	22%
Refusing to engage with services	**35**	**21**	**0**	**10**	**4**	**0**	**60%**	**29%**	**11%**
Significant concerns about education/training	15	8	0	6	1	0	53%	40%	7%
Risk of, or engaging in, criminal activity	**34**	**12**	**0**	**8**	**11**	**3**	**35%**	**24%**	**41%**
Concerns about unaccounted money	8	2	0	2	1	3	25%	25%	50%
At risk from youth homelessness	**16**	**2**	**0**	**5**	**4**	**5**	**13%**	**31%**	**56%**

131. Of those not admitted to special care, 50% had worsened risks related to criminal activity (n=9 out of 18), just under a third had worsened risks related to alcohol and substance misuse (n=6 out of 16), and a third (n=2 out of 6) had worsened risk factors relating to youth homelessness.

132. A fifth of the individuals (n=12 out of 59) experienced homelessness after the special care application. This included eight of the 14 who had experienced homelessness prior to the application. Some 54% of those whose overall risk factors worsened (n=7 out of 13) had experienced homelessness prior to the application. In combination with the fact that youth homelessness was the individual risk factor most likely to worsen, this suggests that children in acute need who have experienced homelessness are not having that need adequately addressed. There were regional patterns to this issue. 38% of the individuals from Dublin Mid-Leinster (n=8/21) experienced homelessness after the application, and 27% of those from Dublin North East (n=4/15). Individuals from South or West may have accessed emergency accommodation but were not regarded as homeless.

133. For eight of the individuals, part of the reason for the application for special care was to separate them from a known individual(s), usually an adult male. Applications for five of these individuals were successful, two were not, and one was withdrawn. For 38% (n=3), however, risk factors were perceived to have worsened, including two children who were admitted to special care. Injunctions and barring orders were taken against some of the men involved and some were cautioned: a few of these injunctions were taken in parallel with the application for special care although this detail was not included in the application documentation. In a small number of these cases, the social work departments described situations that had arisen that suggested there was a need to put in place an information sharing protocol between An Garda Síochána and the HSE, including appropriate pathways within each agency for escalating concerns. A joint protocol between An Garda Síochána and the HSE is now in place for 'children missing from care' but that was not the specific concern for these cases.

Table 41: Where separation from a known individual(s) was an issue, application outcome by overall change in risk factors

	Total	Improved	Mixed	Worsened
Admission	5	2	1	2
Not admitted	2	1	0	1
Withdrawn	1	0	1	0

Endangering Others – Changes

134. Endangering others includes assaults and threats to a range of children and adults, arson, property damage, and possessions of weapons. Earlier in this report we provided details from the application against this criteria to demonstrate which groups had been endangered. Within this current section, we will assess change according to how dangerous the threats were perceived to be, and whether social workers felt that there had been a change to the seriousness and/or frequency of those threats.

135. For 42% of the individuals (n=25), the risks posed to others were felt to have gone completely or improved. Another 8% (n=5) posed the same risk but it was felt to be at a low level, while 17% (n=10) were never felt to have provided a risk to others. The risks posed by 17% (n=10) had worsened in terms of both seriousness and frequency of risk, those posed by 5% (n=3) were less frequent but more serious, and those posed by 10% (n=6) remained at the same worrying levels as at the time of the application.

Table 42: Changes to Endangering Others

	Number	%
Gone or improved	25	42%
Same, low level	5	8%
Same, concerning	6	10%
More serious, less frequent	3	5%
Worse	10	17%
Never posed risk to others	*10*	*17%*
Total	**59**	**100%**

136. We have previously noted that overall risks were regarded as having worsened for 13 individuals. Six of these also posed a worse risk of endangering others, two posed the same high level of risk, and one posed the same low level of risk. In other words, for 69% of these individuals, the risk of endangering others had stayed the same or become worse. Of the remaining four, three were not deemed to pose any risks to others and one was actually felt to have improved in this area.

Impaired Socialisation / Impulse Control – Changes

137. With regards to impaired socialisation/impulse control, the risk factors most likely to have gone or improved since the application was made in 2007 were: poor insights into risks of current behaviour (63%, n = 10 out of 16); absconding frequently (57%, n=26 out of 46); challenging boundaries (52%, n=12 out of 23). Very few of the individual risk factors relating

to the criteria for impaired socialisation/impulse control were perceived by social workers to have worsened since the application was made.

138. Several risk factors remained largely unchanged: diagnosed conduct disorder (92%, n= 12 out of 13); cannot judge, impressionable, or seeks out unsafe/risky situations (73%, n=11 out of 15); vulnerable to predatory individuals (67%, n=10 out of 15); struggles to form long-lasting/healthy/appropriate relationships with peers (55%, n=11 out of 20).

Table 43: Changes to Impaired Socialisation / Impulse Control

	Total	Gone or Improved	Same	Worsened	New	% Gone, Improved or Mixed	% Same	% Worsened or New
Total absconding	55	**32**	**22**	**1**	**0**	**58%**	**40%**	**2%**
Absconds frequently	46	26	20	0	0	57%	43%	0%
Absconds occasionally	4	2	2	0	0	50%	50%	0%
Total with risk-taking behaviour	**31**	**17**	**8**	**6**	**0**	**55%**	**26%**	**19%**
Cannot judge, impressionable, or seeks out unsafe/risky situations	15	3	11	1	0	20%	73%	7%
Vulnerable to predatory individuals	15	4	10	1	0	27%	67%	7%
Poor insights into risks of current behaviour	16	10	5	1	0	63%	31%	6%
Total with poor anger management / challenging behaviour	31	17	10	3	1	55%	32%	13%
Total with impaired socialisation	**27**	**12**	**13**	**2**	**0**	**44%**	**48%**	**7%**
Struggles to form long-lasting/healthy/appropriate relationships with peers	20	8	11	1	0	40%	55%	5%
Lacks social skills	15	7	8	0	0	47%	53%	0%
Total where challenging boundaries is a significant concern	**23**	**12**	**9**	**1**	**1**	**52%**	**39%**	**9%**
Total with poor impulse control / quickly drawn into trouble / highly influenced by peers	**20**	**10**	**7**	**3**	**0**	**50%**	**35%**	**15%**
Poor impulse control / quickly drawn into trouble	19	8	9	2	0	42%	47%	11%
Highly influenced by peers	4	2	2	0	0	50%	50%	0%
Total with lack of remorse / empathy / understanding of impact of own behaviours	**12**	**5**	**5**	**2**	**0**	**42%**	**42%**	**17%**
Total with diagnosed conduct disorder	**13**	**1**	**12**	**0**	**0**	**8%**	**92%**	**0%**

New Risks since the Application was Made

139. Twelve of the individuals (20%) acquired new risk factors over the two years. Overall, risks improved for four of these individuals, had mixed fortunes for four, stayed the same for two and worsened for two. It might be expected that the younger children are the most likely to have acquired additional risk factors but this was not the case. Only three of the individuals aged 12, 13, 15 or 17 (out of 38) acquired additional risks, but 60% of the 14 year-olds did (n=6 out of 10) and 27% of the 16 year-olds (n=3 out of 11). The individual risk factor most likely to be acquired was the risk from youth homelessness (n=5). Six of those who acquired new risks were females, six were males. Of these 12 individuals, five had been admitted to special care, three were not admitted, and the applications for four had been withdrawn.

Placement History

Known to HSE Social Work

140. Improvement in risks overall was more likely for those individuals who had been known to HSE social work teams for the least amount of time: 81% of those known to HSE social work within the last two years (n=13 out of 16) had risks that improved or had mixed fortunes, compared to 67% of those known to HSE social work for two to five years (n=10 out of 15) and 54% of those known to HSE social work for five years or more (n=15 out of 28). Almost a third of those known to HSE social work for five years or more had risks that had worsened overall (32% compared to only 13% for the other categories) but this goes hand-in-hand with the fact that older children are more likely to have risks that worsened.

Table 44: Risks change for each individual subject to a special care application in 2007 x Length of time since HSE became involved

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Within last two years	16	8	5	1	2	81%	13%
More than two years and less than five years	15	8	2	3	2	67%	13%
Five years or more	28	11	4	4	9	54%	32%

Contact with Social Work Department

141. In November 2009, 71% (n=42) of the individuals were still in contact with HSE social work, including 38% (n=8 out of 21) of those aged 18 or over. The HSE was still in contact with 89% (n=34 out of 38) of those who were still children: all four where the case was closed and the

social work department was no longer in contact were aged 17, two of whom were in the juvenile detention system.

Table 45: Contact with social work department in November 2009 x Age of child in November 2009

	Total	14	15	16	17	18	19	20	% In contact
SW Service being provided	24	3	5	7	8	1			71%
SW Service being provided, planning aftercare	6			1	5				
Aftercare service being provided	9				2	6	1		
Child, case closed but still in contact	2		1		1				
Child, detained, case open	1				1				
Child, detained, case closed	2				2				7%
Child, case closed	2				2				
Adult, open to aftercare but not availing	4					3		1	44%
Adult, detained	3					3			
Adult, no longer in touch	6					4	2		
Total aged 18 and over	**21**								**38%**

142. Perhaps unsurprisingly, risk factors were more likely to have improved for those individuals still in contact with HSE social work: this reflects engagement with support offered, and the general point made earlier that older children at the point of the application were perceived to have had poorer outcomes. In addition, individuals who were detained in the justice system were usually regarded as having poor outcomes and social work departments were often no longer in touch with these individuals as a result of the detention.

Table 46: Contact with social work department in November 2009 x Overall change in risks

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Still in contact (children and adults)	42	23	9	5	5	76%	12%
Child: case closed	4	0	0	1	3	0%	75%
Adult: no contact	13	4	2	2	5	46%	38%

143. There was, however, a difference in levels of contact with HSE social work department according to care status at the point of the application for special care: only 59% (n=13 out of 22) of those who had been on full care orders were still in contact compared to 81% (n=21 out of 26) of those who had been in voluntary care.

Placement Moves

144. Of those who had had four or less placement moves prior to the application for special care, the risks had improved or had mixed fortunes for 88% (n=14 out of 16). Given that very few of these children were admitted to special care, this suggests that, with the exception of extreme emergencies, children with fewer than five previous care placements should not be admitted to special care. Positive outcomes then decline as the number of previous care placements increase.

Table 47: Risks change for each individual subject to a special care application in 2007 x Number of care placements prior to application for special care[16]

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
0	2	1	1	0	0	} 88%	} 13%
1–4	14	11	1	0	2		
5–9	21	10	4	4	3	67%	14%
10–14	15	3	4	2	6	47%	40%
15–19	5	0	1	2	2	20%	40%
20 and Over	2	2	0	0	0	100%	0%

Highest 'Degree' Care Placement to November 2009

145. For this analysis, the 'degree' is ranked according to the order in the table below. This shows that 61% of the individuals in this study (n=36 out of 59) experienced special care at some point up to November 2009.

Table 48: Risks change for each individual subject to a special care application in 2007 x Most intensive care placement to November 2009

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Special care	36	16	7	4	9	64%	25%
High support	12	4	3	3	2	58%	17%
Residential	10	6	1	1	2	70%	20%
High support in the community	1	1	0	0	0	100%	0%

[16] Note: care placements include all moves in placements since the child care into care, even where the child returned to a former placement, excluding placements for the purposes of respite/short-breaks.

Special Care Placements

146. The number of special care placements that the individual experienced, up until November 2009, does not appear to have a significant relationship one way or another to changes in risks. Note that four children who were not admitted to special care on their first application in 2007 were later admitted.

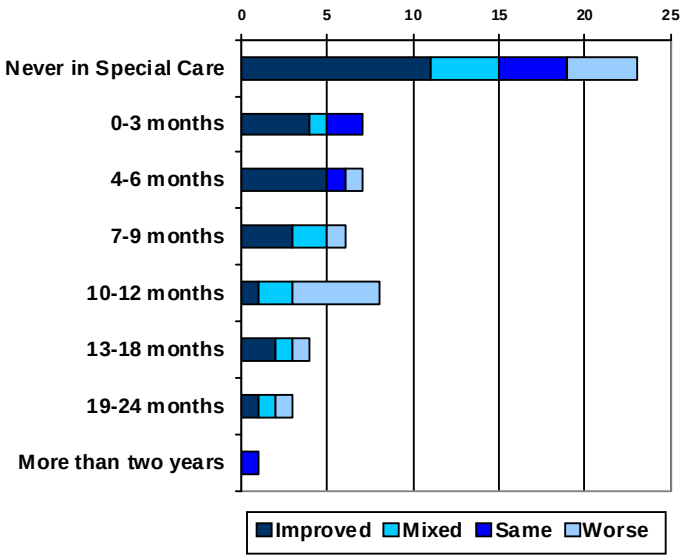
Table 49: Risk change overall x Total number of special care placements to November 2009

Number of Special Care Placements	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
4	2	1	1	0	0	100%	0%
3	5	0	3	0	2	60%	40%
2	9	1	2	0	6	33%	67%
1	20	14	1	4	1	75%	5%
None	23	11	4	4	4	65%	17%

147. However, placements in special care prior to 2007 did have an impact. Fourteen children had been placed in special care prior to 2007 and of these 43% (n=6) had risk factors that worsened, three of whom were admitted to special care in 2007 and three of whom were not.

148. Of the 36 children who experienced special care, 22 (61%) had been placed in special care for more than six months of their life by November 2009 (either in a single episode or several episodes).

Figure 7: Total Length of time spent in special care to November 2009 x Changes to risks



149. Children who spent up to nine months in special care up to November 2009 had better outcomes than those who had not spent time in special care. Those who spent 10–12 months of their life in special care were more likely to have worsened risks. However, those who spent more than 12 months in special care had similar changes to risk factors as those who never went into special care.

Table 50: Total length of time spent in special care to November 2009 x Changes to risks

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
None	23	11	4	4	4	65%	17%
Less than 6 months	14	9	1	3	1	71%	7%
7–9 months	6	3	2	0	1	83%	17%
10–12 months	8	1	2	0	5	38%	63%
More than 12 months	8	3	2	1	2	63%	25%

150. Of five children placed in special care as a result of their 2007 application for 12 months or more, 80% (n=4) did not have a discharge placement arranged at the time of the application. Social work departments said that they had experienced difficulties securing an onward placement for three of these.

151. Some of the social work interviewees also commented on the impact of special care on the children, sometimes expressing concern that children were becoming institutionalised, sometimes that the children learned the system quickly and understood what they needed to do to keep their placement in special care to as short a time as possible. Of the five children where there were concerns about the risk of them becoming institutionalised, four (80%) were deemed by social work interviewees to have risk factors that had worsened by November 2009. Of the five who were described as 'playing the system' by behaving well to speed up their discharge, only one had risk factors that worsened, for two risks improved, for one there were mixed fortunes, for one the risks stayed the same.

Placements after Special Care

152. It is both possible and useful to analyse placements for children on exit from special care by application rather than by individuals. The researcher was able to interview social workers about placements that followed special care for 31 of the 32 applications in 2007 that resulted in an admission to special care. For those applications, the onward placement matched that specified in the application for special care for only 32% of the applications (n=10). Another 16% (n=5) had the same placement type but a different placement (e.g. still placed in a mainstream residential unit but a different unit to the one specified in the application). However, 35% (n=11) had an onward placement that was not even the same placement type.

Table 51: For those admitted to special care, was the onward placement the same as that specified in the application form (applications rather than individuals)?

	No.	%
Same as in discharge plan	10	32%
Different place to discharge plan but same placement type	5	16%
Different placement type to discharge plan	11	35%
Unclear in discharge plan	5	16%
Total	**31**	

153. Risks seem to have improved most for those children whose onward placement was the most different to that specified in the application, although 38% of those who went to their planned discharge placement had overall outcomes that worsened.

Table 52: For those admitted to special care, was the onward placement the same as that specified in the application form (individuals) x Overall change to risks?

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Same as in discharge plan	8	4	1	0	3	63%	38%
Different place to discharge plan but same placement type	3	2	0	0	1	67%	33%
Different placement type to discharge plan	10	5	2	2	1	70%	10%
Unclear in discharge plan	5	3	2	0	0	100%	0%

154. Some 39% (n=12) of the onward placements were to mainstream residential care and 26% (n=8) to high support units. Seven went home or returned to foster care, and three went to single occupancy placements. Note that 43% of the applications (n=30 out of 70) had identified high support as the preferred onward placement (usually without securing that placement), so the actual proportion admitted to high support was considerably below this figure.

Table 53: For those admitted to special care, what was the placement type of the onward placement (applications rather than individuals)

	No.	%
At home	4	13%
Foster care	3	10%
Residential general (seven HSE, five private sector)	12	39%
Single occupancy placement	3	10%
High support unit	8	26%
Detention	1	3%
Total	**31**	

155. Numbers are too small to see patterns between onward placement type and changes in overall risks.

Table 54: For those admitted to special care, onward placement type x Overall change to risks[17]?

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
At home	4	2	0	2	0	50%	0%
Foster care	2	1	0	0	1	50%	50%
Single occupancy unit	2	1	1	0	0	100%	0%
Residential general	11	7	2	0	2	82%	18%
High support unit	6	2	2	0	2	67%	33%
Detention	1	1	0	0	0	100%	0%

156. Only 26% (n=8) of the individuals were perceived by social work interviewees to have settled into reduced risk behaviour soon after leaving special care; a further 19% (n=6) were perceived to have reverted to their risk taking behaviours for 2–3 months before settling and for another 6% (n=2) this risk-taking behaviour was perceived to have continued for a substantial period before settling. However, social work interviewees felt that 39% (n=12) immediately reverted to the same risk-taking behaviours and continued with this.

[17] Note that this table is by *individuals* rather than applications, hence the variation from the previous table.

Table 55: How soon did the children's risky behaviour begin to settle after leaving special care?

Settling	No.	%
Settled very quickly	8	26%
Reverted to risk taking behaviour then settled	6	19%
Risk taking behaviour continued for a substantial period before settling	2	6%
Stable for a long time then broke down	3	9%
Risk taking behaviour did not reduce or got worse	12	39%
Total	**31**	

157. Numbers are too small to draw any conclusions about the effectiveness of different types of placements for discharge but are shown in the table below. Note that only one child was discharged to the placement that they had been in prior to the application for special care, and that broke down very quickly.

Table 56: Placement type after special care x How soon did the children's risky behaviour begin to settle after leaving special care?

	Total	Stabilised	Reverted	% Stabilised	% Reverted
At home, foster care	7	3	4	43%	57%
Residential	12	7	5	58%	42%
High support units	8	3	5	38%	62%
Individual placement	3	2	1	67%	33%
Detention	1	1	0	100%	0%
Total	**31**	**16**	**15**	**52%**	**48%**

Placement in November 2009

158. Twenty-two of the individuals were adults by November 2009 and 37 were still children. Their placement type was as shown below.

Table 57: Current placement type (as of November 2009)

	Total	Adult	Child
At home	11	4	7
Independent living/ Semi-independent living/Supported lodgings	10	6	4
Foster care	3	0	3
Residential General - HSE	7	1	6
Residential General - private	7	2	5
High support unit	3	0	3
Special Care Unit	3	0	3
B&B	1	0	1
Crisis Intervention Services	1	0	1
Homeless	4	3	1
Detention	7	4	3
Adult, unknown	2	2	0
Total	**59**	**22**	**37**

159. This means that 46% (n=17 out of 37) of those who were still children in November 2009 were in some form of residential placement, while a further 38% (n=14) were either at home, in independent/semi-independent living or foster care. Only a marginal percentage more of those who were adults by November 2009 were either at home, in independent/semi-independent living or foster care (45%, n=10), but almost a third (32%) were either accessing homeless/crisis services (n=3) or were in detention (n=4) compared to 16% (n=6) of those who were children.

Table 58: Summary of current placement type (as of November 2009)

	Total	% of Adults (n=22)	% of Children (n=37)
At home; independent living/semi-independent/supported lodgings, foster care	24	45%	38%
Residential general, high support, special care	20	14%	46%
B&B, Crisis Intervention Service, homeless	6	14%	8%
Detention	7	18%	8%
Adult, unknown	2	9%	0%

Return Home at Any Stage

160. Some 49% of the individuals (n=29 out of 59) went home at some stage after the application for special care in 2007 (including those who went home as part of shared care arrangements with a residential unit). Perhaps surprisingly, there was little difference in terms of care status: ten of the 23 who were on a full care order returned home and 14 of the 26 who were in voluntary care. Nor was there any difference in gender.

161. Only for 34% (n=10) of those who returned home was this the preferred choice of the social work department. For 48% (n=14) the child simply refused to stay in any other placement, while for 14% (n=4) the child went home because the social work department was unable to find a residential placement that would accept the child (in total, social workers experienced difficulty securing an onward placement for almost a third of all children who were placed in special care [n=11]). This difficulty of accessing mainstream residential placements was a recurrent theme within the research, with some social workers feeling that units have too much power to block an admission or to end a placement.

162. Some 41% of those who returned home at some point after the application had risk factors that either worsened or stayed the same, compared to only 30% of those who never went home after the application.

Table 59: Risks change for each individual subject to a special care application in 2007 x Whether they went home at any stage after the application

	Total	% of those who returned home at some point after application (n=29)	% of those who never returned home (n=30)
Improved	27	45%	47%
Mixed	11	14%	23%
Same	8	17%	10%
Worsened	13	24%	20%

163. Although numbers are small, there is a marked difference in terms of the success of returning a child home as a planned outcome (60% stable, n=6 out of 10) compared to where the child refused to stay in any other placement (21%, n=3 out of 14).

Table 60: Success of placements where individuals went home

	Total	Too early	Stable	Still there but shaky	Broke down	% Stable	% Broke down
Planned outcome	10	0	6	0	4	60%	40%
Child would not stay in any other placement	14	0	3	3	8	21%	57%
Refused by residential units	4	0	2	0	2	50%	50%
Other reason	1	1	0	0	0	0%	0%

Other Case Characteristics

Offending Changes

164. Children who were not involved with the justice system at the time of the application were the most likely to have overall risk factors that improved or had mixed fortunes (79%, n=16).

Table 61: Risk change overall x Offending at the point of the application

Offending status when application was made	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened	% with this offending status at point of application who were admitted
Not currently involved with the justice system	28	16	6	2	4	79%	14%	58%
Garda investigation	9	3	2	2	2	56%	22%	36%
Ongoing proceedings	9	3	1	2	3	44%	33%	45%
Remanded in custody	13	5	2	2	4	54%	31%	27%

165. Not surprisingly, the history of detention of the child is closely related to social worker perceptions of whether risk factors overall had worsened. 80% of those who never experienced detention (n=24 out of 30) were felt to have had overall risk factors that improved or had mixed fortunes. Note that some 56% of individual males (n=15 out of 27) were detained at some point after the application compared to just 29% of individual females (n=6 out of 32). So males are struggling to access special care but are more likely than females to end up in juvenile criminal detention.

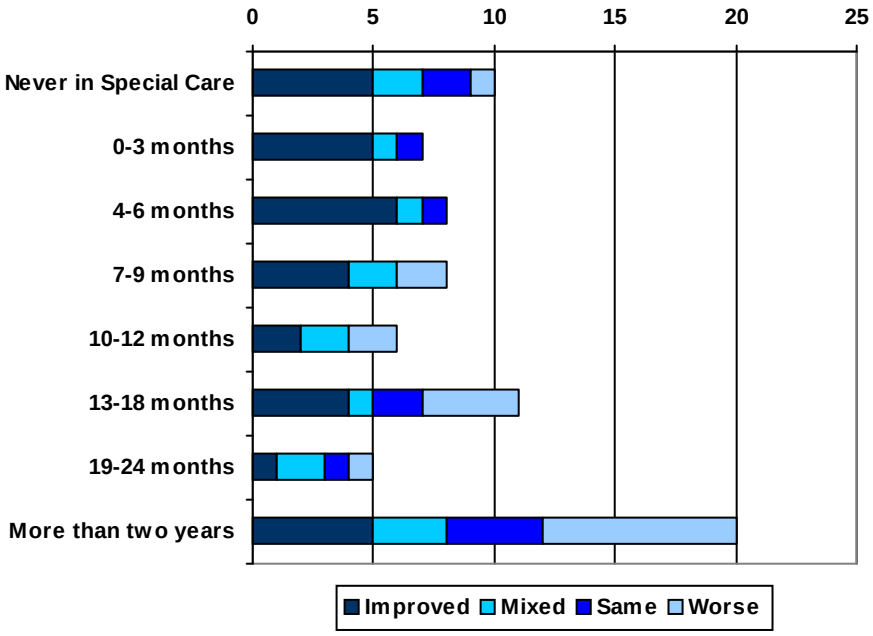
Table 62: Risks change overall x Detention history

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Never detained	30	18	6	2	4	80%	13%
Detained before application for special care, but not after	8	3	1	2	2	50%	25%
Detained after application for special care, but not before	9	3	2	2	2	56%	22%
Detained before and after application for special care	12	3	2	2	5	42%	42%

166. Four interviewees expressed concerns about lack of speed and co-ordination of the justice system with the welfare system. Three said that significant delays in dealing with outstanding charges for children led the children to fail to recognise the consequences of their actions. When the child was brought to trial, often the sentence was appealed and the child released the same day, again, according to interviewees, resulting in them not recognising any consequences for their actions. One interviewee commented that the lack of a multi-disciplinary approach for children in care who offend meant that there was too much buck-passing between justice services and the HSE, saying that detention centres were too ready to recommend special care for children remanded in custody, and fearing that the proposed changes in the Child Care (Amendment) Bill, 2009 might lead to an increase in the number of times that district courts might try to direct the HSE to make applications for special care.

167. Of the 59 individuals, 58% (n=34) had spent six months or more of their life detained in either special care or the justice system by November 2009. 42% (n=25) had spent more than 18 months detained. Only ten had never been detained in either special care or the justice system. As the care and justice systems are operating separately, this fuller picture of the care and custodial histories of children is not currently available on a routine basis to the partner agencies or strategic bodies, suggesting the need for more co-ordination in terms of strategic response.

Figure 8: Total Length of time spent in special care or detained in justice system to November 2009 x Changes to risks



168. Children who have had longer periods of their life detained in special care or juvenile criminal detention generally were regarded as having had poorer outcomes: again, however, this will be strongly influenced by social workers regarding juvenile criminal detention as a poor outcome.

Table 63: Total length of time spent detained in special care or the justice system to November 2009 x Changes to risks

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Never detained	10	5	2	2	1	70%	10%
Less than 6 months	15	11	2	2	0	87%	0%
7–9 months	8	4	2	0	2	75%	25%
10–12 months	6	2	2	0	2	67%	33%
More than 12 months	20	5	3	4	8	40%	40%

Education Changes

169. By November 2009, around 47% (n=28) of the individuals were engaged in education or training but 41% (n=24) were not. Seven were detained in the justice system and it was not known whether they were engaging in education or training programmes there.

Table 64: Current engagement in education, training and employment (as of November 2009)

	No.	%
Education	23	39%
Training	5	8%
Detained in justice system	7	12%
Not in education, training or employment	24	41%

170. Forty-six of the individuals had experienced significant school non-attendance in the 12 months prior to the application for special care. By November 2009, 46% of these individuals (n=21) were in training or education, 43% (n=20) were not, and 11% (n=5) were detained by the justice system. There is no relationship between school non-attendance and whether social workers believed that risk factors overall had improved. Clearly, however, there were gains in terms of engagement with education or training for many of the individuals.

Table 65: Risk change overall x Non-attendance at school in previous 12 months at the time of the application

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Problems of school non-attendance in 12 months prior to special care application	46	22	8	6	10	65%	22%
No problems of school non-attendance in 12 months prior to special care application	13	5	3	2	3	62%	23%

171. Significant concerns about education were also noted against the eligibility criteria for 'real and substantial risks to self' for 15 of these individuals and, again, 46% (n=7) were in either education or training by November 2009.

172. With regards to learning disability, 53% (n=18 out of 34[18]) of those with no learning disability were in training or employment compared to 40% (n=8 out of 20) of those with a learning

[18] For five individuals it was not clear whether or not they had a learning disability.

disability. 41% (n=14) with no learning disability were not in education or training, whereas this was the case for only 35% (n=7) of those with a learning disability. The major difference was in detention in the justice system, where only 6% (n=2) of those with no learning disability were detained, compared to 25% (n=5) of those with a learning disability. Although numbers are small, this pattern is reflected in risks changes overall: individuals with learning disabilities who end up detained in the justice system are more likely to be perceived to have had worse outcomes. Note that in interviews learning disabilities were never mentioned by social workers as contributing to poorer outcomes but juvenile criminal detention was; nevertheless, numerous studies over the years have identified that a disproportionate number of people in prison have learning disabilities.

Table 66: Risk change overall x Learning disability

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
No learning disability	34	16	6	6	6	65%	18%
Learning disability	20	9	3	2	6	60%	30%

173. Note that our understanding is that the HSE is currently working with the National Educational Welfare Board to develop joint working protocols.

Health Changes

174. With regards to substances, risk factors overall were as likely to worsen for those who had no history of substance abuse (33%, n=4 out of 12) as for solvents (33%, n=1 out of 3), prescription drugs (30%, n=3 out of 10), or heroin (29%, n=2 out of 7).

Table 67: Substances x Risk change overall

Substances	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened	% misusing this substance who were admitted
Cocaine (social work interviewees were sceptical about three of these)	10	6	4	0	0	100%	0%	50%
Mixture (social work department were never sure what)	4	4	0	0	0	100%	0%	50%
Amphetamines	2	2	0	0	0	100%	0%	0%
Other	1	0	1	0	0	100%	0%	0%
Ecstasy	12	6	4	1	1	83%	8%	60%
Aerosols	8	4	2	1	1	75%	13%	44%
Heroin	7	2	3	0	2	71%	29%	30%
Prescription Drugs	10	5	2	0	3	70%	30%	54%
Alcohol	**39**	**16**	**10**	**6**	**7**	**67%**	**18%**	**52%**
Cannabis	28	12	6	4	6	64%	21%	49%
No substances	*12*	*6*	*0*	*2*	*4*	*50%*	*33%*	33%
Solvents	3	1	0	1	1	33%	33%	67%

175. Some 57% (n=4 out of 7) of those who had misused heroin experienced homelessness some time after the application for special care, 67% (n=2 out of 3) of those who had misused solvents, and 50% (n=1 out of 2) of those who had misused amphetamines. This compares to only 32% (n=9 out of 28) who had misused cannabis and 26%(n=10 out of 39) of those who had misused alcohol.

176. Eight children in the study were diagnosed with ADHD. Five of these had risk factors that worsened (63%) and one stayed the same. None of these children had risk factors that

showed overall improvement, and only one had mixed fortunes. Numbers are small but nevertheless this is a distinct pattern.

177. In the 12 months prior to the application for special care, 42% (n=25) of the individuals had hospital admissions related to the risk factors identified in the application for special care. After the application and up until November 2009, 32% (n=19) had hospital admissions related to the risk factors, of whom just over half had not been admitted to hospital in the 12 months prior to the application. 41% (n=24) never had a hospital admission related to the risk factors. This may be imperfect, however, as this may be an area where social workers have less knowledge about hospital admissions where the individuals were no longer in care.

Table 68: Admission to hospital related to risk factors before and after the application for special care in 2007

	No.	%
No hospital admissions	24	41%
Prior hospital admissions related to risk factors, none since	16	27%
Hospital admissions related to risk factors before and since	9	15%
Only since application has there been hospital admissions linked to risk factors	10	17%

178. Some 63% (n=10 out of 16) of those who had had prior hospital admissions but were never admitted again were individuals who had been admitted to special care. But only 37% (n= 7 out of 19) of those with later hospital admission had been admitted to special care in 2007.

179. Hospital admissions appear to be linked to social worker perceptions in risk changes overall. Those with hospital admission before and after the application were perceived as having the worst outcomes, those with no hospital admissions or admissions only prior to the application, had the best outcomes.

Table 69: Risk change overall x Admission to hospital related to risk factors before and after the application for special care in 2007

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
No hospital admissions	24	11	5	4	4	67%	17%
Prior hospital admissions related to risk factors, none since	16	11	1	2	2	75%	13%
Hospital admissions related to risk factors before and since	9	3	1		5	44%	56%
Only since application has there been hospital admissions linked to risk factors	10	2	4	2	2	60%	20%

180. Eleven of the individuals (19%) had experienced bereavement of a close relative, seven before the application for special care and four since. 64% (n=7) of these individuals had risk factors overall that improved or had had mixed fortunes, and 27% (n=3) had worsened.

181. Ten of the individuals (17%, six adults, four children) were either parents or pregnant. Interviewees often saw this as having a positive effect, with 60% having overall risk factors that improved or had mixed fortunes, compared to 20% that worsened. Apart from two of the parents, no serious child protection concerns were expressed with regards to the children of these individuals although some of the pregnant females were undergoing an assessment of their potential for safe parenting. Others were regarded as not needing a formal assessment.

Protective Factors

182. Social work interviewees were asked to identify whether there were any protective factors or positive interventions that the child had experienced. Of the 38 individuals where the overall risk factors were felt to have improved or had mixed fortunes, 55% (n=21) identified protective factors that related to changes within the child, 42% (n=16) explicitly mentioned the impact of placements other than special care, 37% (n=14) identified good relationships in a number of settings and/or factors within the family/home environment. The impact of community resources, social work, psychiatry and psychology were much lower on this list.

Table 70: Protective factors x Overall risk changes

	Total[19]	Improved	Mixed	% (n=38)
Internal to the child	21	14	7	55%
Positive impact of non-special care placements	16	12	4	42%
Improvements in relationships	14	11	3	37%
Factors within the family/home environment	14	10	4	37%
Improvements linked to community resources	12	10	2	32%
Improvements linked to social work inputs	11	9	2	29%
Positive impact of special care	8	7	1	21%
Improvements linked to multi-agency working inputs	7	6	1	18%
Positive impact of boundaries and structures	6	4	2	16%
Improvements linked to other professionals	4	4	0	11%
Improvements linked to psychology inputs	3	3	0	8%
Deterrent effect of an experience in special care or juvenile justice system	3	2	1	8%
Improvements linked to psychiatry inputs	2	2	0	5%
Positive impact of the justice systems	1	1	0	3%
Separation from risky people and situations	1	1	0	3%

183. Of the 21 where factors were identified that were internal to the child, maturity was mentioned ten times (nine of these individuals were admitted to special care at some stage of their life), time for reflection nine times (seven of whom were admitted to special care at some stage in their life), and improved engagement six times. Other factors identified were the positive impact of a personal relationship, the positive impact of becoming a parent, improved self-esteem (especially linked to educational progress), and the child's own likeable personality. This does not mean that had those children would have 'matured' and 'reflected' as a natural process had they not been admitted to special care, given the chaos of their lives.

184. Of the 16 comments relating to the impact of placements, most related to staff within those placements establishing effective, constructive relationships with the child, although a couple also mentioned external training to enable staff to employ different strategies to handle

[19] Note: multiple options were possible so this does not add up to the 38 individuals

children. Changes in approach also took place for a couple of children where Asperger's Syndrome had been diagnosed in the period since the 2007 application for special care.

185. Of the 14 comments relating to the family, four related to good relations between the family and the social work department, one related to improved relations between the same parties, and in five it was noted that the extended family had become more involved. Only for three of these were factors identified that related to improvements in the parents' ability to parent, linked to increased toleration of challenging behaviour and a decline in parental substance/alcohol misuse. So where the family helped, they were either already positively engaged with the social work department, or extended family members became involved, rather than as a result of family therapy interventions. Again, with hindsight it would have been interesting to explore in more detail the services offered to families where the individual went home and their effectiveness or otherwise in supporting reintegration.

186. Although community resources were mentioned 12 times, there was no distinct pattern. Support from Extern was mentioned only four times, Youth Advocate Programme twice, child care leaders/workers five times, Youthreach three times. Add to this the fact that psychological support was only mentioned three times and psychiatry twice, and the use of and perceived effectiveness of community supports appears to be low.

187. The positive impact of social work support, particularly constructive relationships between child and social worker, is probably under-stated. These comments were more likely to be made where the social work team leader was being interviewed in praise of the efforts of their staff member: where the social worker alone was being interviewed, this was not usually mentioned.

Summary of Case Characteristics Present when Overall Risk Factors are believed to have Improved or had Mixed Fortunes

188. Some 46% (n=27) of children had overall risk factors that improved since the application and a further 19% (n=11) had risk factors that had mixed fortunes. Taking this as a baseline, we can compare what case characteristics had a higher success rate than this (the baseline comparator has been rounded up to 70% for simplicity).

Table 71: Overall risk factors worsened x case characteristics present

	70% or more of overall risk factors improved or had mixed fortunes where
Admission	Admission to special care (75%) Application was withdrawn (75%)
Gender	Female (72%)
Age	12–13 (80%)
Care status	■ Not in care when application was made (100%) ■ On an interim care order (80%) ■ In voluntary care (77%)
Real and substantial risks to self	Sexualised behaviour (70%)
Placement history	Known to HSE for less than two years (81%) Social work department still in contact (76%) Four or fewer previous care placements (88%) 20 or over previous care placements (100%) Residential care was highest 'degree' previous care placement (70%) Experienced special care at any time to November 2009: ■ once (75%) ■ four times (100%) By November 2009, they had spent 7–9 months of their life in special care (83%) or less than six months (71%) Onward placement was: ■ Different placement type to discharge plan (75%) ■ Unclear in discharge plan (100%)
Offending history	At the point of the application: ■ no current involvement with the justice system (79%). Never detained by the justice system (8%) Total time spent in special care or the justice system to November 2009: ■ less than six months (87%); ■ 7–9 months (75%); ■ never detained (70%).
Education	-
Health	Misuse of: ■ cocaine, mixture (social work department never sure what), amphetamines (all 100%); ■ ecstasy (83%); ■ aerosols (75%); ■ heroin (71%); ■ prescription drugs (70%). Prior hospital admissions related to risk factors, none since (75%) No hospital admission, prior or since application (67%) Experience of bereavement of someone close (27%)

Summary of Case Characteristics Present When Overall Risk Factors are Believed to have Worsened

189. Some 22%n=13 out of 59) of individuals were felt to have overall risk factors that worsened since the application was made. Again this can be used as a baseline to see which risk factors had a worse success rate (rounded up for simplicity to 25%). Case characteristics most likely to be present where overall risk factors worsened are shown below.

Table 72: Overall risk factors worsened x case characteristics present

	More than 25% of overall risk factors worsened where
Admission	Not admitted to special care (30%)
Gender	Male (26%)
Age	Age 16–17 (33%) Age 14 (30%)
Ethnicity	Irish Traveller (50%)
Care status	Full care order (38%)
HSE Areas making application	Dublin North East (27%)
Real and substantial risks to self	■ At risk from youth homelessness (56%) ■ Experience of homelessness prior to the application (54%) ■ Risk of, or engaging in, criminal activity (41%) ■ Special care to separate child from a known individual (38%) ■ Alcohol and substance misuse (31%)
New risks acquired since application	■ Aged 14 (60%) ■ Aged 16–17 (27%)
Placement history	Known to HSE for five years or more (32%); Child, case closed (75%); Adult, no contact with social work department (38%); 10–19 previous care placements (40%) Experienced special care at any time to November 2009 (25%): ■ twice (67%); ■ three times (40%). Had a previous placement in care prior to the 2007 application (43%) By November 2009, they had spent 10–12 months of their life in special care (63%) Concerns expressed that child becoming institutionalised (80%) Onward placement was: ■ same as in discharge plan (38%); ■ different place to discharge plan but same placement type (33%).

	More than 25% of overall risk factors worsened where
Offending history	At the point of the application: ■ subject to ongoing proceedings (33%); ■ remanded in custody (31%). Detained before and after the application for special care (42%) Total time spent in special care or the justice system to November 2009: ■ more than 12 months (40%); ■ 10–12 months (33%) .
Education	Low/mild/borderline learning disability (30%)
Health	ADHD (63%) Misuse of: ■ solvents (33%); ■ no substance misuse issues (33%); ■ prescription drugs (30%); ■ heroin (29%). Hospital admissions related to risk factors before and since (56%) Experience of bereavement of someone close (27%)

INTERVIEWEE VIEWS ON THE IMPACT OF SPECIAL CARE

Children and Parents/Carers' Views

190. Five children[20] were interviewed as part of this review, and four parents/carers. An appropriate adult was present for all the face-to-face interviews with children and it was stressed by the interviewer that the researcher was independent of the HSE. All of the children were female and all had experienced special care in either Ballydowd or Gleann Alainn or both. None had experience of Coovagh House. Note that it was not within the remit of this report to explore in detail the differences in the models being applied within the three special care units. It is worth noting that both Gleann Alainn and Coovagh House had smaller numbers at the time than Ballydowd (capacity in 2007: Ballydowd 15, Gleann Alainn five, Coovagh House five although as Coovagh House had reopened in early 2007 it never exceeded a capacity of three). Note also that Gleann Alainn was a female only unit whereas the other three units were mixed. Also, clearly the number of interviewees was small.

191. All of the interviewees felt that they did not have any real prior understanding of what special care was. Several of the parents/carers said that they were quite shocked by the physical appearance of the units, saying that, even though it was explained to them beforehand, the units were more prison-like than they had expected. One of the parents/carers nevertheless said that it 'was meant to be that way', and two of the parents/carers said that the sheer deterrent effect had helped to change their child's behaviour because the child did not want to be sent back there. One said that their child's behaviour had not been as bad as some of the other children in the unit and that in itself 'was an eye-opener' and scary for the child. Two of the parents/carers noted that it can be demanding on parents to travel across the country to visit their child.

192. The harsh physical appearance and in particular the hardness of the beds was noted by a couple of the children. Two also commented on the fact that they were restricted from having mobile phones, smoking, and who they could contact: this was a major complaint from one although the other said that she understood that the rules 'are there for a reason'. The moment of arrival can also be difficult: 'When you first arrive, they go through your stuff, it's scary, like going to jail. They take away anything you can harm yourself with, even deodorant'.

[20] For simplicity, the individuals who were placed in special care are referred to as children in this section, even though some were adults at the time of the interview.

193. The children had mixed views of the impact of special care. One said that she was very annoyed at the time but has since realised that it gave her time to think about what she wanted: she 'couldn't go out, couldn't be influenced by certain people, had lots of time to think about things.' She also recognised that she 'grew up in there. It didn't happen overnight but it did eventually.' One said that she had never taken drugs since and that the unit 'could not have helped more' and that such units are definitely needed, that it had made a difference to her. Another felt that it had not helped and had deprived her of part of her childhood, saying that it does not work and it 'made lots of kids cut themselves'. Another, who also felt that it did not work, said that she thought she should have been in special care earlier, but in Gleann Alainn rather than Ballydowd.

194. Some of the children who had experienced both Gleann Alainn and Ballydowd expressed a preference for Gleann Alainn. One said that Gleann Alainn was 'brilliant' and that she 'would recommend it', finding it very helpful, 'with a good structure and a good school'. She said that 'staff are there for the kids, you get your own person, have time to sit down and talk, everything I needed in a safe way' whereas Ballydowd 'was more of a jail, it felt like punishment', the staff were 'less nice' and 'made me not want to change.' The child who felt that she may have benefited from being in Gleann Alainn at a younger age said that there was a huge difference between the two units, with the staff being 'more respectful in Gleann Alainn', saying that 'if you show respect, you get respect.' She said: 'I can't stress enough, it's about how you manage the young person' saying that children are much happier in Gleann Alainn and are less trouble as a result. Two of the children noted that they were restrained on a regular basis in Ballydowd whereas it had almost never happened to them in Gleann Alainn. She said: 'They get it totally wrong in Ballydowd'. Note that none of these children were asked specific questions about the different sizes of the unit or the fact that one was a mixed gender unit and one was female only: these would be interesting questions to ask in the future if there is further research into the views of children who have experienced special care.

195. Nevertheless, most of the children and their parents/carers, were positive about most of the staff in both Gleann Alainn and Ballydowd, saying they were 'nice' or even for Ballydowd 'priceless'. There were some exceptions, particularly staff seen as too keen to use restraints or described in very derogatory terms. Two of the children were still in touch with staff at the units and one said that she would like to go back to see them.

196. Views on the services received while in special care were mixed. One child found the one-to-one sessions and the groupwork around the dangers of drugs and alcohol very useful. One noted that the activities provided were quite boring but the time to think was useful. One said that the keyworker sessions were pointless, 'you knew what they were going to say anyway

about drugs, sex and pregnancy' and commented also that further admissions to special care were also pointless, 'if it didn't work first time, they are just doing it to scare you.' One parent felt that 'everything was put on hold' while their child was in special care, saying that 'the psychiatrist just wrote a prescription', there was no psychologist, bereavement counselling or anger management. She also said that having a child in special care does not lead to quicker access to support services, the child is 'in the queue with everyone else'.

197. One of the children noted the impact of not having an onward placement. She said that 'you can only work towards things for so long, then it becomes frustrating if you don't know where you are going next.' In other words, failure to secure an onward placement in a timely manner can undermine any good work done in the special care placement. Two children said that when they left special care, the immediate impact of that level of containment was, as one put it, that 'you have been so sheltered from everything, you just want to run amok'. Two of the parents/carers and one of the children felt that there were inadequate supports in place where the child was discharged to home. The child said: 'There was no support for me and me mam', while one of the parents/carers said that 'adolescent services are a sham' and she did not feel that the HSE and partner agencies helped enough, particularly with housing difficulties. One of the parents/carers felt it had been a mistake to discharge their child to a mainstream residential unit, as their child subsequently did better in a high support unit and the parent felt that was where she should have been discharged to in the first place.

198. When asked what they would change, the children who expressed a view clearly felt that the Gleann Alainn way of working was better than the Ballydowd one. Use of restraints in Ballydowd was a particular issue. One of the children also felt that mixing children from Dublin and other areas led to some tension, feeling that country children could get picked on and 'you have to act older than you are' so she would change that. One of the parents/carers felt that 'if residential care had been more structured and they had been able to prevent [her child] from absconding' that child would not have needed special care. One of the parents/carers felt that the units should have somewhere close by that parents who have to travel a long way can stay at overnight. One parent/carer felt that, while acknowledging there had been some benefits, the system became the enemy, that the ethos was to teach the children a lesson, that they were 'just there till they were not a nuisance to people, or people can handle them at home, or they turn 18' although the child herself thought that special care had helped her.

Views of Guardians *ad Litem* and Solicitors

199. SIS met with two groups of guardians *ad litem* and solicitors in Dublin and Cork, arranged by the local guardian *ad litem* service, to ask about their views on special care. A number of

independent guardians *ad litem* and guardians *ad litem* employed by Barnardos were invited to participate. Eight guardians *ad litem* and three solicitors participated.

Decision Making

200. There was concern amongst both groups about a perceived lack of transparency and accountability in the decision making of the NSCADC. Several participants in both groups said that they did not know officially who the members of the NSCADC were or whether its decisions were unanimous[21]. One person said: 'social workers want one thing, and another branch of the organisation sits in secret and is not subject of review or appeal unless the case gets to the High Court.' They felt that social workers did not feel able to appeal properly and noted that at this stage of the process (i.e. prior to the case going to court) solicitors and guardians *ad litem* would not often be appointed. Some also felt that, where the CAAB's views supported the application, this gave the applicant 'false hope', given that the NSCADC views were the significant ones in terms of deciding which cases the HSE should take to the High Court (note that no comments were made about lack of knowledge of the membership of CAAB Panels but, as already established earlier in this research, the CAAB was more likely than the NSCADC to support the application). One person said that 'some social work departments try to get guardians *ad litem* appointed in a district court to help in a judicial review'. A solicitor said that both the social work department and the special care units are represented in the High Court by the same legal team on behalf of the HSE, and the perception was that, where the social work department and the special care unit have differing views about whether special care was appropriate, the view of the special care unit tended to take precedence[22].

201. Linked to this were the issues of when guardians *ad litem* are appointed to the cases, and by whom. Within both groups, the perception was that, as the HSE currently decides when to go to the High Court and pays for the guardians *ad litem*, there was little opportunity to challenge the application prior to this point. As a result, there was some concern that some children who may require special care were being filtered out by the NSCADC before the application reached the High Court. Some even stated that the HSE appoints guardians *ad litem* rather than the Court. Similarly, there was also a perception that sometimes guardians *ad litem* were discharged too early, again implying that this was a decision of the HSE rather than the Court.

[21] Response from the NSCADC on this point: 'Membership of the Committee was included in the original road show by status and name and in subsequent reports by status i.e. the three Managers of the special care units and the Chairs of the former individual Units Admissions and Discharges Committees and the Independent Chair. The Independent Chair and his contact details are also known as all applications and queries are addressed to him and responses made by him. He also made several appearances in the High Court. The criteria for the Appropriate Use of Special Care is also in the public domain as are the application forms'.
[22] Note, however, that every application that went to the High Court in 2007 was admitted to special care.

Thus there appears to be some confusion about who appoints and discharges guardians *ad litem*[23].

202. The clarifications with regards to ongoing criminal proceedings in the Child Care (Amendment) Bill, 2009 were welcomed in both groups. One person noted that when special care was originally conceived, the types of cases that were of concern were of usually younger males who were involved in petty crimes and homeless.

203. One group raised concerns about the requirement to consider a family welfare conference within the special care application process, saying that the delays that were involved could cause problems and that, in general, social work departments had exhausted all other options by the time they applied for special care.

Interventions in Special Care

204. Perhaps surprisingly, while most social work interviewees registered concerns about depriving a child of their liberty, this phrase was not used in either of the guardian *ad litem*/solicitor consultation groups. Both, however, questioned the three month time limit, some saying that very little could be achieved in that time period, some that shorter periods may at times be more beneficial, according to the needs of the child.

205. The nature of interventions provided within the special care units came up in both groups. Both noted that none of the special care units had dedicated psychiatric and psychological support and felt that these were necessary. While it was understood that the major intervention provided was via the relationships formed between keyworkers and the child, there were concerns about the lack of definition of therapeutic processes and, on occasion, the lack of transparency in feedback from the special care units to guardians *ad litem* and the child's solicitor. One person said that 'lack of resources was used as an excuse for bad practice'. Nevertheless, numerous examples were given from both groups about positive outcomes from special care, although one group unanimously felt that Ballydowd provided little more than containment. The National Assessment and Remand Service at Finglas (within the justice system) was felt to have access to better resources by some.

Discharge from Special Care

206. Comments were also made on the perception that the three units operated separately both from each other and from the country's high support units. One group noted systems in other

[23] Note that the current application form does not ask applicants to state whether there is already a *guardian ad litem* appointed to the child (e.g. if there are juvenile justice proceedings before a district court) and it may be useful to amend to it ensure that this information is recorded.

countries, often provided by the private sector, where provision of special care and high support on the same site allowed a child to move between the two according to changes in behaviour, achieving both flexibility and continuity of staff between the different units. When asked if this was an argument for further developing the private sector market in Ireland, views were mixed.

Community Resources

207. A person in one group noted that there was no imperative for partner agencies to link in at local level. The difficulty of accessing child psychiatric services, especially where the child was aged 16 or over, was particularly noted.

Social Work Department Views

Impact of Special Care

208. Twenty-eight of the 59 children were admitted to special care as a result of a 2007 application. For only 54% (n=15 out of 28) of these admissions did the HSE social work department believe that special care had had a positive impact, while for an additional 21% (n=6) it was only believed to have provided a place of safety (although often safety was all that the social work department wanted and expected). For two cases, the admission was believed to have come too late or the child was believed to have 'played the system' by feigning engagement in order to be discharged as soon as possible. For 18% (n=5), special care was believed to have had a negative effect. However, for these five, two of the social work departments nevertheless believed special care to be an effective model overall, two felt that it needed reshaping and only one thought it was ineffective (more will be said on views of the model of special care later).

Table 73: Impact of 2007 admission to special care on the child (HSE social work department views)

	Number	%
Positive impact	15	54%
Safety only	6	21%
No impact: too late or played the system	2	7%
Negative impact	5	18%
Total	**28**	

209. Overall risk factors were felt to have improved or had mixed fortunes for all 15 of the children where the social work department felt that special care had had a positive impact. Only 46%

(n=6 out of 13) of the children for whom special care had not been a positive experience still had risk factors that improved or had had mixed fortunes. This suggests that, where it works, special care can contribute significantly to reducing risks, but, as might be expected of an option of last resort, it may not be successful for all children.

Table 74: Impact of 2007 admission to special care on the child (HSE social work department views) x Overall changes in risks

	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Positive impact	15	12	3	0	0	100%	0%
Safety only	6	1	2	1	2	50%	33%
No impact: too late or played the system	2	0	0	0	2	0%	100%
Negative impact	5	2	1	1	1	60%	20%
Total	**28**	**15**	**6**	**2**	**5**	**75%**	**18%**

210. Some 56% (n=33 out of 59) of the individuals had been admitted to special care at some stage in their life up to November 2009. Those who had been admitted to Gleann Alainn during that period had a higher likelihood of having overall risk factors that improved or had mixed fortunes (77%, n=10 out of 13), while there was comparability on the same measure for Ballydowd (61%, n=14 out of 23), Coovagh House (63%, n=5 out of 8) and no admission ever to special care (63%, n=15 out of 24). 30% (n=7) of those who had ever been admitted to Ballydowd had overall risk factors that worsened compared to 25% for Coovagh House (n=2) and 23% for Gleann Alainn (n=3).

Table 75: Overall changes in risks x special care units that the child was ever admitted to in their life up to November 2009

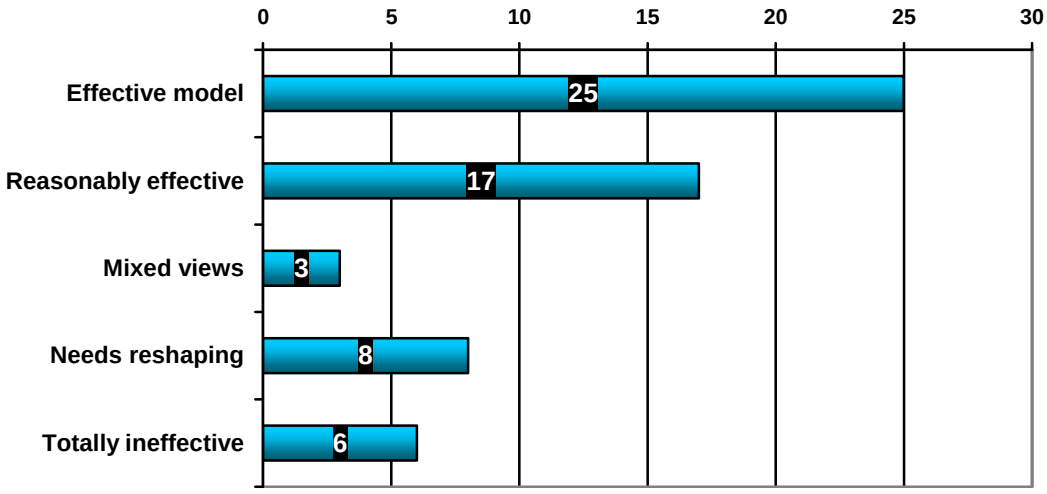
	Total	Improved	Mixed	Same	Worsened	% Improved or Mixed	% Worsened
Ballydowd, Gleann Alainn and Coovagh House	2	1	0	0	1		
Ballydowd only	18	6	4	2	6		
Ballydowd and Gleann Alainn	3	2	1	0	0		
Gleann Alainn only	6	4	1	0	1		
Coovagh House and Gleann Alainn	2	0	1	0	1		
Coovagh House only	4	3	0	1	0		
Ever in Ballydowd	23	9	5	2	7	61%	30%
Ever in Gleann Alainn	13	7	3	0	3	77%	23%
Ever in Coovagh House	8	4	1	1	2	63%	25%
Never admitted to special care	24	11	4	5	4	63%	17%
Total	**59**	**27**	**11**	**8**	**13**	**64%**	**22%**

Special Care Overall

211. Social work interviewees were asked for their views on the model of special care in Ireland, given the needs and risks of the individual child being considered, and invited to comment on this with the overall context i.e. the adequacy and accessibility of mainstream options and community options.

212. Some 42% (n=25) of the 59 interviewees who responded to this question felt that special care was an effective model and 29% (n=17) felt that it was reasonably effective. Three had mixed views and 24% felt that it either needed reshaping significantly (n=8) or was totally ineffective (n=6).

Figure 9: Model and context of special care overall



213. Those interviewees who felt that their child's risks overall had improved were the least likely to say that the overall model needed reshaping (15%, n=4 out of 27), while those who felt that their child's risks overall had worsened were the least satisfied with the model overall. Even for the latter group, however, 62% (n=8 out of 13) felt that special care was an effective or reasonably effective model compared to the 38% (n=5 out of 8) who felt that it needed significantly reshaping or was totally ineffective.

Table 76: Model and context of special care overall x Overall changes in risks

Overall change in risks	Total	Effective model	Reasonably effective model	Mixed views	Needs reshaping	Ineffective model	% saying effective or reasonably effective	% saying needs reshaping significantly or totally ineffective
Improved	28	15	6	2	4	0	78%	15%
Mixed	11	3	4	1	0	3	64%	27%
Same	8	3	3	0	1	1	75%	25%
Worsened	13	4	4	0	3	2	62%	38%

214. Social workers who had had their child placed in Gleann Alainn were the most likely to think that the model of special care in Ireland was effective. Those whose child had been placed in Coovagh House were the least likely to think this (Coovagh House re-opened afresh in 2007). Only 58% (n=14 out of 24) of those whose child was not admitted to special care thought that the model was effective or reasonably effective (many of whom would have had other children who had been admitted before or since).

Table 77: Model and context of special care overall x special care unit that the child was ever placed in up until November 2009

	Total	Effective model	Reasonably Effective model	Mixed views	Needs reshaping	Ineffective model	% saying effective or reasonably effective	% saying needs reshaping significantly or totally ineffective
Ballydowd, Gleann Alainn, Coovagh House	2	1	0	0	1	0		
Ballydowd only	18	9	5	0	2	2		
Ballydowd and Gleann Alainn	3	2	1	0	0	0		
Gleann Alainn only	6	4	2	0	0	0		
Coovagh House and Gleann Alainn	2	1	0	0	0	1		
Coovagh House only	4	1	1	0	2	0		
Ever in Ballydowd	23	12	6	0	3	2	78%	22%
Ever in Gleann Alainn	13	8	3	0	1	1	85%	15%
Ever in Coovagh House	8	3	1	0	3	1	50%	50%
Never admitted to special care	24	6	8	3	3	3	58%	25%
Total	**59**	**23**	**18**	**3**	**8**	**6**	**69%**	**24%**

215. When asked to elaborate on reasons for their views on the model and context of special care, 76% (n=45 out of 59) made comments relating to interventions, 41% (n=24) talked about options in the community, 29% (n=17) talked about issues relating to accessing special care,

the same percentage talked about discharge arrangements from special care, and 22% (n=13) mentioned others aspects of special care. These will be discussed below

Table 78: Range of comments on effectiveness of special care x Model and context of special care overall

	Total	Effective model	Reasonably Effective model	Mixed views	Needs reshaping	Ineffective model	% saying effective or reasonably effective who commented on this	% saying needs reshaping significantly or totally ineffective who commented on this
ACCESSING SPECIAL CARE	**17**	**6**	**5**	**0**	**4**	**2**	**19%**	**10%**
Justice system	10	3	4	0	3	0	12%	5%
Age	6	3	1	0	1	1	7%	3%
Admission	4	0	0	0	2	2	0%	7%
INTERVENTIONS	**45**	**19**	**12**	**2**	**6**	**6**	**53%**	**20%**
Impact	26	14	7	1	0	4	36%	7%
Therapies	19	5	6	0	3	5	19%	14%
Length of time	13	5	3	1	3	1	14%	7%
Engagement	8	7	1	0	0	0	14%	0%
OTHER ASPECTS OF SPECIAL CARE	**13**	**6**	**3**	**0**	**3**	**1**	**15%**	**7%**
Communication	5	1	2	0	2	0	5%	3%
Physical	3	2	0	0	1	0	3%	2%
Security	3	2	0	0	0	1	3%	2%
Distance	2	2	0	0	0	0	3%	0%
DISCHARGE	**17**	**5**	**3**	**0**	**6**	**3**	**14%**	**15%**
Step-down	11	3	3	0	3	2	10%	8%
Discharge	7	3	0	0	2	2	5%	7%
Follow-up	5	0	0	0	3	2	0%	8%
COMMUNITY OPTIONS	**24**	**7**	**7**	**2**	**5**	**3**	**24%**	**14%**
Options	17	5	5	2	3	2	17%	8%
CAMHS	4	0	3	1	0	0	5%	0%
CIS	3	2	0	0	1	0	3%	2%

216. Seventeen interviewees raised issues around difficulty accessing special care.

- Ten mentioned issues in relation to the justice system. However, only three of these expressed dissatisfaction about ongoing criminal proceedings being used as a reason for a child to be denied access to special care. Most (n=8, of whom 7 felt the overall model

and context to be effective or reasonably effective) expressed a concern either that their child had been in juvenile criminal detention prior to the application or ended up there, when they felt that special care would have better met that child's needs. Note that we have also reported general comments about the perceived slow speed of the justice system in the section on 'offending changes'.

- Six felt that special care should be employed earlier in a child's life for it to be effective. The current criteria include a requirement for the child to be aged 11–17 and some interviewees felt that special care should be at earlier ages or that there should be a separate unit for younger children. The issues, maturity and expectations of a 12 year-old are likely to be very different from a 17 year-old.
- Four (all of whom were dissatisfied with the current model and context) felt that the application of the criteria for special care was too stringent, making it too hard to access special care. Two of these also felt that females were easier to get in than males, even when they had the same risk profiles: this concern appears to be borne out by this research.

217. Forty-five interviewees made comments on the interventions available in special care.

- Twenty-one made favourable comments on the impact of special care, of whom 17 felt that it achieved a purpose of meeting a primary aim of meeting an emergency, containment, or stabilisation. Four of these interviewees also noted that, as an option of last resort, special care might not always be successful where problems are too entrenched.
- Four made negative comments on the impact of special care. All four expressed concern that all that special care achieved was to meet an emergency, contain or stabilise a situation. They wanted special care to deliver more.
- Nineteen made comments on the 'therapies' available in special care, with 13 saying that they felt that there were 'insufficient therapeutic interventions' provided. When asked by the researcher to elaborate, most stated that they meant psychiatric and psychological interventions. In 2007 Ballydowd had psychiatric support, Gleann Alainn and Coovagh House had psychological support, but none had both.
- Thirteen commented on the length of time that children can be placed in special care. Seven felt that three months was too short as a general rule, and another three commented that it might be too short. All of these interviewees were concerned that it could take time to settle the child in a special care unit and that by the time this was achieved the child may be close to the end of their three months. Some interviewees from special care units also expressed this concern.
- Eight noted the potential for special care units to engage a child who was otherwise not engaging. Many of the children will not engage with community services and the fact that

they are contained helps to encourage engagement. Three interviewees noted that some children are actually unable to engage outside special care because of the whirlwind of the chaos in their lives and actually welcome the chance to be contained. All of the interviewees who commented on engagement had a positive view of special care. 60% of those for whom concerns were expressed about their failure to engage with services (n=21 out of 35) against the criterion for 'real and substantial risks to self' were felt to have had improved or mixed fortunes with regards to this risk. Special care does seem to impact in this regard: 63% (n=12 out of 19) of those whose 2007 application was successful had an improvement in this risk factor compared to 56% of those who were not admitted or the application was withdrawn (n=9 out of 16).

218. Thirteen interviewees made comments on what we have termed 'other aspects of special care'.

- Five were unhappy with communication/liaison between the special care unit and the social work department, of whom two stated that they felt that the special care unit had taken action contrary to provisions in the care plan. In both these cases, the social work department also felt that the communication breakdown had had a negative impact on relations between the social work department and the child, irretrievably so for one child. These last two examples related to two different special care units. On the other hand, this means that communication/liaison was effective for 23 of the 28 individuals admitted to special care (82%).
- Three interviewees made negative comments about the physical appearance and condition of two of the special care units.
- There were three concerns about the opportunity for absconsions from special care.
- Two comments were made about the difficulties posed where the social work department was a long distance from the special care unit.

219. Seventeen interviewees made comments relating to discharge from special care.

- Eleven felt the model in Ireland places too little emphasis on a managed step-down process. Seven wished to see a model that provided for continuity of care staff between the special care units and the step-down placement, either through having an on-site/nearby step-down unit or linked step-down units. Several had sourced these types of arrangements abroad. They commented on the separate historical development and line management of high support units and special care units as being a missed opportunity. They felt that the provision of a step-down unit on the same site would enable a child to move in and out of special care over the three month period of their order as needs and responsiveness changed. Six also commented on the difficulty of accessing high support units as step-down placements and a perception that high support units do not differ sufficiently in terms of skills and capabilities from mainstream residential units.

- Seven felt that too much emphasis was placed on discharging the child before the social work department was ready. Four of these interviewees were dissatisfied with the model and context for special care. Earlier in this report we noted that difficulties were experienced by social work departments in sourcing onward placements for 13 of the children admitted to special care.
- Five felt that the special care units should provide a follow-up/discharge service, all of whom were dissatisfied with the model and context for special care.

220. Twenty-four made comments relating to options within the community.

- Three said that more family therapy services might be more productive than special care, particularly to support the child when they return home.
- Two felt that more specialist foster carers or enhanced support to foster carers would be beneficial.
- Four commented on deficiencies in mainstream residential care, primarily in terms of levels of training to deal with challenging children. One said that residential units often want to take in the type of children that should really be in foster care. There were numerous comments from social workers about individual high support units or mainstream residential units having too much power to decide whether a child was able to access a place at their unit; again, this relates directly to the number of social work departments who experienced difficulties in finding an onward placement for the child.
- Four said that there can be difficulties accessing child and adolescent mental health services on a speedy basis. In addition, they noted a gap in service provision for 16–17 year-olds with mental health needs, as CAMHS in many areas of the country were reported to be reluctant to take on a child with emergent mental health needs at that age while adult services were equally reluctant.
- Three Dublin-based interviewees expressed concerns about placing children in Dublin's crisis interventions service, feeling that the problems of the child may be further worsened through meeting with children who may have more acute problems of substance misuse and homelessness.
- Four explicitly preferred placement abroad to special care in Ireland but were required to try an application to special care first (two of these children were subsequently placed abroad).
- One mentioned the absence of in-house drug treatment, one the absence of psychological assessment/treatment units, one the absence of long-term therapeutic units.

- Another noted that had there been an emergency/short-term respite unit available locally, then the application would probably not have been made (such provision had become available by the time this report was being written).

Special Care Unit Views

221. Interviewees in the special care units identified issues relating to 15 of the individual cases within the cohort (not just from the 28 individuals who were admitted to special care in 2007, but also some who had been admitted earlier but refused in 2007 or who were admitted after 2008).

222. For six of the children, interviewees from the special care units noted problems in communication/liaison, largely corresponding to social work departments' views of the same. For three of these, the social work department had expressed dissatisfaction with the model and context for special care.

223. Other issues included:

- important gaps in the information provided by the social work department (n=3);
- concerns about the failure of social work departments to address adequately cultural issues for Irish Travellers (n=3);
- a concern that the social work department expected the special care unit to 'fix' the child (n=2);
- concerns that high support or mainstream units to whom the child was discharged failed to build on the progress made (n=3);
- extension of placements solely because the social work department had failed to secure an onward placement, particularly where senior management locally were not felt to be giving sufficient priority to the child's case (n=2);
- placement in special care not being deemed appropriate (n=2);
- for five children, a sense that the children themselves did not want to leave special care because they felt safe there.

224. One of the interviewees from the special care units felt that the application process had been improved and information was generally robust, but that where there were weaknesses it was in defining strengths and resilience or what the placement was intended to achieve. Another said that information on substances and criminal charges in particular were often not stated adequately in the application form and supporting documents. One said that it would always be difficult to know the extent of involvement in drugs, the social work department may have suspicions and know the child is in the company of known drug dealers but not the extent of the problem. Two interviewees expressed a view that, as one put it, 'you can never get

everything you need from the application form, you have to meet the child', especially around issues such as substance misuse, self-harm or suicidal ideation, noting also that children's behaviour changes in different environments. One interviewee also felt that female sexualised behaviour with older males was sometimes exaggerated, and that suicidal tendencies and self-harm were terms that 'set off alarm bells at the NSCADC' whereas sometimes the reality was less worrying.

225. One interviewee felt that there was little chance of instituting change for a child after the age of 15 and that sometimes for older children it was like 'flogging a dead horse'. The same interviewee thought that children should be considered for special care at a much younger age, possibly even nine or ten. Another said that they suspected that more children should be in special care than actually were.

226. Several interviewees said that positive relationships and opportunity for one-to-one discussions were the most important interventions that special care units can provide. Some also noted that it can take a few weeks for the child to become settled enough in the special care unit for constructive work to be undertaken with them.

227. One interviewee from the special care unit commented that principal social workers were not sufficiently involved when children were in special care, feeling that they could have a positive impact when involved, both in terms of professional knowledge and in securing appropriate placements and resources for discharge. One interviewee said that it was important to have good relations with the child's social work department as poor liaison/communication might replicate conflicts at home.

228. Two interviewees felt that the special care units should have on-site social workers (Ballydowd has one although their role is different to the child's allocated community social worker). One said that they felt that this would assist in identifying onward placements (although this seems to contradict the view that it is essential to have local PSWs involved to secure local resources). Another stated that '80% of them hardly know their social worker when they come here', attributing this to high workloads for community-based social workers.

229. Most of the interviewees from the special care units said that social work departments were weak in terms of securing onward placements. One said that they had no problem with the planned onward placement changing but regarded it as a necessity that such a placement was identified in the application. Another said social workers just put a name down for the onward placement in the application without securing it. The same interviewee said that the onward placement was meant to link in during the transition process but estimated that only

50% did so. Another interviewee described it as a ‘disgrace’ that some children could be in special care for weeks without knowing where they were going, saying that the child’s behaviour can ‘regress’ as a result, emphasising that ‘it is all about relationships and attachments.’

KEY FINDINGS

230. The terms of reference for this work posed five broad questions:

1. What was the profile of applicants to special care?
2. What was the previous service/intervention history of applicants (e.g. social care, educational, juvenile justice)?
3. What services/interventions have been provided since each special care application was made?
4. Where did the children go to and where are they now?
5. What are the views of stakeholders on benefits and services/interventions?

231. The main body of the report is structured into several chapters that address these issues, as outlined in detail in the methodology section:

- The characteristics of cases subject to an application for special care. This chapter of the report addresses questions 1 and 2 above.
- The application process. This is relevant to question 2 on the previous services and interventions.
- Outcomes by November 2009. This chapter addresses questions 3, 4 and 5 above.
- Interviewee views on the impact of special care. This chapter addresses question 5 above in particular.

232. Within this current chapter, findings have been brought together under key emergent themes rather than the strict order of the questions above. So, for example, when considering age, this enables commentary to be provided in one place on demographic profile, differences in terms of admissions or risk profiles, and perceived outcomes by November 2009.

233. With regards to numbers, it is important to note that, because there were 70 applications and 59 individuals[24], the former is generally used for process issues (i.e. profile of applications and whether or not they led to an admission to special care) whereas the latter is generally used to trace and track where individuals were by November 2009. The relatively small number of cases prevents meaningful statistical analyses being performed for most of the emergent data, but the patterns that are present are nevertheless interesting and hopefully informative. Special care, as an option of last resort, will always involve small numbers. As a result, some of the recommendations in the next chapter of this report are deliberately written

[24] There were actually 61 children in total but two have been excluded from the tracing and tracking exercise, with the agreement of the commissioners, for a variety of reasons that will not be recorded in this report in order to preserve anonymity.

with an element of caution, highlighting emergent issues that need to be considered rather than stating them to be definitive positions.

Applications, Admissions, Outcomes

234. In 2007, there were 70 applications for special care in Ireland, for 61 children. 46% (n=32) of the applications led to an admission to special care, 41% (n=29) were refused admission and not admitted, and 13% (n=9) were withdrawn.

235. By November 2009, 46% of individuals (n=27 out of 59) who had been subject to an application had overall risk factors that were perceived by social workers to have improved, 19% (n=11) had mixed fortunes (some risks improved, some stayed the same or worsened), 14% (n=8) had the same level of overall risk, and 22% (n=13) had worsened. For both those who were admitted to special care and those application was withdrawn, 75% had those overall risk factors that improved or had mixed fortunes, while only 48% of those who were not admitted had improved or mixed fortunes (n= 21 out of 28 for those admitted, 6 out of 8 for those withdrawn), while only 48% of those who were not admitted had improved or mixed fortunes (n=11 out of 23) and 30% of this same group had risk factors that actually worsened (n=7). At face value, this would appear to suggest that either special care has the desired effect and causes positive change, or, conversely, that some children who would benefit from special care are not getting in and their behaviours worsen as a result.

236. Of those children admitted to special care in 2007, social workers felt that it had had a positive effect for 54% (n=15 out of 28), with it providing a place of safety only for another 21% (n=6) (for many of the social workers this was all they wanted and expected). For 18% of the children (n=5) special care was perceived by social workers to have had a negative effect. All of the social workers who had a positive view said that overall risk factors for their child had improved or had mixed fortunes, compared to 46% of those (n= 6 out of 13) for whom special care had not been a positive experience. This suggests that, where it works, special care can contribute significantly to reducing risks, but that, as may be expected for an option of last resort, it may not work for all children.

237. Those who had been admitted to Gleann Alainn at some stage of their life had a higher likelihood of overall risk factors that improved or had had mixed fortunes compared to those admitted to Ballydowd, Coovagh House, or not admitted at all. The children who were interviewed who had experienced both Gleann Alainn and Ballydowd were also more positive about Gleann Alainn, feeling that there were fewer uses of restraints and it felt less like a prison.

238. Some 42% of social work interviewees (n=25 out of 59) felt that special care was an effective model and 29% (n=17) felt that it was reasonably effective. Again, social workers who had had children placed in Gleann Alainn were most likely to think that special care was effective. Nevertheless, 24% felt it needed reshaping significantly (n=8) or was totally ineffective (n=6).

239. Social work interviewees, guardian *ad litem*/solicitor discussion groups, and some of the parents/carers were unhappy about the 'therapies' available in special care. By this, they primarily meant the availability of psychiatric and psychological support. In 2007 Ballydowd had psychiatric support, Gleann Alainn and Coovagh House had psychological support, but none had both. Nineteen social work interviewees made comments on the 'therapies' available in special care and this was a contributory factor to some thinking that special care needed to be reshaped.

240. Eleven social work interviewees also felt that the model in Ireland places too little emphasis on a managed step-down process: more is said on this later but it was again one of the themes noted by those who were dissatisfied with the model.

Gender

241. Special care appears to cater more for the needs of females than the needs of males. 59% of applications were for females (n=41), of whom 61% were admitted to special care (n=25). 41% of applications were for males (n=29), of whom only 24% were admitted to special care (n=7). The discrepancy was not just at the application stage, therefore, but also in terms of likelihood of admission to special care. Twenty-five females were admitted, compared to only seven males. Figures for 2009, however, show closer parity between applications for females and males.

242. While a similar percentage of females and males experienced improvement in overall risk factors (47% of females and 44% of males), males were more likely to have worse outcomes or the same level of overall risks than females, both proportionally and in absolute terms (45% of males, n=12; 28% of females, n=9).

243. Females with the same 'real and substantial risks to self' as males (one of the criteria for admission to special care) were much more likely to be admitted to special care. Males were more likely to be at risk of, or engaging in, criminal activity (72%) than females (39%) and females were more likely to have one or more of the three sexual behaviour risk features (83%) than males (24%). As stated in previous research (SIS 2008), this raises questions about whether the same sexual behaviour risks are tolerated more in males than in females.

244. Males were highly unlikely to be admitted to special care where they were at risk of, or engaging in criminal activity (only 24% admitted to special care); self-harming (25%); at risk from youth homelessness (33%); involved with a negative peer group (33%).

245. Females, in contrast, were highly likely to be admitted to special care where they had suicidal ideation (75%); were at risk of sexual exploitation/prostitution (74%); engaging with unsafe/inappropriate adults (73%); at risk of aggression/threatened by others (71%); had risks to their sexual health (62%) or sexualised behaviour (62%).

246. There was also a difference in terms of placement histories. While 83% (n=5 out of 6) of females who had never been placed in residential care (i.e. had only experienced community or family placements) were admitted to special care, only 20% of males (n=1 out of 5) with such a placement history were admitted.

247. Only 31% (n=9) of the males had no involvement with the criminal justice system at the time of the application (i.e. were not remanded in custody, subject to ongoing criminal proceedings, or subject to investigation by An Garda Síochána) compared to 59% of the females (n=24). The interpretation given to the judgement of Judge MacMenamin in Health Service Executive (Southern Area) v. S (S) (A Minor) was that where there were criminal matters before a district court , these needed to reach a conclusion before a child could be considered for special care. This therefore is a substantial part of the reason why fewer males were admitted than females in 2007. The Child Care (Amendment) Bill, 2009, if enacted, will clarify this situation so that 'generally, unless a child has been remanded in custody or received a custodial sentence, the HSE can apply for a special care order'. (Oireachtas 2009, p14). Feedback from social workers, guardians *ad litem* and solicitors suggests that this would be a useful clarification.

248. Males were also more likely to have a low/mild/borderline learning disability (48%, n=14) than females (20%, n=8). 51% of those with no learning disability were admitted to special care compared to only 27% of those who had a low/mild/borderline disability. Note also that only 6% of those with no learning disability were detained in the justice system since the 2007 application (n=2), compared to 25% of those with a low/mild/borderline disability (n=5).

249. With regards to substance misuse, females were more likely than males to be misusing the range of substances than males. Males only exceeded females with regards to misuse of cannabis and where no substances were being used at all.

Age

250. Children aged 12–14 were the subject for 33% of the applications (n=23), 15 year-olds were the subject for 43% (n=30), and 16–17 year-olds were the subject for 24% (n=17). 61% of the applications for children aged 12–14 (n=14 out of 23) led to an admission to special care, 47% of those for children aged 15 (n=14 out of 30), and only 24% for those aged 16–17 (n=4 out of 17). Ten of the 17 aged 16–17 were believed to be misusing heroin and five were regarded as being at risk of youth homelessness.

251. Improvements in overall risk factors were most likely for those aged 12–13 at the time of the application (80% improved or had mixed outcomes, n=8 out of 10), compared to 60% for those aged 14 (n=6 out of 10), 65% for those aged 15 (n=17 out of 26), and only 54$ of those aged 16–17 (n=7 out of 11). 33% of those aged 16–17 had risk factors that actually worsened (n=4); perhaps surprisingly, 30% of the 14 year-olds also worsened (n=3).

252. Given that 16–17 year-olds also are least likely to be admitted to special care, this raises a question about whether the needs of 16–17 year-olds exhibiting behavioural difficulties are being effectively addressed, not just within special care but within the services provided by the HSE in general and its partner agencies. It is very easy to explain away the poorer outcomes for 16–17 year-olds in terms of entrenched behaviours by that age, meaning that the capacity to influence change is less. This may well be true. Children approaching adulthood also have greater expectations about living independently than younger children. The key question is: are policy makers and professionals happy with the poorer outcomes for children aged 16–17 or is a debate needed about the appropriate shape of services overall for children with behavioural difficulties at this age?

253. The high percentage of 14 year-olds whose behaviours worsened is more difficult to explain. The general pattern seems to be that the younger the child, the more the chances of changing risks positively, but the 14 year-olds are a blip in this pattern that this research has been unable to explain.

254. The positive impact on younger children led some interviewees to think that either special care should be used at a younger age and/or that there should be some form of special care aimed specifically at younger children.

Ethnicity

255. Some 74% of the applications were for children whose ethnicity (using Census definitions incorporated into the special care application form) was White Irish (n=52) and 14% were Irish

Travellers (n=10). Only 40% of Irish Travellers were admitted to special care (n=4, compared to 48% [n=25] of those whose ethnicity was White Irish), matching the views of the National Special Care Admissions and Discharge Committee but different to the views of the CAAB, who supported 90% of these applications. 63% of the Irish Travellers had overall risk factors that worsened or stayed the same (n=5 out of 8) compared to 36% for White Irish (n=16 out of 44).

256. Although numbers are small, this does raise questions about whether Traveller-oriented services are sufficiently accessible and available nationally, whether social work staff are sufficiently trained to deal with cultural issues, or whether the presenting needs of Irish Travellers are not being treated the same way by the system. It is impossible to draw conclusions given the small number of such cases but there is a pattern here that needs to be considered further.

Care Status

257. Some 43% (n=30) of applications were for children in voluntary care and 41% (n=29) for children on a full care order. 53% of the former were admitted to special care (n=16), but only 38% of the latter (n=11). While 77% of the children in voluntary care had overall risk factors that improved or had mixed fortunes (n=20 out of 26), only 43% of those on a full care order had the same results (n=10 out of 23) and 35% had overall risk factors that worsened (n=8). All of the children who were not in care when the application was made had risk factors that improved.

HSE Areas Making the Application

258. Some 33% of applications came from the Dublin Mid-Leinster HSE Area (n=23), 30% from Dublin North East (n=21), 20% from the South (n=14), and 17% from the West (n=12). 52% of applications from Dublin North East resulted in an admission to special care (n=11), 48% for Dublin Mid-Leinster (n=11), 43% for South (n=6) and only 33% for West (n=4). Part of the reason for the West being so low was that it had the highest percentage of withdrawn applications (25%, n=9).

259. The South had the highest percentage of applications not admitted (57%, n=8). There appears to be two reasons for this. All of the applications from the South that were not admitted were for children who had never experienced anything more intensive than a mainstream residential or community/family placement, implying that the applicants may have been deemed to have not fully explored alternative placements. In addition, only 25% of these applications had secured an onward placement (n=2) for discharge from special care at the

point of the application: applications are much more likely to succeed where an onward placement is secured.

Homelessness

260. Only 38% of the applications for children at risk from youth homelessness were admitted to special care (n=5 out of 13). Only 33% of applications for children who were homeless when the application was made were admitted to special care (n=2 out of 6).

261. Some 56% of the individuals who were at risk from youth homelessness when the application was made had overall risk factors that worsened (n= 9 out of 16). Twelve experienced homelessness after the application. There was also a regional pattern, with the highest percentage of individuals who experienced homelessness after the application coming from Dublin Mid-Leinster (38%, n=8 out of 21) and Dublin North East (27%, n= 4 out of 15).

262. All of this suggests that the needs of children who are at acute risk who have experienced homelessness are not being addressed adequately, and that these issues are more pertinent in Dublin Mid-Leinster and Dublin North East. In addition, several interviewees from these areas also had concerns about placing children with the Dublin Crisis Intervention Service when a placement broke down, feeling that this increased the child's risk of acquiring additional risk factors.

Placement History Prior to the Application

263. The likelihood of an application succeeding has some relationship to the child's placement at the time the application was made. Seventy-three 73% of children in high support (n=8 out of 11) and 67% of children in an emergency placement (n=2 out of 3) were admitted. Only 23% of those remanded in custody were admitted (mainly for applications made before Judge MacMenamin's SS judgement, n=3 out of 13). On the other hand, those who highest 'degree' of placement by November 2009 was mainstream residential care were more likely to have had overall risk factors that improved or had mixed fortunes (70%, n=7 out of 10) than those who at some point experienced special care (64%, n=23 out of 26) or whose highest 'degree' placement ever was high support (58%, n=7 out of 12).

264. Children who had only experienced between one and four previous care placements were not likely to be admitted to special care (21%, n=3 out of 14), whereas those who had between five and nine previous care placements were most likely to be admitted (62%, n=16 out of 26). However, risk factors were most likely to improve where the child had had the fewest previous care placements at the time of the application, ranging from 88% improvement/mixed fortunes

for those with four or fewer previous care placements (n=14 out of 16) to 20% of those with 15–19 (n=1 out of 5).

265. Some 61% of the individuals had experienced one or more special care placements by November 2009 (n=36 out of 59). Children who had been admitted to special care in the past for less than nine months in total were more likely to be admitted to special care (67%, n=4 out of 6) than those who had previously been in special care for a total of nine months or more (14%, n=1 out of 7).

266. By November 2009, overall risk factors were most likely to have improved for those who had spent 7–9 months of their life in special care (83%, n=5 out of 6) or less than six months (71%, n=10 out of 14), better than those who were never admitted to special care (63%, n= 15 out of 23) or who were admitted for 10–12 months (38%, n=3 out of 8). This would appear to support the maximum period of nine months (three consecutive sets of three months) contained within the Child Care (Amendment) Bill, 2009 although it also suggests that nine months in total out of a child's life should be the maximum period in special care.

267. Applications were likely to be successful where the child had been the subject of a previous unsuccessful application for special care (69%, n= 9 out of 13).

Interventions

268. Social work interviewees, guardians *ad litem*/solicitors in discussion groups, and some of the parents/carers were unhappy about the 'therapies' available in special care. By this, they primarily meant the availability of psychiatric and psychological support (note that within the section of this report on protective factors, however, neither psychological nor psychiatric support was mentioned by many social work interviewees when asked what had contributed to reducing risk factors). In 2007 Ballydowd had psychiatric support, Gleann Alainn and Coovagh House had psychological support, but none had both. As special care develops within a nationally integrated HSE structure, this inconsistency needs to be addressed. All of the special care units emphasised the importance of keyworker relationships with the children as being the basis for their work, particularly given the short period of time. There are also issues of continuity of support and co-ordination with similar services from the home area, given that special care is a short-term intervention. It would be fair to say, however, that this inconsistency is at the heart of some of the negative comments about special care, and more accessible psychiatric and psychological support in all units would address much of this complaint.

269. Related to this is the difficulty cited by some social workers, some of the special care units, and some of the guardians *ad litem* and solicitors, about the short length of time that children are able to access special care. Primarily this is because children can take time to settle in a unit, limiting the time available for constructive work. Interviewees were not asked whether the process proposed in the Child Care (Amendment) Bill, of a maximum of three consecutive three monthly periods of special care, with monthly reviews in the High Court, would improve this.

Discharge from Special Care[25]

270. Only 51% of applications had an onward placement that was specified and secured at the point of the application (n=36), with mainstream residential units most likely to be secured (64%, n=16 out of 25) and high support units least likely (30%, n=9 out of 30). It is regarded as good practice to have the onward placement secured and interviewees from the special care units regarded this as particularly important. While 56% of the applications with the onward placement secured were admitted (n=20 out of 36), this was the case for only 35% of those where it was not secured (n=12 out of 34).

271. Interviewees from social work departments commented on how difficult it can be to secure an onward placement when making the application and that often they would not be able to name an onward placement until they knew what needs or behaviour management strategies were identified through the placement in special care. Special care unit interviewees said that they were comfortable with onward placements changing, but that it was important to have one identified and secured from the start. Social work interviewees who were dissatisfied with the model of special care often felt that they had been pushed to discharge a child from special care before a robust onward placement had been identified. They had experienced difficulties finding onward placements for almost a third of the children who were placed in special care.

272. Very few onward placements were the same as those specified in the application (only 32%, n= 10 out of 31) or even the same placement type (a further 16%, n=5). High support in particular was the identified onward placement for 43% of the applications (n=30) but only 26% of children were actually discharged to a high support unit (n=8 out of 31). Some social work interviewees stated that there was lack of co-ordination in admissions arrangements between the special care units and the high support units. Given that so many applications specified high support as the discharge option without being able to secure that placement, and that a smaller proportion were discharged to high support than was planned in the

[25] Note that at the time that this report was being written, the CAAB was soon to publish criteria for discharge from special care. An extract from this document is shown as Appendix C.

applications, this does raise questions about whether more co-ordination of admissions and discharges between special care units and high support units is required. Several social work interviewees felt that more co-ordination was required. On the other hand, research has suggested that the current shape of high support in Ireland does not differ substantially from mainstream residential care (Laxton 2008).

273. As already noted, Social work interviewees who were least satisfied with special care and some of the guardians *ad litem* and solicitors felt that the model needed reshaping by linking high support units directly to the special care units, with a shared management structure, or even having them on the same sites as the special care units. Several had sourced these types of arrangements abroad. They felt that the provision of a step-down unit on the same site would enable a child to move in and out of special care over the three month period of their order as needs and levels of engagement changed. Eleven social work interviewees made comments on this subject.

274. The difficulty of accessing mainstream residential placements was a recurrent theme within the research, with some social workers feeling that units have too much power to block an admission or to end a placement unilaterally. Both social work interviewees and the special care units gave examples of children who stayed in special care for longer than was deemed necessary because of difficulties in identifying and securing an onward placement. This is an extremely important issue. Effectively, children have been deprived of their liberty when the professionals involved felt that there was no justification to do so. Difficulty in obtaining placements from local admission and discharge committees, and the power of individual units to refuse admission, were usually cited as the reasons why a mainstream placement could not be accessed: four children were discharged home when this was not the preferred option of the social work department because a mainstream placement could not be found. One interviewee felt that mainstream units wanted to take in the type of children who would have been better placed in foster care. Laxton (2008) recommended that the skills, capacities, confidence and expectations of care staff should be extended by the establishment of staff training/development capacity at local level. In addition, one of the interviewees from a special care unit felt that senior staff such as Principal Social Workers needed to be more directly involved with the cases of children in special care to help remove this blockage. It has to be questioned whether local admissions and discharge committees are sufficiently supportive of special care in identifying and securing a discharge placement both at the point of application and in preparation for discharge.

Placement History since the 2007 Application

275. While 26% of children were perceived by social work interviewees to have settled down into improved behaviour soon after leaving special care (n=8), 39% were perceived to have immediately reverted to their risk-taking behaviour or their behaviour became even worse (n=12). A further 25% were perceived to be unstable for a while then settled down (n=8), while around 9% were felt to have settled for a while then reverted to their previous risk-taking behaviours (n=3). Interviews with the children, their parents/carers and social workers suggested that sometimes the immediate effect of discharge can be that the child 'runs amok' before reflection on the lessons learnt in special care are remembered and assist them to more controlled behaviour. At other times, a single episode of special care can both have a deterrent effect and provide lessons that the child immediately takes on board. This could be interpreted to suggest re-application to special care should not be made soon after the child has been discharged and that where this occurs the social work department is failing to manage risk within the community. However, five of eight re-applications made within four months of discharge from special care were admitted (one withdrawn, two not admitted), suggesting that where speedy re-applications occur they are generally regarded as appropriate by the professionals involved.

276. By November 2009, 46% (n=17 out of 37) of those who were still children were in residential care (mainstream, high support, special care) and 38% (n=14) were either at home, in independent/supported living arrangements or foster care. The remainder were accessing homeless services (n=3) or detained in the justice system (n=3). However a third of those who were adults by November 2009 were either accessing homeless services (14%, n=3 out of 22) or in detention (18%, n=4), with 45% either at home, in independent/supported living arrangements or foster care (n=10), 14% were in residential care (n=3), and the whereabouts of 9% was unknown (n=2).

277. 49% of the individuals went home at some stage after the application (n= 29 out of 59) but for only 34% (n=10) was this the preferred choice of the social work department, with 48% (n=14) of the children refusing any other placement and 14% (n=4) going home because mainstream placements would not accept them. While 60% of children who went home as a planned outcome experienced a stable placement, placement at home broke down for 57% (n=8 out of 14) of those who refused to go into any other placement and 50% (n=2 out of 4) of those who had been refused admission by mainstream residential units. Interviews with the children and their parents suggested that inadequate support is provided when a child who has experienced special care returns home. Some social work interviewees also felt that improved family therapy services would be helpful, and some suggested that family welfare conferences would be useful to support discharge from special care. This research did not

explore the services and supports offered to children and families in this circumstance and it would be beneficial for any future research in this area to look at this issue. Laxton (2008) also noted consensus within that research that the development of intensive community-based care/support services would assist in reducing the need for special care.

Offending and Justice Systems

278. We have already noted the fact that more males had risk factors related to being at risk of, or involved in criminal activity, and that children with this risk factor were less likely to be admitted to special care. The impact of the SS and DT judgements and the potential impact of the Child Care (Amendment) Bill, 2009 have also been noted.

279. Outcomes were certainly better overall for children who were not involved with the criminal justice system at the point of the application (79% had overall risk factors that improved or had mixed fortunes, n= 22 out of 28) or who were never detained by the criminal justice system (80% improved or mixed fortunes, n=24 out of 30). Involvement with the criminal justice system would in itself be regarded as a poor outcome, so this in itself will be a significant factor influencing social worker perceptions of changes to risk factors overall.

280. However, given that 56% of the males (n= 15 out of 27) were detained by the criminal justice system at some point after the application to special care in 2007 compared to just 29% of the females (n=6 out of 32), it would seem that, while males are struggling to access special care, they are more likely that females to end up in juvenile criminal detention. Several interviewees were also concerned about the slow speed of the justice system, citing, for example in one case, charges that were more than two years old that had still not been dealt with. Significant delays led to children not seeing the consequences of their actions. Some social workers also noted that, where a child received a custodial sentence but was immediately released pending an appeal, that child was again not seeing any consequences for their behaviours, resulting in those behaviours worsening. There was little evidence of a joined-up approach between justice and child protection/welfare systems to assess and act on a multi-disciplinary basis where children in care were at risk of offending: several social workers noted that children were either in one system or the other.

281. For eight of the individuals, part of the reason for the application for special care was to separate them from a known individual(s), usually an adult male. Applications for five of these individuals were successful, two were not, and one was withdrawn. Injunctions and barring orders were taken against some of the men involved and some were cautioned: a few of those injunctions were taken in parallel with the application for special care although this

detail was not included in the application documentation. In a small number of these cases, the social work departments described situations that had arisen that suggested there was a need to put in place an information sharing protocol between An Garda Síochána and the HSE, including appropriate pathways within each agency for escalating concerns. A joint protocol between An Garda Síochána and the HSE is now in place for 'children missing from care' but that was not the specific concern for these cases.

Education and Learning Disabilities

282. 76% (n=53 out of 70) of applications were for children who had been school non-attenders in the previous 12 months. By November 2009, 47% of the individuals were engaged in education (n=28 out of 59), many of whom were involved in education outside school settings, Youthreach, or FÁS. Of those for whom significant concerns about their education had been recorded against the criterion for 'real and substantial risks to self' a similar proportion (46%, n=21) were engaged in education by November 2009. While there was no relationship between these improvements and perceptions of whether risks overall had improved, there were clearly gains in terms of engagement with education and training. Given that 41% (n=24) of the individuals were not engaged in any education, training or employment, however, there were also still some significant gaps. Laxton (2008) noted that 'the apparent failure of some mainstream schools to "hold on" to the young person raises important policy and practice questions that need to be addressed'.

283. 25% of those with a low/mild/borderline learning disability (n=5 out of 20) were detained in the justice system at some point after the 2007 applications compared to only 6% (n=2) of those with no learning disability. As a result, some 30% of individuals with learning disabilities (n=6 out of 20) were felt to have had risk factors that had worsened.

Health

284. 79% of the applications (n=55) identified alcohol and/or substance misuse as a risk factor for the children, although the nature of this misuse was often unclear in the application documentation. Through a mixture of the application documentation and interviews with social workers, the researcher was able to establish that alcohol was a concern for 45 of the applications and cannabis for 34. For almost all of the substances, proportionally more females were misusing them than males (cannabis being the exception). Nine of the females were misusing heroin, of whom a third were admitted to special care (n=3). 57% of those who misused heroin experienced homelessness after the application (n=4 out of 7) compared to only 32% of those who had misused cannabis (n=9 out of 28) and 26% of those who had misused alcohol (n=10 out of 39). However, risk factors were as likely to worsen for those

who had no history of substance abuse (33%, n=4 out of 12) as for solvents (33%, n=1 out of 3), prescriptions drugs (30%, n=3 out of 10) or heroin (29%, n=2 out of 7).

285. Eight children in the study were diagnosed with ADHD[26], of whom only 25% (n=2) were admitted to special care. 63% of the children with ADHD (n=5) had risk factors that worsened. Numbers are small but this may be significant.

286. Hospital admissions related to risk factors also appear to be related to social work perceptions of risk factors overall, with 56% (n=5 out of 9) of those who had hospital admission before and since the application being seen as having had overall risk factors that worsened.

287. Some 24% (n=17) of the applications were for children who were in receipt of psychiatric services at the point of application, of whom only 35% (n=6) were admitted to special care. Given that special care is not intended to provide acute psychiatric interventions, this may not be surprising. However, a substantial number of applications were for children who appeared to have received some form of psychiatric assessment or intervention in the past. Some social work interviewees said that this was little more than an assessment at times while others noted difficulty in accessing child and adolescent mental health services where children were aged 16–17. The research did not explore in detail the nature of psychiatric interventions received and this is an omission that should be addressed in any future research. One of the parents/carers noted that children in special care do not gain speedier access to support services. This raised a question about whether protocols are needed between social work and psychiatric services so that children who have been in special care have fast-track access to psychiatric supports, thus prioritising those who have a combination of medical and social needs.

The Application Process

288. At the time of the application to special care in 2007, family welfare conferences had not been held for 70% (n=49). Only 24% (n=12 out of 50 who expressed a view) of social work interviewees felt that family welfare conferences have a positive role to play within the special care application process. 50% opposed the requirement to hold a family welfare conference or consult with the family welfare conference service (n=25). 26% (n=13) gave mixed or neutral views. Eighteen of the respondents said that they found family welfare conferences useful in other contexts (i.e. at an earlier stage of intervention), but believed that, as special

[26] The current application form does not specifically ask if the child has a diagnosis of ADHD, so it is possible that this figure was under-reported.

care was a measure of last resort, all options within the family and extended family would normally have been exhausted by this stage. One of the solicitors involved in a guardian *ad litem*/solicitor consultation group also felt that the family welfare conference slowed down the process. The role of family welfare conferences within the special care process is therefore of questionable value. guardians *ad litem*, solicitors and some of the social work interviewees wished to see increased transparency in the operation of the NSCADC. In particular, they said that membership of the committee needed to be published officially. The NSCADC feels that there has been much publicity in this area but it may be that a refresher is required to address this perception amongst some of a lack of transparency: this may be the result of changes in staff at local level.

RECOMMENDATIONS

Recommendations for the HSE at National Level and Policy Makers

	Recommendation	Relevant findings
1	The HSE and policy makers should review whether variations in patterns of applications, admissions and outcomes between males and females are acceptable and in the best interests of the children. If this is not the case, the implications in terms of the configuration of special care provision and guidance to staff will need to be considered.	Females are much more likely than males to be the subject of special care applications, be admitted to special care, and have better outcomes.
2	The HSE and policy makers should review whether the current low levels of admission to special care and poor outcomes for children aged 16–17 (who were subject to a special care application) are acceptable and in the best interests of the children, or whether service reconfiguration in the HSE and in partner agencies may be required to better meet the needs of this group.	Only 24% of children aged 16–17 at the point of application were admitted to special care. In addition, 16–17 year-olds were much more likely than other age groups to have risk factors that worsened by November 2009. Children of this age may well be more likely to have entrenched behaviours (and therefore less capacity to change) and, approaching adulthood may also have greater expectations about living independently than younger children. There needs to be a debate about whether special care and associated services (from HSE and partner agencies) are appropriate to this age group.
3	The HSE and policy makers should review whether the current low levels of admission and poor outcomes for children at risk of youth homelessness (who were the subject of a special care application) are acceptable and in the best interests of the children, or whether special care and/or other HSE services need to be reconfigured to better address and prioritise the needs of this group of children.	Children subject to a special care application who have experienced homelessness are amongst those least likely to be admitted to special care and most likely to have poor outcomes in terms of changes to risk factors. 20% of the children experienced homelessness since the 2007 application. Numbers are small but the pattern is distinct.
4	The HSE should consider whether low levels of admission and poorer outcomes for Irish Travellers are acceptable and in the best interests of the children, and whether this has any implications in terms of training for social work staff and/or reconfiguration/accessibility of Traveller services.	Irish Travellers were less likely to be admitted to special care than children whose ethnicity was White Irish. They were also almost twice as likely to have overall risk factors that worsened by November 2009. Although numbers are small, this raises questions about whether Traveller-oriented services are sufficiently accessible and available nationally, whether social work staff are sufficiently trained to deal with cultural issues, or whether the presenting

	Recommendation	Relevant findings
		needs of Irish Travellers are not being treated as effectively by the system.
5	The HSE should ensure that admissions and discharges from and between special care units and high support units are better co-ordinated. This might be achieved through centralised national structures and/or processes. In addition, with the imminent closure of Ballydowd, the HSE should consider opportunities to increase the co-location and joint management of special care units and high support units.	High support was frequently identified in the application as the preferred onward placement on discharge from special care but only 30% of these onward placements were secured and fewer children still were actually discharged to a high support unit. Although previous research has questioned whether the current shape of high support differs substantially from mainstream residential care (Laxton 2008), there appears to be scope to improve the co-ordinated response to applications for both special care and high support to ensure that high support is used more often as a 'step-down' from special care. In addition, several interviewees sourced placements abroad where the management of special care and high support arrangements was directly linked, enabling children to move between secure and less secure environments in a co-ordinated manner as their behaviours changed. These interviewees were generally negative about the model for special care in Ireland.
6	The HSE should consider developing increased consistency in the models of special care offered by the special care units. Each unit should have the same access to psychiatric and psychological support (as required by the needs of the child).	In 2007, the national structure was still new, the units were reported to be operating different models and had different capacities. Nineteen of the social work interviewees made comments on the 'therapies' available in special care, the primary comment being that the pattern of psychiatric and psychological input was uneven between the units and this was perceived to be a weakness. Those who had negative views of special care often cited this. As the national approach to special care becomes more consolidated, this should be reviewed.
7	The HSE should consider if there should be a separate special care facility for younger children.	Several social work interviewees felt that special care should be aimed more towards younger children and some felt that the provision of a facility for younger age groups would be beneficial, given that their maturity and expectations may be very different from 16 and 17 year-olds. Such a facility might be for 12–13 year-olds, with some 14 year-olds and possibly on occasion some 15 year-olds, depending on

	Recommendation	Relevant findings
		levels of maturity, understanding and vulnerability. On the other hand when considering the above issue it is important to also take into account that children aged 12–14 who entered special care in 2007 seemed to have generally positive outcomes by November 2009.
8	The OMYCA should take into account the findings in this report related to the length of time children spend in special care when developing future policy for special care. The court, HSE and guardians *ad litem* should also be mindful of these findings when considering the best interests of the child.	Although numbers are small, children who had previously been admitted to special care for nine months or less were much more likely to gain a further admission to special care than those who had spent more than nine months there. Outcomes in terms of changes to risks were also better for children who had spent less than nine months in total in special care by November 2009. This certainly supports the proposals within the Child Care (Amendment) Bill, 2009 that children may only be placed in special care for a maximum of three consecutive three month periods; but the recommendation made here goes further by suggesting a working presumption that a child should spend no more nine months of their life in special care, consecutive or otherwise.

Recommendations to Support Inter-agency Working

	Recommendation	Relevant findings
9	Where a child is deemed to be at risk from specific, known adults, protocols need to be developed between the HSE and An Garda Síochána on actions to be taken, information sharing, escalation of concerns, and processes to monitor the effectiveness of the above.	In a small number of cases where the child was deemed to be at risk from a known adult(s), the social work departments described situations that had arisen that suggested there was a need to put in place an information sharing protocol between An Garda Síochána and the HSE, including appropriate pathways within each agency for escalating concerns. A joint protocol between An Garda Síochána and the HSE is now in place for 'children missing from care' but that was not the specific concern for these cases.
10	There are opportunities to increase the integrated assessment of children's needs: **a.** The OMCYA, HSE and Department of Justice, Equality and Law Reform should consider whether any measures should be put in place to increase the integrated assessment of risks and needs (offending and child protection/welfare) for children in care who offend. **b.** The OMCYA, HSE and Department of Education and Science and education agencies (e.g. the National Educational Welfare Board, the National Council for Special Education, the National Educational Psychological Service, need to consider whether levels of poor school attendance for children who become the subject of a special care application are acceptable and in the best interests of the children, and whether this should have any implications in terms of future policies and monitoring arrangements. There may be scope for: ■ improved co-ordination and delivery of holistic assessments and service responses between social work and education agencies; ■ the HSE to routinely monitor how many	Numerous interviewees 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. Within the cohort, males were more likely to have offended than females and by November 2009 were also more likely to end up in the juvenile detention system than females. A more holistic approach might help to improve outcomes for the children. Some 76% of applications were for children who had been school non-attenders in the previous 12 months. This suggests that children whose behaviour leads to concerns in terms of their social care needs are also coming to the attention of education agencies. Responses to those needs do not at present appear to be co-ordinated and holistic, with little evidence of joined-up assessments or information exchange, again suggesting the possibility of social care and education agencies operating in isolation.

	Recommendation	Relevant findings
	children in its care and protection systems have problems with school non-attendance every year and share this information with the OMCYA and the relevant education agencies. This issue should be considered in the ongoing work between the HSE and the National Educational Welfare Board to develop joint working protocols.	
11	The OMCYA, HSE and Department of Justice, Equality and Law Reform and Courts Service should consider if any measures should be put in place to speed up the administration of justice for children in care who offend, to benefit the holistic welfare of the child.	Several social work interviewees felt that the time taken for the administration of justice can be too slow. Those who raised this issue said that this contributed to deteriorating behaviour, as the child was perceived to have never seen any consequences for their behaviour. In other jurisdictions, priority has been given to speeding up the administration of justice for children. When considering these issues it is important to note that it may well be that the perceptions of the social workers were misplaced (as it was not within the remit of this research to consult with the Department of Justice, Equality and Law Reform, these perceptions are unverified). It should also be borne in mind that the interpretation of the *SS* and *DT* judgements in the research period meant that, where there were ongoing criminal proceedings in the district court, children were not being admitted to special care, with the potential negative impact on their welfare. This emphasises further the need for swift administration of justice.

Recommendations for Practice and Processes

	Recommendation	Relevant findings
12	Within practice, social work professionals need to be mindful of whether and in what circumstances they respond differently to the same types of risk-taking behaviour shown by females and males, particularly in relation to sexual risks and risks of involvement in the criminal justice system.	Females are more likely to be subject to a special care application and those applications are much more likely to be successful. There are distinct differences between the genders with regards to sexual risks and risks of involvement in the criminal justice system.
13	The guidance for special care should be amended to state that where a child has had fewer than five previous care placements, they are unlikely to be admitted to special care, except in cases of emergency, on the grounds that not all options have been exhausted.	Only three out of 14 applications made where the child had a maximum of between one and four previous care placements were admitted to special care. This would serve as a reminder to applicants that they must make every effort to ensure that all options have been exhausted before applying for special care.
14	Discharge from special care: **a.** The HSE should refresh understanding of its staff, particular at senior level and within local admission and discharge committees, of the importance of securing an onward placement when a special care application is made. **b.** Local admissions and discharge committees should support and prioritise children who are the subject of special care applications in allocating placements. **c.** The HSE should take action to ensure that all relevant staff are briefed and trained in the recently published *Special Care Discharge Criteria* (CAAB 2010).	It is regarded as good practice for the onward placement to be identified at the outset, both to prevent drift in the case and to provide the child her/himself with an idea of what will happen next. Applications with an onward placement secured are much more likely to be successful. Some social work interviewees also felt that the discharge options for children in special care were not being prioritised by their local admissions and discharge committees. For example, in four cases the child was discharged home from special care, despite this not being the preferred option of the social worker, because a mainstream residential placement could not be found.

Recommendations for Monitoring and Research

	Recommendation	Relevant findings
15	The HSE should report annually on special care and the operations of the NSCADC, including a statement of the NSCADC's terms of reference and criteria, its membership, the number of applications it considered, the outcomes of the applications, and the demographic profile of the applications. Given the findings in this research, it may be useful to report: **a.** the pattern of applications and admissions by gender; **b.** the pattern of applications and admissions by age; **c.** the pattern of applications and admissions by ethnicity; **d.** the pattern of applications and admissions where the application suggests that the child is at risk from youth homelessness; **e.** the pattern of applications and admissions by learning disability and by whether the child has had chronic school non-attendance during the previous 12 months; **f.** the pattern of applications and admissions of children with ADHD; **g.** for all children admitted to special care in a year, the total time that such children have spent in special care in the past or in custody.	Special care is an area of interest to policy makers, social workers, guardians *ad litem* and solicitors alike, as well as to the general public. Some perceptions of lack of transparency might be easily addressed by publicly providing on an annual basis a report containing the recommended information. There are also a number of emergent patterns contained within this report, some of which had substantial data behind them (e.g. gender variations) but some of which were based on very small numbers (e.g. children with ADHD) that would benefit from ongoing monitoring and public reporting.
16	The application form for special care should be amended: **a.** to prompt the applicant to state whether the child has previously experienced homelessness, is regarded as being at risk of youth homelessness, and any actions taken to reduce this risk; **b.** so that where risks identified relate to alcohol and substance misuse the applicant must specify what substances are involved and what actions are being taken, or have been taken, to manage the harm from this abuse; **c.** to ensure that, where a child subject to a	The recommendations here are based on information that the researcher found difficult to obtain directly from the application form and supporting documentation but which may be useful to draw out explicitly from those making an application for special care.

	Recommendation	Relevant findings
	special care application is deemed to be at risk from specific, known adults, information is recorded on any actions taken or planned against that adult by the social work department; **d.** to ensure that, where a child 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; **e.** to establish whether a guardian *ad litem* is already appointed for the child, and, if so, by what court and when; **f.** to ensure that it is clear whether the planned onward placement has been secured or not.	
17	Future research into special care outcomes should identify in detail: **a.** the subsequent placements of children, in particular the number of children who go home at any stage, the range of supports offered if they go home, and the effectiveness of those supports; **b.** 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 those supports; **c.** processes for accessing education supports for children subject to a special care application and the effectiveness of those supports.	The three topics identified in this recommendation were areas in which the researcher feels that more in-depth investigation than was achievable within this research would be beneficial. These are all substantial topics in their own right. The comments relating to the subsequent placements of children focus particularly on supports provided if the child goes home. Twenty-nine of the 59 individuals in the study went home at some stage after the 2007 application, only ten of which were the planned, preferred choices of the social work department. The research touched on how many went home, whether this was planned and how successful it was, but not on the supports offered to maintain those placements and their effectiveness in promoting better outcomes. Almost all of the children were receiving psychiatric interventions or had received a psychiatric assessment/intervention in the past. 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 research examined whether the children

	Recommendation	Relevant findings
		who were subject to a special care application were accessing education, training or employment by November 2009. There was also an attempt to ascertain social work views of the effectiveness of education agencies in assisting with engaging children into education, training or employment, with limited success. Given that we understand the HSE and the NEWB are working on developing protocols for joint working, it may be useful in the future to examine the effectiveness of those protocols for children who have accessed special care.
18	Further research should be conducted into whether the requirement to hold a family welfare conference should be a component part of the application process for special care.	Some 50% of social work interviewees (n=25 out of 50 who expressed a view) opposed the requirement to have a family welfare conference for special care, 24% (n=12) found it useful and 26% (n=13) did not have a strong view. At the time of the application, family welfare conferences had not been held for 70% of the applications. Social workers supported family welfare conferences in other contexts, but many felt that the requirement to hold one for special care came much too late, given that, as a measure of last resort, all family/extended family options would normally have been exhausted. They often saw it as an unnecessary bureaucratic burden. Previous research (SIS 2008) also indicated that family welfare conference co-ordinators had some doubts about the usefulness of family welfare conferences for special care applications.
19	Further research should be conducted into future cohorts of children who were subject to special care applications, using findings in this current report as a comparative baseline.	This current research has produced findings that are hopefully of benefit and interest to policy makers and practitioners. It is based on 70 applications and 59 individuals so some of the emergent patterns, while interesting and informative, have a narrow evidence base. Further research would widen this evidence base.

APPENDICES

A REFERENCES

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B GLOSSARY

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

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

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

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

Carers: a) trained staff caring for children in a children's residential centre; and b) foster carers.

Case management team: In a special care unit the case management team usually includes: Social Worker; Social Work Manager; Centre Manager; Keyworker; Teacher; parent; other professionals directly involved with the child (e.g. youth worker, psychologist etc.)**.**

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

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

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

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

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

Children detention school is a secure residential unit set up to care for juvenile offenders. Children are referred to the schools on the order of the courts. Children detention schools are also designated as remand centres under the Children Act, 2001, for the remand in custody of a child charged with a criminal offence.

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

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

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

Family welfare conference was introduced by the Children Act, 2001 and made it a requirement to convene a family welfare conference prior to an application being made for special care. The purpose of the family welfare conference is to bring together the child, parents, relatives and professionals in an attempt to come up with a family plan to prevent the seeking of a special care order.

FÁS: The National Training and Employment Agency.

Foster care: means children in care of the HSE who are placed with approved foster carers in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995,* and the *Child Care (Placement of Children with Relatives) Regulations, 1995.* This can include relative or non-relative carers.

Guardian *ad Litem* literally 'guardian for the case', a person appointed by a court under S. 26(1) of the Act of 1991 to represent the wishes, feelings and interests of a child who is the subject of proceedings under parts IV, IVA or VI of the Act of 1991.

Health Information and Quality Authority Social Services Inspectorate: The Health Act, 2007 placed the Social Services Inspectorate within the Health Information and Quality Authority on a statutory basis. The work of the Inspectorate has been focused on children in care, primarily on the inspection of residential care.

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

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

High Support Units are open residential units set up as a response to the needs of a minority of highly troubled children and managed by the HSE. Children placed in high support need intensive support away from home when other supports are not suitable at the time. High support units are part of the welfare system and care for non-offending children.

HSU see 'High support units entry.

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

Interim Special Care Order means an order made by a court in respect of a child in accordance with s.23C of the Child Care Act, 1991, as inserted by s.16 of the Children Act, 2001. A court will grant this order when there is reasonable cause to believe that there is a real and substantial risk to the health, safety and development or welfare of a child and that it is in the best interests of that child to place

and detain a child in a special care unit. An interim special care order differs from a special care order in that it can only be for a maximum period of 28 days as it is used for cases where there is an immediate threat to a child's health, safety and welfare. See special care order. Note that interim special care orders had not been operationalised in 2007.

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

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

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

National Educational Welfare Board (NEWB). The NEWB is the national agency with the responsibility for encouraging and supporting regular school attendance. The NEWB was established to ensure that every child attends school regularly, or otherwise receives an education or participates in training.

The National Special Care Admission and Discharge Committee (NSCADC) is comprised of an independent Chairperson, the Centre Manager of each special care unit, and the Chairperson of the previous admissions committee of each special care unit.

NEWB see National Educational Welfare Board.

NSCADC see National Special Care Admission and Discharge Committee.

The **Office of the Minister for Children and Youth Affairs (OMCYA)** is part of the Department of Health and Children. The role of the OMCYA, which was set up by the Government in December 2005, is to improve the lives of children under the National Children's Strategy and bring greater coherence to policy-making for children.

OMCYA see Office of the Minister for Children and Youth Affairs.

Parents/Carers includes a surviving parent and, in case the child who has been adopted under the Adoption Acts 1952 to 1998, or, where the child has been adopted outside the State, whose adoption

is recognised by virtue of the law for the time being in force in the State, means the adopter or adopters or the surviving adopter. This also includes extended family such as a brother, sister, uncle or aunt or a spouse of the brother, sister, uncle or aunt or a grandparent or step-parent, and foster carer.

Principal social worker is a senior manager in the social work structure, responsible for the overall operational and strategic management of a social work department.

Remand placement is the remand of a child or young person to one of the children detention schools under the Children Act, 2001, as amended by the Criminal Justice Act, 2006 and the Child Care (Amendment) Act, 2007, pending finalisation of a criminal charge.

Residential placement refers to placement in a residential centre, either in a mainstream (or residential – general) placement, a high support unit or a special care unit. These can be run by the HSE, voluntary or private sectors.

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

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

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

Risk assessment is a process of assessing risk. The factors typically considered are: nature of risk, likelihood of risk occurring, likely impact and protective factors. A risk assessment can be a written document, detailing the assessment and supporting evidence. It can also be a process, where risk is assessed in a situation with the information available at the time.

Risk-taking behaviour means in this report, within the context of the Criteria on Impaired Socialisation/Impulse Control, risks associated with:

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

SCUs – see special care units entry.

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

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

Social work team leader is a line manager position with responsibility for a team and/or a specific project within a social work department.

Shared care is where a child transitions between two placements e.g. residential care and home, high support unit and home.

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

Special Care Order refers to an order detaining a child in a special care unit. The court may make such an order where the behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development and welfare and the child requires special care or protection. This order is for a minimum period of three months, less than six months. See Part IVA Child Care Act, 1991 as inserted by S16 of Children Act, 2001. Note that special care orders were not operationalised in 2007.

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

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

SRSB – See Special Residential Services Board entry.

Young person – see child.

Youth Advocate Programmes Ireland is a not for profit organisation which offers intensive support of up to 15 hours a week of one-to-one work with a young person for up to six months. One of the main aims of Youth Advocate Programme is to maintain young people at risk of out of home placements and to reintegrate them back into their communities when necessary.

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

Youthreach: A national programme directed at unemployed young early school leavers aged 15–20. It offers participants the opportunity to identify and pursue viable options within adult life, and provides them with opportunities to acquire certification.

C CRITERIA FOR DISCHARGE FROM SPECIAL CARE[27]

The decision to discharge a child from a special care placement must be based on a **comprehensive needs assessment** involving the child and their parent(s)/guardian(s), the social work department, guardian *ad litem* and special care unit staff, including any professionals that have been involved. The assessment must examine:

- **the specifics of the each case;**
- **the criteria under which the child was placed in special care;**
- **the presenting behaviours and risks and how these may differ from the behaviours and risks displayed by the child when they were initially placed in special care;**
- **the aims and objectives of the placement in special care and if they were achieved.**

Furthermore the decision to discharge from special care **must demonstrate that:**

- **it is in the best interests of the child;**
- **it is consistent with the child's statutory care plan;**
- **where the onward placement is not within the same campus there must be a clear transition placement plan which includes day and overnight visits to the onward placement for the period agreed necessary to effect a successful transition;**

Given that detention of children should be a measure of last resort and for the shortest appropriate time, any decision to discharge or to continue the placement in special care must clearly demonstrate that it is necessary and appropriate to do so.

CAAB, 2010.

[27] The above criteria are extracted from the agreed Special Care Discharge Criteria published in January 2010.

D MAP OF HEALTH SERVICE EXECUTIVE AREAS AND LOCAL HEALTH OFFICES DURING THE RESEARCH PERIOD