

A Formative Evaluation of the Jobstown Alternative Response Model (ARM)

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Glossary of Terms

CAAB – Children’s Act Advisory Board

CAWT – Cooperation and Working Together

HSE – Health Service Executive

NEWB – National Education and Welfare Board

OMCYA – Office of the Minister for Children and Youth Affairs

SDCSC – South Dublin Children’s Services Committee

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Appendix B – *Working Together for Children: An Inter-agency Caseworking Protocol*, South Dublin Children's Services Committee, April 2010

Chapter 1 - Introduction

1.1 Introduction

Ever since the publication of the Kennedy Report in Ireland in 1970 (Kennedy, 1970), the challenge of how best to meet the needs of children and families has been increasingly debated in policy, practice, academic, political and media circles. Central to this debate has been the reform of services involved in this work. More recently, the reform agenda has returned to the forefront in the light of the *Report of Commission to Enquire into Child Abuse (2009)* known as the Ryan Report; the Reports into the deaths of two young people in care published by the HSE in April 2010 and the *Report of the Enquiry Team into the Roscommon Child Case (2010)*. The role of the HSE in protecting children and promoting their welfare has come under intense scrutiny, as have the relationships between the various statutory and non-statutory agencies also involved in this endeavour. The failure of agencies to cooperate effectively in this regard has been a feature of many review and enquiry reports.

The introduction 10 years ago of *Children First, National Guidelines for the Protection and Welfare of Children*, and the publication of the *National Children's Strategy* both point to the important position of children and families in the Irish policy context. Children's Services Committees are set to play a significant role under the new National Children's Strategy, and the need for integrated working has become an increasingly-accepted norm. National Policy has also charted a new course in terms of an explicit family-support orientation, exemplified by the *Agenda for Children Services (2007)*.

It is within this context that the Differential Response Model, also referred to as the Alternative Response Model (ARM) has arrived in Ireland. This model was originally developed in the United States. The ARM model has been viewed as one potential way to operationalise the family support orientation charted in the *Agenda*. This report is about the experience of one alternative response model operating in Jobstown in South Dublin.

The Children's Act Advisory Board (CAAB, now subsumed in the Department of Health and Children) supported South Dublin Children's Services Committee (SDCSC) with funding, through the medium of Barnardos, to implement their work plan with particular reference to the adoption of key elements of the ARM in South Dublin and the implementation of an inter-agency protocol and information-sharing guidelines. The ARM is being piloted in Jobstown in conjunction with SDCSC.

The adoption of key elements of the ARM is overseen by the ARM Management Committee, and the implementation of an inter-agency protocol and data-sharing guidance is overseen separately by the Inter-agency Case Working subgroup. The ARM Management Committee is an inter-agency group with representation from the statutory and voluntary sectors.

The ARM is currently operational in Jobstown, and 18 families have received an alternative response to date. The model being delivered has been tailored and adapted to the local context, following discussion and consultation amongst the key partners involved. While some initial planning took place, there was also a deliberate intention to quickly operationalise the initiative

with a small number of families. Therefore greater formalisation of the model is required, and greater clarity about its short, medium and long-term outcomes. The Child and Family Research Centre (CFRC) at NUI Galway was engaged by Barnardos, on behalf of SDCSC, to undertake a formative evaluation of the ARM, and to provide supports for the SDCSC's work on developing two documents: *Sharing Information about Children & Families, Best Practice Guidelines for Practitioners and Managers*, South Dublin Children's Services Committee, January 2010 (Appendix A), and *Working Together for Children: An Inter-agency Caseworking Protocol*, South Dublin Children's Services Committee, April 2010 (Appendix B).

1.2 Evaluation Aims and Objectives

The overall aim of the evaluation is to describe the development of the model to date, and to inform its continued evolution and implementation. Despite the fact that the research process outlined in this report involved discussion and analysis of outcomes, the evaluation is formative in nature. Therefore, it has not sought to draw any summative conclusions at this point.

The formative evaluation also includes an element of training needs analysis in order to inform a training strategy, needed to support the further roll-out of the model. The Jobstown ARM operates at both the intervention level and also at a broader service planning level. The evaluation therefore relates to both of these levels in tandem.

Considering this, the specific objectives of the evaluation are:

1. To establish stakeholders' experiences of the ARM committee process;
2. To establish stakeholders' experiences of the interventions occurring under the oversight of the ARM committee;
3. To establish stakeholders' views on how the ARM is progressing in respect of its aims;
4. To improve outcomes for children and families through enhancing inter-agency collaboration and the cohesive response of services to families;
5. To facilitate timely access by children and families to appropriate early intervention support services on the basis of assessed need;
6. To reduce the number of children and families notified under the child protection notification system;
7. To establish the level of training needs of staff involved in the delivery of the ARM;
8. To identify recurring themes, issues, barriers or challenges in respect of the aims of the ARM.

Whilst not a specific objective of the evaluation, it is anticipated that the learning from this report will contribute to national discussion in relation to service planning and policy in children services.

1.3 Evaluation Methodology

According to Patton (1997, p.286), a “...formative evaluation typically connotes collecting data for a specific period of time, usually the start-up or pilot phase of a project, to improve implementation, solve unanticipated problems and make sure that participants are progressing towards desired outcomes”. The evaluation is qualitative in nature, although some quantitative data will also be gathered in the form of existing administrative data. In line with Chen’s (2005) approach to formative evaluation, two primary data collection methods were used: intensive interviewing and focus groups. The evaluators liaised with the Project Advisory Group throughout the fieldwork, to ensure all necessary participants were given the option of becoming involved in the evaluation.

The fieldwork commenced with a review of the administrative data associated with the ARM process, principally the template used by the ARM committee to track the progress of cases that receive an alternative response. Any documentation generated by the ARM committee was analysed, including meeting minutes. Patterns or themes emerging from this review were used to inform subsequent fieldwork. Intensive telephone interviews were held with all members of the ARM committee. The interview schedule for these interviews was based on the evaluation aims and objectives, and patterns or themes emerging from the review of administrative data. Intensive telephone interviews were also held with front-line practitioners to gather data on stakeholder perception of the ARM intervention.

The review of administrative data was also used to identify a purposive sample of two cases for which focus groups were held with the staff that directly participated in the intervention in those cases. These focus groups also gathered data on stakeholders’ perceptions of the ARM intervention.

Two focus groups were held with members of the ARM committee, one with those committee members working in the voluntary sector and one with this members working in the statutory sector. These focus groups collected data on stakeholder perception of the ARM committee process and how the ARM is progressing in respect of its aims. The rationale for holding the voluntary sector focus group separate to the statutory sector focus group is that power and status related to agency roles can be an important dynamic in inter-agency working. Thus, each category was free to explore its unique experience of the process in a more in-depth manner.

A survey was distributed to all members of the management committee and front-line practitioners who participated in the ARM interventions. This data, along with any data relevant to training from the focus groups or intensive interviews, informed the training needs analysis for ARM. Additionally, any stakeholder who directly participated in an ARM intervention, was not a

member of the ARM committee and was not included in any of the case-specific focus groups, was offered the opportunity to contact the researcher by phone to give their views on the ARM. A summary of the fieldwork undertaken is shown in Table 1.1

Table 1.1: Summary of Fieldwork Undertaken

Data Collection Method	Participant Number and Background
Individual Intensive Telephone Interviewing	19 management committee members and 7 front-line practitioners.
Focus Group Interviews	1 with members of management committee from statutory sector; 1 with members of management committee from voluntary sector; 2 with front-line practitioners on the intervention in a specific case.

Data Analysis

All individual intensive interviews and focus group interviews were transcribed. A thematic analysis of the data was undertaken, guided by objectives. In the findings, the terms “most”, “many” and “some” are used. “Most” refers to more than two-thirds; “many” refers to more than half, and “some” refers to less than half. Where the terms refer to interviewees, it is applied to all the data in its totality. Where these terms refer to the sub-categories of members of the management committee or front-line practitioners, this is stated.

Ethical Approval

Ethical approval for this study was sought from and granted by the Research Ethics Committee at NUI Galway. All research participants were provided with information about the evaluation, prior to their involvement, and were informed that there would be no adverse implications for choosing not to participate.

1.4 Support of the Inter-Agency Case Working Sub-Committee

In parallel with the ARM evaluation, support was also provided to the Inter-agency Case Working Sub-Committee of the SDCSC. A quality assurance check was carried out on two draft documents developed by the committee. These were the inter-agency case working protocol and information-sharing guidelines. Information on approaches to inter-agency training was provided. Two online training needs surveys were carried out, in partnership with the committee, to inform the committee’s training strategy.

1.5 Report Structure

Following this introductory chapter, Chapter 2 provides the context and rationale for the ARM, by outlining the policy and legislative context, the theoretical context, the local context and the

ARM model as applied in Jobstown. Chapter 3 presents the findings on the stakeholders' perspectives of the Jobstown ARM. Chapter 4 offers a discussion of the findings in light of the theory discussed in Chapter 2, while Chapter 5 provides a set of conclusions and recommendations.

Chapter 2 - Context and Rationale

2.1 Introduction

This chapter provides a context for the development of ARM, as well as for the related work of the inter-agency case working sub-committee of South Dublin County Council. In Section 2.2, the policy and legislative context is set out. This is followed in Section 2.3 by the theoretical context, which addresses recent developments in integrated working, outcomes-focussed working and information sharing, as well as examining the inherent tensions involved in child protection and welfare. In addition, the origins of the differential response model and its applicability to the Irish context are also discussed. Section 2.4 provides a brief description of the local context of South Dublin and Jobstown, while Section 2.5 characterises the Jobstown-Alternative Response Model.

2.2 Policy and Legislative Context

The key policies and legislation relevant to both the ARM and the development of an Inter-agency Protocol and Information-sharing Guidelines are as follows:

- The Child Care Act 1991
- The Data Protection Acts 1988 & 2003
- Protection for Persons Reporting Child Abuse Act 1998
- The National Children's Strategy: Our Children – Their Lives, 2000
- The Agenda for Children's Services, 2007
- Children First, National Guidelines for the Protection and Welfare of Children, 1999.
- National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, 2008
- The Report of the Commission into Child Abuse 2009 Implementation Plan, 2009
- "Towards 2016" — Ten-Year Framework Social Partnership Agreement 2006 – 2015.

The Child Care Act 1991

The Child Care Act 1991 as amended by the Children Act 2001 provides the legislative framework for the protection and welfare of children in Ireland. Part II Section 3 of the Act states that it shall be a function of the HSE to promote the welfare of children in its area who are not receiving adequate care and protection. It also states that in the performance of this function the HSE shall take such steps as it considers requisite to identify children who are not receiving adequate care and protection, and co-ordinate information from all relevant sources relating to children in its area. The HSE must perform these duties, having regard to the rights and duties of parents, whether under the Constitution or otherwise. They must also regard the welfare of the child as the first and paramount consideration, and, in so far as is practicable, give due consideration to the wishes of the child and have regard to the principle that it is generally in the best interests of the child to be brought up in his or her own family. Section 3 of The Child Care Act also states that the HSE shall provide child care and family support services.

The Data Protection Acts 1988 and 2003

The Data Protection Acts 1988 and 2003 deal with the right to personal privacy. The relevance of the Acts to inter-agency working is outlined in *Appendix A — Sharing Information about Children & Families, Best Practice Guidelines for Practitioners and Managers*, South Dublin Children's Services Committee, January 2010

Protection for Persons Reporting Child Abuse Act 1998

The Protection for Persons Reporting Child Abuse Act 1998 provides protection from civil liability for persons who have communicated to the appropriate authorities their opinion that a child has been or is being assaulted, ill treated, neglected or sexually abused, or that a child's health, development or welfare has been or is being avoidably impaired or neglected, unless it is proved that he or she has not acted reasonably or in good faith. This provision provides a legal framework for early reporting to the HSE when there are reasonable grounds for concern that the health, development or welfare of a child has been or is being avoidably impaired.

The National Children's Strategy: Our Children — Their Lives, 2000

The National Children's Strategy sets out a vision for all children and young people in Ireland: "An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential." The Strategy is grounded in six operational principles, that all action taken will be child centred, family oriented, equitable, inclusive, action oriented and integrated. The strategy outlines the concept of the "whole child" perspective. This perspective helps to shape the three National Goals in the Strategy, which are:

- Children will have a voice;
- Children's lives will be better understood;
- Children will receive quality support and services to promote all aspects of their development.

The Agenda for Children's Services, A Policy Handbook, 2007

The *Agenda* builds on the work of the National Children's Strategy and other policy to promote a whole child/whole system approach to meeting the needs of children, and a focus on better outcomes for children and families. The *Agenda* identifies seven national outcomes for children and young people, which are that children should be:

- healthy, both physically and mentally;
- supported in active learning;
- safe from accidental and intentional harm;
- economically secure;
- secure in the immediate and wider physical environment;
- part of positive networks of family, friends, neighbours and the community;
- included and participating in society.

The *Agenda* proposes that children and families should experience services as being:

- whole child/whole system focused;
- accessible and engaging;
- coherent and connected to other services and community resources;
- responsive to their needs;
- staffed by interested and effective staff;
- culturally sensitive and anti-discriminatory.

In order to achieve the above services, the *Agenda* identifies five characteristics that services need to strive to achieve:

1. Connecting with family and community strengths;
2. Ensuring quality services;
3. Opening access to services;
4. Delivering integrated services;
5. Planning, monitoring and evaluating services.

Children First, National Guidelines for the Protection and Welfare of Children, 1999

The Children First Guidelines are intended to assist people in identifying and reporting child abuse. The Guidelines provide guidance for the definition and recognition of child abuse. The Guidelines apply equally to the welfare of children and to their protection. The Guidelines outline 12 best practice principles. Principles (iv) and (vii) state:

“(iv) Early intervention and support should be available to promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection;”

“(vii) Effective prevention, detection and treatment of child abuse or neglect requires a co-ordinated multi-disciplinary approach to child care work and effective inter-agency management of individual cases. All agencies and disciplines concerned with the protection and welfare of children must work co-operatively in the best interests of children and their families.”

Chapter 7 of the Guidelines comprehensively outlines the purpose of family support, its characteristics and dimensions, guidelines for the assessment of need and delivery of family support and provision for a family support plan and agreement. The Children First Guidelines are currently being revised by the OMCYA.

National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, 2008

The Office of the Minister for Children and Youth Affairs produced a national review of compliance with Children First in 2008. Referring to the *Agenda for Children's Services*, the Review states the *Agenda* “is part of, and reflects, the fundamental change now underway in how Government policy in relation to children's services is formulated and delivered, and seeks to remedy the ‘disconnect’ between policy at the higher levels and services on the ground” (2008, p.17).

In relation to protection and welfare services, the Review summarises the new approach under the heading “Development of Family Support Services”. This summary is outlined below:

“Child welfare and protection services now need to focus on need or vulnerability, as opposed to child abuse. This approach allows children and families to be identified as needing support before a child protection concern develops. It should also have the effect of reducing the stigma attached to child protection interventions, if they are based around supporting a family rather than investigating a child protection concern. This may make it easier for parents to admit to vulnerability and to seek help since the view has been expressed that the current system, with its emphasis on investigation of potential child abuse, is not conducive to parents admitting to inadequacy or inability to cope” (2008, p. 16).

The analysis of submissions made by key stakeholders for the Review highlighted the perceived difficulties in relation to support services for children, and early intervention. The Review stresses that the Children First Guidelines emphasise the importance of early intervention and family support, but less than 5% of the respondents to the public consultation believed that the Guidelines are being adhered to in respect of the provision of support services. Recommendation 4.1 of the Review states “That early intervention and family support services be strengthened as the most effective mechanism to address child welfare issues, and that child welfare and protection services be addressed in this context” (2008, p.15).

The Report of the Commission into Child Abuse, 2009: Implementation Plan

In the aftermath of the Ryan Report (2009) the Office of the Minister for Children developed an Implementation Plan in response to the Report. The Plan identifies children in need of welfare and support as a distinct category, along with children at risk of chronic neglect or harm and children at risk of offending. According to the Plan, in general, children are best served by community-based family support services that work directly with them and their families. The plan states that:

“Generic services, such as youth services, have much to offer and should be involved at planning and operational level with those services that work with neglected children and those at risk. It is a failing of the current child care system that cooperation among agencies and staff is dependent on local leaders rather than on standard practice. Agencies working together with families for whom there are child welfare concerns should identify a key worker – not necessarily a social worker – to ensure duplication of services does not occur and the child’s needs are met.”

The plan further reiterates the new policy direction of the State set out in the *Agenda* and also referred to in the *Review of Compliance with Children First*. The plan emphasises the role of the *Agenda* as the “overarching national policy for all children’s health and social services” that promotes a whole child-whole system approach to meeting children’s needs, with a clear focus on achieving better outcomes for children and families through the promotion of inter-agency work.

“Towards 2016”— Ten-Year Framework Social Partnership Agreement 2006-2015

This Social Partnership Agreement sets out the government’s commitments in relation to children’s services committees. The Agreement identifies the HSE as the organisation of choice to chair these committees, and outlines the objective of this initiative as follows:

“At local level a multi-agency Children’s Committee will be established within each of the City/County Development Boards. These committees will be chaired by the HSE who are best placed to drive this initiative to achieve coordinated and integrated services....The objective of this initiative [the Children’s Services Committees] is to secure better developmental outcomes for disadvantaged children through more effective integration of existing services and interventions at local level” (Cited in CES, 2010, p.8).

Summary of the Policy and Legislation Context

It is clear from the above information that the ARM and the work of the Inter-agency Case Working Sub-committee, are operating within a complex and evolving policy and legislative context, and that a reform agenda based on integrated working in children’s services and family support is continually being formulated and updated. Box 2.1 below provides a summary of the policy and legislative context as discussed above.

Box 2.1: Summary of Policy and Legislative Context

The key policies and legislation relevant to both the ARM and the development of an Inter-agency Protocol and Information Sharing Guidelines are:

- The Child Care Act, 1991
- The Data Protection Acts, 1998 & 1993
- Protection for Persons Reporting Child Abuse Act, 1998
- The National Children’s Strategy: Our Children – Their Lives, 2000
- The Agenda for Children’s Services, 2007
- Children First, National Guidelines for the Protection and Welfare of Children, 1999
- National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, 2008
- The Report of the Commission Into Child Abuse 2009: Implementation Plan, 2009
- “Towards 2016” — Ten-Year Framework Social Partnership Agreement 2006-2015

2.3 Theoretical Context

This section addresses recent developments in integrated working, outcomes-focussed working, and information sharing, as well as examining the inherent tensions involved in child protection and welfare. It also discusses the origins of the differential response model and its applicability to the Irish context.

Integrated Working

In relation to inter-agency working, Frost (2005) proposes that there is a hierarchy of partnerships going from cooperation, to collaboration, to co-ordination, through to integration which is often viewed as the highest level of inter-agency working. The benefits of this way of working include the pooling of resources, greater accessibility to services for service users and the identification and reduction in wastage of resources (Costongs and Springnett, 1997; Richardson and Asthana, 2006; Whyte, 1997).

The importance of relationships to integrated working is a key factor. Often, positive examples of joint working are based on the good-will of individuals (Laming, 2009). Differences in perceived power or status can hamper relationships, and in turn can impede outcomes. These differences can be between agencies, between professional groupings or between professionals and service users. “Recognition of the power differentials at play in such processes is crucial to effective process, with a commensurate method to overcome such differentials so as to allow all to participate and contribute equally in it” (Canavan et al, 2009). In recognition of this need for a shared approach to interagency working, and a shared understand across all professionals of what it entails, the South Dublin Children’s Services Committee have produced a set of guidelines: *Working Together for Children: An Inter-agency Caseworking Protocol* (See Appendix B).

Outcomes-focused Working

The *Framework for Integrated Planning for Outcomes for Children and Families* (CAWT, 2008, p. 9) defines outcomes as “an articulated expression of well-being of a population in a place which provides all agencies with the opportunity to contribute to that outcome with their individual programmes”. Key concepts associated with an outcomes-focused approach are *indicators* and *participation*. The CAWT Framework defines indicators as “measures which permit organisations to ascertain the degree to which identified outcomes are being achieved; they provide information on the status of a situation or event with a view to improving the situation” (CAWT, 2008, p.12). The Framework outlines how indicator development is critical to the success of an outcomes-focused approach. An outcomes-focused approach is intimately linked to the principle of participation set out in Article 12 of the *United Nations Convention on the Rights of the Child, 1989* and also to the participation of families, because failure to include all stakeholders in the process of agreeing outcomes means that meaningful participation cannot occur.

Benefits of adopting an outcomes-focused approach include a greater awareness of the effectiveness of resource use; enhanced accountability of organisations; reduction and elimination of duplication; and, when accompanied by appropriate indicators, the opportunity to identify inefficient or sub-optimal programmes and initiatives (Canavan et al, 2009). Frost and

Stein (2009, p.16) identify some of challenges associated with the outcomes-focused approach as:

- Disentangling the impact of services from the wide range of contextual and interpersonal factors that may shape the life chances of children and young people;
- The contested nature of what outcomes should be measured and attributed to services — for example, should Sure Start projects be viewed as making a direct contribution to the five universal outcomes of Every Child Matters, reflecting societal goals for all children, or measured against more contextualised questions such as whether children access a toy library at a local children's centre;
- The dynamic nature of 'outcomes', which often change between 'official' measurement periods;
- The separation of outcome areas (for example, education, health and well-being) from each other, even though they are often closely inter-connected; and
- Finally, who should define outcomes — service managers and commissioners, or service users?

Integrated Working and Outcomes-focused Working Together

Frost and Stein (2009) argue that the move towards integrated, multi-professional working, and the increasing emphasis on improving outcomes for children and young people are the two most significant shifts in contemporary child welfare. They also maintain that these concepts are intimately connected, as the move towards integrated working is based on the intention of improving outcomes for children and young people. Canavan et al (2009) elaborate on the connection between the two concepts, arguing that thinking about outcomes necessitates thinking about the way organisations work with each other and with services users, and collaboration becomes key in how outcomes are decided upon and achieved. Outcomes then provide the framework within which collaboration occurs (McTernan and Godfrey, 2006). The shift to outcomes-focused working should then be seen as equally significant to the shift towards integrated working.

It is important to highlight that the evidence base in relation to these developments is in its infancy; a cautious approach is appropriate, and an absolutist stance on their effectiveness should be avoided. There is some criticism, in relation to inter-agency working, that increased co-ordination of services leads to increased surveillance and control over families (Frost, 2005), has a negative effect on service quality and no effect on outcomes (Glisson and Hemmelgarn, 1998 cited in Frost 2005). Dowling and others (2004) have argued that to date the *process* of partnership approaches has been emphasised without adequate attention to the *outcomes*.

There is, however, a growing body of literature relating to inter-agency working outlining different types and levels of working, principles and factors associated with success, and challenges and obstacles associated with the process of the work. The terminology associated with the broader concept of partnership is complex, and there are subtle differences between types and levels of working that can occur. The *Guidance to Support Effective Inter-agency Working Across Irish Children's Services* (CAAB, 2009) provides an accessible summary of the literature for practitioners.

Information Sharing

Much of the literature relating to information-sharing is consists of guidelines and procedures, relating to the legal aspects of the area and good practice in this regard (CAAB, 2009; DCSF, 2008; EURIM, 2008). Some of this literature is specific to children's services, and some relates to sharing information in general. *Information Sharing: Guidance for Practitioners and Managers*, produced by the Department for Children, Schools and Families (DCSF) in the UK, and used in conjunction with the other various resources available under 'Every Child Matters', forms the basis of information-sharing practice in the UK. The DCSF guidance identifies the development of an information-sharing governance framework as good practice. Such a framework should recognise the importance of professional judgement, focus on improving practice in information-sharing, and communicate this clearly to front-line staff so that they have confidence in their organisation's commitment and support for professional information sharing (DCSF, 2008). Such a governance framework would include:

- **An information-sharing code of practice**, which outlines the principles and standards of expected conduct and practice of the organisation, and staff within the organisation. The Code of Practice establishes the organisation's intentions and commitment to information-sharing, and promotes good practice when sharing personal information.
- **Information-sharing procedures**, which describe the chronological steps and considerations required after a decision to share information has been made; for example, the steps to be taken to ensure that information is shared securely. Information-sharing procedures set out, in detail, good practice in sharing information.
- **Privacy, confidentiality, consent (service users)**: The organisation should have in place a range of processes and documentation for service users, such as "Privacy/Confidentiality Statement", "Fair Processing Notice", "Consent", and "Subject Access". Relevant staff within the organisation must understand these processes, and be able to access documentation when required.
- **Information-sharing protocols (ISP)**: Where the organisation is involved in pre-specified, regular or bulk sharing of personal information with other organisations, then the framework would also be expected to include one or more Information-sharing Protocols. An ISP is a signed agreement between two or more organisations or bodies, in relation to specified information-sharing activity and/or arrangements for the routine of bulk sharing of personal information. An ISP relates to a specific information-sharing activity and explains the terms under which both (or all) organisations have agreed to share information and the practical steps that need to be taken to ensure compliance with those terms (DCSF, 2008, p. 27).

The DCSF guidance highlights that there have been some uncertainties in relation to information-sharing governance frameworks in the UK, and makes two important clarifications. The first is that an information-sharing protocol does have to be in place in order for information to be shared. The second is that some information-sharing protocols are designed to support regular bulk sharing of information between agencies, and are not intended for front-line workers.

The majority of secondary comment on information-sharing is contained within general literature on inter-agency working. Throughout the literature on inter-agency working, lack of clarity regarding information-sharing is frequently mentioned as a potential obstacle or barrier to effective inter-agency working (Sloper, 2004; Percy-Smith, 2006). Much of the literature refers to the highlighting by various enquiries of a lack of information-sharing as a factor in poor outcomes for children, and lack of clarity as a reason given for the poor information-sharing. This is most notable in respect of Lord Laming's Report into the death of Victoria Climbié (Laming, 2003). In his Report on progress since the initial Climbié Report, Laming states that despite clear guidance from the Department of Children, Schools and Families in 2006 and 2008, there continues to be a real concern across all sectors about the risk of breaching confidentiality or data protection law (Laming, 2009). This concern exists despite the fact that information can lawfully be shared. Although the legal framework is different in Ireland, the point to note is that despite the fact that a legal framework does exist, some concern and confusion still arises. This suggests that the communication and implementation of guidance is critical.

Information-sharing is frequently identified as necessary in order for practitioners to engage effectively in integrated working, outcomes-focused working, and comprehensive needs assessment. Percy-Smith (2006) highlights information-sharing as a factor that must be reviewed when moving from development to delivery of strategic partnerships for children. Considering the link between integrated working and an outcomes-focused approach, it follows that information-sharing is required in order for practitioners to plan and work towards outcomes in an integrated way. Park and Turnbull (2003) emphasise the distinction between structural and interpersonal factors; in their synthesis of literature, information-sharing was influenced by both.

An additional way in which a lack of clarity around information-sharing can act as a barrier to effective inter-agency working is that agencies can "hide behind" confidentiality requirements in order to protect organisational boundaries or to limit agencies' responsibilities (Atkinson et al, 2002). A change in culture may be required in some organisations in order for the Guidelines to be implemented effectively.

Some of the literature highlights the risk that excessive information-sharing may lead to a culture of surveillance (Frost, 2005; Penna, 2005; Hudson, 2005). It is important to highlight that much of this criticism pertains to developments in the UK using information technology for tracking purposes and is not necessarily as relevant to the Irish context. Concerns relating to excessive surveillance or privacy violation can be addressed by awareness of the rights of children and their parents; confidence in the exercise of practitioner's discretion in relation to the professional ethic of confidentiality; emphasising the importance of informed consent in information-sharing, and involving children and parents in the assessment and intervention process (Munro, 2007).

Child Protection and Welfare, and Family Support

Child protection and welfare is increasingly complex and ambiguous and subject to tensions and contradictions (Parton, 1997). Parton argued that child protection was the dominating concern and that child welfare was merely framed within child protection. The dominance of child protection over child welfare considerations highlighted by Parton is evident in the National Review of *Children First*, discussed above. Spratt (2001) proposes that there is a fear factor

amongst social workers caused by public opinion that leads to child welfare referrals receiving child protection responses.

The tensions between child protection and child welfare can be understood in terms of a distinction between surface and depth issues. Buckley (2009), writing in relation to reform of the child protection system in Ireland, uses the distinction made by others (Howe, 1996; Cooper, 2005) between surface and depth in child protection. Surface issues consist of the law, policies, procedures, performance indicators and auditing tools, which combine to provide a visible framework for the delivery of services. Surface issues are based on the assumption that definitions of child abuse and thresholds for intervention are fixed and clear to everyone involved, and that performance and quality may be judged by the application of technical rationality. Depth issues are more subtle, and include the ideological basis for the work, the dynamics that occur within and between professions and organisations, the nature and quality of relationships between practitioners and service users, the struggle to balance helping relationships with statutory obligations, and variable thresholds for intervening with families. Parton (1998) argues that the uncertainty and ambiguity of these “depth issues” needs to be acknowledged when refocusing children’s services, and that “surface issues” that are overly concerned with gaining certainty in the assessment of risk are not focused on meeting the needs of children or protecting them from abuse. Spratt (2001, p. 952) states that “the need to manage risk has proved to be a pervasive influence on practice not only with families that are the subject of child protection investigations, but also with those who receive child welfare interventions.” He goes on to call for a move from surface to depth in how we understand what social workers do and why they do it.

It follows that assessment of child protection and welfare concerns is not straightforward. Horwath, in a small-scale study on the assessment of neglect by social workers in Ireland, found that assessment practice in cases of child neglect varied in terms of the way front-line staff approached the assessment task and process (Horwath, 2005, p. 108). The assessment was influenced by two particular factors: the role of the team in determining the focus of assessments, and subjective factors which impact on the way the individual social worker works with children, families and other professionals. Platt, in research into how social workers prioritise referrals of child concern, found that five key factors were considered: specificity, severity, risk, parental accountability, and corroboration, which resulted in either an initial assessment or an investigation of alleged abuse (Platt, 2006, p.4). The research highlights that this decision-making often takes place with limited referral information and without the input from the child. According to Platt, the notion of a continuum of abuse with scaling degrees of abuse or neglect in order to set the height of a threshold is inadequate in the face of the complexity of referrals and the methods used to assess them.

Buckley (2007) summarises the difficulties associated with the existing child protection services as follows:

1. The response to concerns about children tended to be shaped around inquiries into incidents which focused on whether or not the parent/carer was culpable of committing them against a child. Child abuse inquiries and high-profile child deaths had led to a risk-averse culture which prioritised compliance with procedures.

2. At the same time, the rate of referral to the child protection and welfare system in all countries had been increasing steadily, for example, inclusion of “witnessing domestic violence” as a category of child harm acted to accelerate the number of reports made to Canadian services. These cases rarely met the threshold for action and were frequently closed without services.
3. The investigative process was clearly not providing support services for the complex family problems, *e.g.* reports of poverty-related neglect, relationship or custody problems or child behavioural issues; once any immediate safety aspects were resolved, the case was frequently closed without the underlying issues having been addressed.
4. There was a very high rate of re-referral to the services, often involving families who had not been considered eligible for services on the previous occasion, but whose problems had subsequently escalated.
5. Community services for children and families tended to be fragmented and not linked into an overall strategy. Family support services were grafted on to child protection rather than forming an integral part.
6. Without exception, public perceptions of the statutory children’s services were negative, portraying practitioners as either “babysnatchers” or as totally inefficient.
7. There was growing recognition of the value of engaging families in promoting protective behaviours.
8. There was a need for a clearer environment of accountability to achieve measurable outcomes in child welfare.

Jack (1997, p. 674) argues that as long as limitations are imposed by the child protection discourse, inevitably many of the real needs of children and families will continue to be ignored. Jack argues that we must recognise the difficulty of the task of raising children in the contexts of poverty, deprivation and discrimination and the need for action to support families at a local level. He challenges the reliability of risk assessment models, and calls for the crucial issue of children’s empowerment to be addressed. Many of these limitations have led to a greater interest in family support as an approach to working with children and families. In England, the Department of Health publication *Child Protection: Messages from Research* (1995) espoused the diversion of resources away from an exclusive child protection focus towards a family support approach.

Maintaining such a family support orientation in child protection and welfare has been proposed as one potential way of ensuring that the risk only approach is avoided. Dolan, Canavan and Pinkerton (2006) define family support as, “... both a style of work and a set of activities that reinforce positive informal social networks through integrated programmes. These programmes combine statutory, voluntary, community and private services and are generally provided to families within their own homes and communities. The primary focus of these services is on early intervention aiming to promote and protect health and well-being and rights of all children, young people and their families. At the same time attention is given to those who are vulnerable

or at risk.” The *Agenda for Children’s Services* (2007) defines family support as “activities for families that are developmental (e.g. parenting for the first time), compensatory (e.g. helping a child cope with a disability) and/or protective (ensuring safety of a young person).”

Dolan, Canavan and Pinkerton (2006, p.16) elaborate on their above definition by outlining ten principles of family support. These principles are frequently applied to family support services and programmes. However, they can equally be applied to social work interventions and to child protection and welfare services. Child protection and welfare services can develop a family support orientation if they are based on these family support principles.

Table 2.1, first compiled by Hill, Stafford and Lister (2002) and adapted by Connolly (2005) contrasts services with a child protection orientation with those having a family support orientation.

Table 2.1: Contrasting Child Protection with Family Support

Child Protection Orientation	Family Support Orientation
<i>Characterised by child protection systems in the United States, UK, and Australia, reflecting:</i>	<i>Characterised by child protection systems in Continental West European (Belgium, Sweden, France, Germany) reflecting:</i>
A tendency toward residual and selective provision of welfare	A tendency toward universal welfare provision
Child protection services being separated from family support services	Child protection services embedded within broader family support orientation
A more legalistic, bureaucratic, investigative, adversarial response to child protection	A voluntary, flexible, solution-focused, collaborative approach to child protection
Emphasis on children’s rights and child protection	Emphasis on family unity and a systems approach to family
Emphasis on investigating risk	Emphasis on support and therapeutic assistance
Concentrating state resources on families identified as immediate and high risk	Resources available on the basis of early intervention

The *New Beginning Programme* is an example of altering child protection and welfare services towards a family support orientation. The programme is founded on the basic principles of prioritisation in order to meet need, and family support orientation. The Evaluation Report of the programme found that “there was unanimous agreement that the core Family Support principle underpinning New Beginnings was well founded. Importantly, there was an understanding that Family Support was not a ‘soft’ service provided in the community, but equally applicable to child protection and alternative care.” (Child and Family Research and Policy Unit, 2006, p.32)

Differential/Alternative Response

The differential response model (DRM) also known as the alternative response model (ARM) could be viewed as a specific attempt to reconcile the inherent tensions between child protection and family support. The differential response model ensures low and moderate risk cases are

provided with a comprehensive family assessment and are offered timely services without a formal determination or substantiation of child abuse or neglect; only high-risk cases receive the traditional investigative response (Merkel-Holguin, 2005). Waldergrove and Coy (2005) view the DRM as a step towards a closer relationship between the statutory-based social work resources and the non-government sector, as well as providing more comprehensive outcomes-focused provision.

There are variations in how the model has been implemented in different settings. Yuan (2005) summarises the common characteristics of the alternative response model as:

- AR is provided to families that are the subject of an accepted report alleging child maltreatment.
- The decision to provide a traditional investigation or AR is made at initial screening, with a provision that the response can be changed based on risk and safety assessments.
- AR may be provided by community-based providers or public child welfare case workers. In some localities, these workers may conduct investigations; in others, these workers may be in different units from investigation workers.
- AR is not considered appropriate for cases that are likely to require court intervention, such as sexual abuse or severe physical harm to a child. Other restrictions may apply based on state statute or departmental policy.
- If an AR assessment is refused by a family, the agency may conduct an investigation. Post-assessment, if voluntary services are refused, the agency may close the case.
- A formal determination of whether the child has been abused is not required.
- Since abuse or neglect is not determined, caregivers are not labelled as perpetrators of child maltreatment and do not become part of the state's central registry of perpetrators.

According to Sawyer and Lohrbach (2005) the alternative response described above is typically offered in circumstances of:

- Low or moderate risk of physical abuse;
- Children who are without basic necessities such as food, shelter, or clothing;
- Health and medical needs that, if left unattended, can result in harm;
- Concerning or damaging adult-child relationships;
- The absence of supervision or proper care;
- Educational neglect.

The traditional child protection response is reserved for situations where:

- Serious physical, medical, or emotional abuse and serious neglect where a referral for law enforcement involvement is indicated;
- Child sexual abuse;

- Children in licensed child care or foster care;
- A serious violation of the criminal statutes;
- Specific acts of the parent or caretaker that have a high probability of leading to court-ordered removal of the child or caregiver from the home, including chronic neglect.

An evaluation of the Minnesota Alternative Response Project piloted in 20 counties in 2001 and subsequently expanded state-wide, was published by Loman and Siegel in the Institute of Applied Research, St. Louis, Missouri, USA in 2005. The results showed that child safety was not compromised by the DRM. Also, children were made safer sooner, and there were improvements in family functioning in a number of cases. Utilisation of community services increased, report re-occurrence declined (or remained static in some areas). The numbers of children received into care declined (Loman and Siegel, 2005).

Buckley (2007) outlines the differences between current child protection and welfare practice in Ireland, and the DRM:

- Under the DRM, consistent methods of preliminary and full assessment are used. Common tools in usage are: structured decision making (SDM); safety assessments; frameworks for comprehensive assessment; the application of eligibility criteria for different streams; and dispute resolution. It is important to bear in mind that tools are different from procedures; tools offer practitioners detailed guidance on decision-making in professional practice whereas procedures are largely administrative mechanisms. Some parts of the HSE in Ireland use tools, but there is no standard implementation.
- Under the DRM, steps to be taken following referral are formalised in a detailed and unitary written policy to be applied throughout a jurisdiction. This includes standard intake procedures, eligibility criteria and methods for linking families with community services. In Ireland, such practices are organised on a localised basis.
- Under the DRM, voluntary/community agencies, sometimes called “Community links”, buy into the model by signing service agreements that align them with child protection services in terms of responsibility, which includes carrying out assessments in what might be termed low-risk child protection cases. Referral pathways between the two are clear and unobstructed. Many of the published accounts of this model in Australia, the US and Canada emphasise the “partnership” required between statutory and voluntary agencies in order to implement the DRM, and it would appear that such partnerships are put on a very clear and formal footing, explicitly outlining the responsibilities to be carried by each partner. Relationships between the voluntary and statutory services in Ireland are less formal and sometimes problematic.
- In some areas, community and statutory services share information databases on children and families. The management of information in the Irish child protection system is still at a developmental stage.

According to Buckley, the DRM makes practice more accessible, integrated, accountable and measurable than the existing child welfare service delivery in Ireland. With the DRM the emphasis is on support and welfare provision, whilst in the current Irish context family support

may be more discretionary and vulnerable to cutbacks (Buckley, 2007). Shannon (2009) in his report to the Oireachtas as Child Protection Rapporteur, suggests that the uniformity of DRM could assist in combating the problems of inconsistency noted in the *National Review* of the implementation of *Children First*.

Summary of Theoretical Context

Box 2.2 provides a summary of the theoretical context described above.

Box 2.2: Summary of Theoretical Context

- Integrated working and outcomes-focused working are intimately linked.
- The shift to outcomes-focused working should then be considered to be as significant as the shift towards integrated working.
- Information sharing is frequently identified as necessary in order for practitioners to engage effectively in integrated working, outcomes-focused working and comprehensive needs assessment.
- Child protection and welfare are increasingly complex and ambiguous, and subject to tensions and contradictions.
- Child protection and risk can become the dominant consideration to the detriment of child welfare and family support.
- Maintaining a family support orientation in child protection and welfare has been proposed as one potential way of ensuring that a risk-only approach is avoided.
- The differential response model (DRM), also known as the alternative response model (ARM), could be viewed as a specific attempt to reconcile the inherent tensions between child protection and family support.
- The DRM/ARM ensures low- and moderate-risk cases are provided with a comprehensive family assessment and are offered timely services without a formal determination or substantiation of child abuse or neglect; only high-risk cases receive the traditional investigative response.
- The DRM/ARM can be viewed as a step towards a closer relationship between the statutory-based social work resources and the non-government sector, as well as providing more comprehensive outcomes-focused provision.

2.4 Local Context

South Dublin Children's Services covers the administrative area of South Dublin County Council. The membership of South Dublin Children's Services Committee (SDCSC) is drawn from a wide range of key statutory, community and voluntary organisations with a remit for young people. The main objectives of the SDCSC are to:

- Develop strong cross-agency working relationships
- Secure support for the joint implementation of policy initiatives
- Maximise integration of service delivery at local level

HSE Services in Dublin South West

Dublin South West LHO covers a relatively small geographical area, but is densely populated. The LHO had a total population in 2006 of 147,837. Tallaght forms a major population centre within the LHO. According to the SAHRU Index, Dublin South West has 17,078 children living in the highest decile of deprivation, and overall 71,501 of the population ranked at decile 10. Additionally, in the National Social Work Survey conducted in 2008 (HSE, 2008), Dublin South West had the ninth highest percentage of children in care nationally. In 2006, 48,311 of the population were covered by the medical card scheme. Overall, this creates a profile of a community of high density and high deprivation, particularly for children and families. The needs of vulnerable children and families are further compounded by other social factors such as crime, poor infrastructure, substance misuse issues, mental health issues, and limited support networks, particularly within newer communities (*Dublin South West Children & Families Social Work & Child Care Service Annual Report, 2009*).

Social Work Services

The Children and Families Department is divided into eight sub-teams in respect of its service provision throughout the Dublin South West Area. The areas covered are Tallaght (including Jobstown), Walkinstown, Drimnagh and Crumlin as well as smaller regions in Dublin 6W. The area is subdivided into five geographical "patches" in respect of the delivery of the child protection and welfare service. Additionally there is a Family Support Service, a Family Resource Centre, a Fostering Team and a Community Work Team that cover the entire catchment area. Each sub-team is managed by a Team Leader, with overall management responsibility resting with the Principal Social Worker (*Dublin South West Children & Families Social Work & Child Care Service Annual Report, 2009*).

Jobstown

The Jobstown patch covers the DED areas of Ballinascorney, Bohernabreena, Firhouse Village, Jobstown and Kiltipper. The Jobstown patch population in 2006 was 28,912. Jobstown ED is densely populated, but the area spreads further out into the less densely populated rural areas of Bohernabreena and Ballinascorney. Jobstown has a large proportion of young people; approximately 50% are under twenty years of age. The area has a high population of lone parents, high levels of deprivation and significant drug-related problems.

2.5 The Model

The Jobstown ARM arose in the context of the work plan of SDCSC. Key local managers attended a seminar held by the Children's Act Advisory Board on the differential response model in 2008. A study visit to the New Beginnings Project in Foyle Trust in Derry also took place. An inter-agency committee was brought together, and a model was developed that sought to capitalise on the strengths of the differential response model as well as operationalising the Agenda for Children's Services. As the terms DRM and ARM are used interchangeably in the literature, the decision was made to use ARM as the title of the pilot initiative.

Rationale and Aims

The rationale of the ARM process is to offer, as part of Jobstown Social Work Department's role in promoting the wellbeing of children and families, a comprehensive family assessment and intervention in partnership with a broad range of statutory and voluntary partners. The aims of the model are to:

- Improve outcomes for children and families through enhancing inter-agency collaboration and the cohesive response of services to families;
- Facilitate timely access by children and families to appropriate early intervention support services on the basis of assessed need;
- Reduce the number of children and families notified under the child protection notification system.

Structure

The structure of the model is based around the ARM Management Committee. The committee is chaired by the Child Care Manager and has representation from organisations involved in providing services to children and families, including statutory services such as the Social Work Department, family support and community work services, public health nursing, the Gardai, NEWB, the Probation and Welfare Service, South Dublin County Council, and voluntary organisations such as Barnardos, Foróige, Jobstown Family Centre and the YMCA. The committee meets on a monthly basis. The ARM process is part of the HSE Social Work Department's operational procedure. The ARM committee is open to new members from any additional agencies identified as relevant to the work of ARM.

Process

The pathway for the model is outlined in the process diagram (See Figure 2.1). The process involves referral, assessment, intervention, case review/closure and service planning.

Referral

- Community, voluntary and statutory agencies, including participating ARM agencies can make referrals to the HSE Social Work Department Jobstown with the ARM specifically in mind. They are encouraged to complete the Children First standard reporting form with an additional two pages of assessment regarding the child's developmental needs and parental capacity based on the HSE initial assessment format.

- The referrals flagged as potentially suitable for the ARM process, along with all other child protection and welfare referrals, are screened by the Jobstown intake team.
- Inappropriate referrals are screened out; information may be given or referrals made to other appropriate services.

Assessment

- Preliminary enquiries are carried out on all accepted referrals.
- The outcome of preliminary enquiries is recorded in an intake form including a categorisation of the referral as involving physical abuse; sexual abuse; neglect; emotional abuse; child welfare issues or “other”.
- The intake team then decide what action should be taken. Amongst the actions available to the intake team to recommend are initial assessment, no further action, other service provider, waiting list, allocated, ARM referral meeting.
- An initial assessment is then completed where preliminary enquiries deem it to be required. Cases identified as ARM referrals are assessed by the intake team within 10 days.
- Where domestic violence is a significant factor, assessment can be done jointly with the HSE Family Resource Centre (FRC) and a DV specific intervention offered with the FRC as the lead agency in the ARM process.
- Cases assessed as involving child protection concerns receive a traditional investigative response.
- All child welfare cases not receiving an alternative response receive a traditional child welfare response.
- Although all child welfare cases are suitable for the ARM process, due to limited capacity a selection of child welfare cases are referred and presented to the ARM committee by the intake social worker, using the initial assessment template.
- When a case is referred to the ARM, the members of the committee discuss the anonymised referral and decide whether or not to accept the referral.

ARM Intervention

- When a case is accepted into the ARM, then a lead ARM agency is agreed based on suitability to meet the assessed need and supported by other ARM agencies appropriate to assessed need. The lead role can be shared, if appropriate, based on assessed need.
- Identifying details are not discussed until informed written parental consent has been received.
- Consent is obtained either by the social worker who completed the initial assessment, the lead agency, the referring agency or another agency based on which worker is best placed to seek consent in terms of having an established relationship with the family.
- In partnership with the family, the lead agency continues the assessment, coordinates the intervention plan designed to meet the assessed need, and reports back to the committee.
- Other agencies not participating in the ARM committee may also be involved in the intervention, appropriate to assessed need.
- The intervention is carried out in partnership with the family to provide timely access to an integrated, needs based, inter-agency response with one point of contact for the family.
- If child protection concerns emerge during the course of the ARM process, then the assessment of the concern is dealt with under the traditional child protection route while the supportive intervention continues.

ARM Case Review/Closure

- The ARM intervention continues with the lead agency reporting back to the ARM committee on progress in an anonymised manner.
- The first report back to the ARM committee happens within four weeks of the lead agency being appointed, and as prioritised by the committee for discussion thereafter.
- The ARM committee oversees the intervention plan, regularly reviews the plan and, if appropriate, agrees that the lead agency should change based on assessed need.
- The ARM committee agrees if and when the case should be closed to the ARM process. Agencies may remain involved with a family after the case is closed to ARM.

Service Planning

- The ARM committee tracks all cases for patterns in relation to population level need, gaps in service provision and common issues encountered in inter-agency working.
- The ARM committee uses the aggregate data to plan in relation to service development such as reconfiguration of services, resource allocation, common practice issues, training needs, developing a common language amongst professionals and organisational issues.

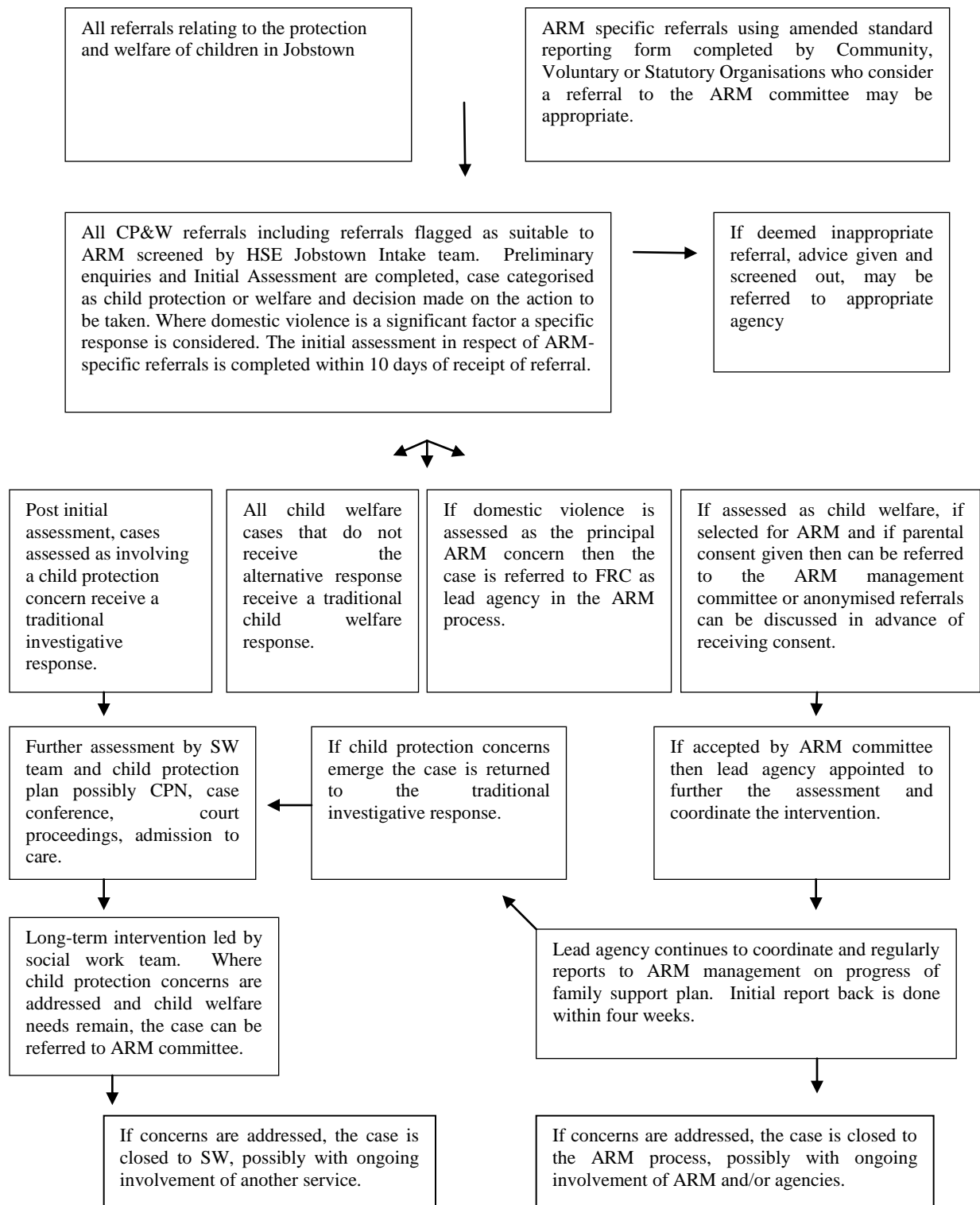


Figure 2.1: Jobstown Alternative Response Model

ARM Information System Data

Data provided to the evaluation team indicates that the ARM group had dealt with a total of 18 cases. The first of the cases was presented to the committee in September 2009, the most recent in June 2010. There were 46 children in the families involved. Nine of the families were headed by a person parenting alone. Referral sources were Barnardos, ISPCC, National Education and Welfare Board, Gardaí, schools (including a school counsellor), the Probation Service, Saint Vincent de Paul and self-referral. In eight of the cases, the family were aware of the referral.

The nature of the referrals varied, extending across parental mental health difficulties, drug and alcohol use, previous physical abuse of a child, sexual assault on a child, parent-child relationships, domestic violence, child behaviour, and more general neglect and child welfare concerns. As assessed by the Social Work team, the needs assessed related to practical supports in housing, mental health, parenting, bereavement, dealing with criminal justice issues, education and therapeutic supports, school attendance and assisting with access to services. After discussions at the ARM, the lead role in relation to the case was outside of the HSE in 11 cases, with Barnardos leading in four cases, and the Family Resource Centre in three. At the time of writing, seven of the cases were closed.

Cases referred to the ARM Committee constituted 5% of the overall number of referrals received during the period of the pilot, and 15% of child welfare referrals. Table 2.2 shows the distribution of referrals through the pathways involved.

Table 2.2: Referral Pathways for Jobstown Social Work Department for the Period of the ARM Pilot

Child protection investigation	Traditional HSE Child Welfare Response	Alternative Response
210 cases	120 cases	18 cases

2.6 Overall Summary

A summary of the rationale and context information which formed the basis for this chapter are provided in Box 2.3 below.

Box 2.3: Summary of Chapter – Rationale and Context

- The ARM and the work of the inter-agency case working sub-committee are occurring within a complex and evolving policy and legislative context, and a reform agenda based on integrated working in children's services and family support is continually being formulated and updated.
- There is also a wealth of theoretical knowledge within which these initiatives have been developed.
- In particular, there is a growing base of theoretical knowledge in relation to integrated working, outcomes-focused working and information-sharing, all of which are interconnected.
- There are limitations associated with the current operation of child protection services internationally, including an excessive focus on investigation and risk.
- Differential response, also known as alternative response, is a mechanism developed in the US to address these limitations.
- The Jobstown ARM is situated within this policy, legislative and theoretical context.

Chapter 3 – Findings: Stakeholders’ Perspectives of the Jobstown ARM

3.1 Introduction

This chapter presents the findings of the fieldwork in relation to the Stakeholder’s perspectives of the Jobstown ARM. Firstly, the Stakeholders’ experience of the setting up of the ARM is outlined. This is followed by their descriptions of the ARM, and their perception of the impact of the ARM and its strengths. Stakeholders’ views on the challenges encountered in implementing the ARM and on improving it are then outlined, along with the findings of the training needs survey. As there were more interviews done with members of the management committee than with front-line practitioners, there are more quotes from members of the management committee. However, the front-line practitioners interviewed raised important issues, which are included in the findings.

3.2 Stakeholders’ Experience of the Setting Up of the ARM

The majority of interviewees gave a positive account of the setting-up process of the Jobstown ARM. A small number of interviewees were involved in the setting up of ARM from the very outset, and others became involved at a later stage, depending on their role. A majority also felt a sense of ownership within the ARM process. The level of engagement in terms of a sense of being consulted about the setting-up, and feeling a sense of ownership, was greater amongst members of the management committee than amongst frontline practitioners. Many frontline practitioners expressed their sense of involvement in terms of their line manager’s involvement rather than their own.

There was a strong sense of partnership amongst those who were involved in the very early stages of the setting up of the ARM. It was felt that although the local HSE management had shown strong leadership and initiative, there was also an openness and willingness to work closely with other key partners, particularly Barnardos and the NEWB, in the early stages. This was identified as a critical starting-point for a sense of shared ownership that was built upon as the pilot developed. Almost all interviewees felt that there was a pre-existing context and culture of good inter-agency working relationships in Jobstown and in Tallaght which was conducive to the setting up of the ARM, and provided an environment that was welcoming of such initiative. In particular, it was felt that there was a core group of senior managers who had an established pattern of collaborating. There were some exceptions to this general sentiment, where some respondents felt that although there was a good history of agencies linking together that this was not exceptionally good compared to other areas, and not without its own natural tensions and difficulties.

There’s a history of working and there is a culture of work on an interagency basis as well and I think people get on, got on with it and I don’t think there was any wastage in terms of

competitiveness or arrogance or any of those negative kind of things that can happen but I think I would score it very highly in terms of focusing on children and families. (MC-FG-Voluntary)

A key issue highlighted by a number of interviewees was the existence of a “patch” system within the Social Work Department, with the result that there was an existing level of deep and consistent engagement by social workers and the social work team leader with agencies locally within Jobstown. The Social Work Department’s pre-existing policy of engaging with cases identified as being child welfare cases, and in offering support services to these families, both from within the “patch” and from the Family Resource Centre and Family Support Service, was also noted. The amount of preparatory or pre-development work done was also identified by some interviewees. A considerable amount of time was spent thinking about what the ARM was seeking to achieve, and developing relationships through open discussion and using hypothetical case studies.

We had eight or ten meetings in that first year, just purely around information sharing, checking things out with each other, developing those kind of relationship issues, role clarity, understanding what our limits are, right? And then before we started talking about real cases....we had the hypothetical cases and I think that was a big shift between moving in the direction of where we currently are, because those three hypothetical cases created huge debate here and challenges, which was brilliant. And I think that moved us into a new phase of having these kind of fairly open discussions, well I think people had put things on the table, sometimes, that haven’t been pleasant to hear, you know? But overall, though people are trying to work together, they are trying to understand each other’s roles, perspectives, and offer something for the children and families, but it takes time. (MC-FG-Statutory)

Each agency presented a profile of their agency to the other agencies, so everyone was clear on each other’s role, and specifically what services each agency did and did not offer. Some interviewees referred to the fact that Jobstown is an area of concentrated socio-economic disadvantage, as relevant to the context of the setting up of the ARM. Box 3.1 summarises the key points about setting up the ARM.

Box 3.1: Summary of Stakeholders’ Experience of the Setting Up of the ARM

- There was a strong sense of partnership amongst those who were involved in the very early stages of the setting up of the ARM.
- There was a pre-existing context and culture of good inter-agency working relationships in Jobstown and in Tallaght, which was conducive to the setting up of the ARM.
- The existing arrangement of social work and family support services was also conducive.
- The preparatory work done by the ARM management committee assisted the setting up of the ARM initiative.

3.3 Stakeholders' Description of the ARM

There was a considerable degree of consistency in how respondents described the ARM, although different respondents emphasised different characteristics. Some descriptions emphasised inter-agency working and coordinated intervention as a key characteristic of the ARM, whilst others reflected a view of it as an early intervention and prevention type initiative that focuses on welfare cases. Some respondents emphasised the fact that it shared responsibility amongst agencies so that the HSE need not be the lead agency in every instance, and some respondents placed considerable importance on the fact that the ARM seeks to deliver services to families quickly, in a timely fashion. One interviewee described it as being a non-stigmatising intervention for families, and another described it as being a short-term intervention, although each of these characteristics was mentioned only once. Front-line practitioners' understanding of the ARM was less clear, as outlined below in relation to challenges.

Very simply I think it's about agencies coming together to promote a much more effective and efficient response to families who are in need of support services. So it's basically pooling resources, pooling knowledge, developing integrated ways of responding to the local community. (MC-1-Statutory)

I'd describe it as a formal inter-agency response that, I suppose for me what it does is it filters child protection and then child welfare cases into two different channels and I suppose the one thing that I think is really valuable in it is that it actually sort of, sort of clearly puts the onus on other agencies around responsibility for welfare cases. (MC-4-Statutory)

A new innovative partnership model between the Social Work Department and other agencies that work in the community with children and families to provide a more cohesive and coherent and immediate response to child welfare cases. (MC-8-Voluntary)

I would see it as a better coordinated forum of inter-agency work that allows for an efficient system of sharing information, of planning services and being clear on what agencies' roles are in trying to meet the needs of children and families. (MC-3-Voluntary)

I suppose managers of different services came together and bought into a joint inter-agency process to try and respond more effectively to families that they were working with and with a commitment to try to deliver resources from within their own organizations to try and respond in a more timely fashion. (MC-5-Statutory)

Interviewees also related characteristics that they thought were unique about the ARM, such as the sense of a more formalised type of inter-agency working with the benefit of a perceived mandate and authority devolving from the ARM management committee and, for some, from the SDCSC. The link to SDCSC was most apparent to senior management members of the management committee and less so to front-line workers. Many had experience of working in an inter-agency way, but felt that the element of joint case planning and review was unique to the ARM. So whilst they had engaged in coordinated inter-agency interventions previously and may have reviewed such interventions individually or in an ad-hoc way, the ARM's formal and accountable approach wouldn't have been present in their former experiences.

Yeah I think because it's much more formalised, I also think that if you are trying to get somebody involved and when they hear it is part of the ARM process, they're more likely to get involved. (MC-3-Voluntary)

I think the fact that there's a management committee that sort of oversees it, I think is sort of different and I think as well because there is a sort of link in with the children's services committee which is fairly strongly mandated that it has, the process has been clear from the get go, that's what I would have felt in it. And it sort of formalizes the issue of the lead agency role that I don't think, whereas other initiatives maybe the way we were working before is that there wasn't that sort of formalization of expectation you know. (MC-4-Statutory)

A few interviewees considered the fact that families do not experience any significant waiting time to be a unique characteristic of the ARM, and that under the previous structure equivalent families would have spent a considerable amount of time on a waiting list.

Families could go on to waiting lists and be on waiting lists for long periods of time whereas this kind of trawling the waiting list to see are there families who can be got off the waiting lists and into services quickly, so it's radically different. (MC-6-Voluntary)

The majority of interviewees thought that while the values underpinning the ARM were not unique, the formal and structured application of them was. Additionally, although the ARM values were already those of individuals and agencies involved in the ARM, now that they were stated and committed to, they had become part of an explicit shared set of values.

I don't know whether they are unique but I suppose a lot of the values are the values that we would have been working off but it just its a more structured approach and it allows you to kind of really, I suppose really, bring about the values that you would have anyway but just to implement that in a better way you know? (MC-13-Statutory)

I think that's what people would, the majority of people I've come into contact with across the community, voluntary and statutory would aspire to, maybe the uniqueness is endeavouring to put structure around the aspiration. (MC-12-Voluntary)

As highlighted above, members of the management committee and in particular more senior managers viewed the ARM as being part of the work of SDCSC. Senior managers were also more aware of the ARM being linked to policy, specifically the *Agenda for Children's Services, 2007*. Front-line practitioners did not generally view the ARM as part of the work of SDCSC, linked to a broader policy agenda, or had not considered this.

Box 3.2 summarises the key points relating to stakeholder descriptions of ARM.

Box 3.2: Summary of Stakeholders' Descriptions of the ARM

- There was a considerable degree of consistency in how respondents described the ARM, although different respondents emphasised different characteristics.
- Some of the characteristics emphasised were inter-agency working; coordinated interventions; preventative, shared responsibilities; quick access to services for families.
- Unique elements of the ARM identified were a perceived mandate from management and SDCSC; joint case planning and review; the reduction of waiting lists; and having a stated and explicit shared set of values.
- The link with policy and with SDCSC was more apparent to members of the management committee and senior management in particular than to front-line practitioners.

3.4 Stakeholders' Perception of the Impact of the ARM

Overall, interviewees related that their participation in the ARM had a positive impact at the individual and organisational level, and for children and families. Although there were challenges, which are discussed later, there was no sense of any negative impact as a result of participating in the ARM. On the **individual** level, a substantial number of interviewees felt that they had learned a lot from being involved in the process. Some felt that their practice had been impacted upon in so far as they were more informed about other agencies and had developed relationships with representatives of other agencies. As a result, they were more aware of working in an inter-agency way, and more inclined to think about how the needs of children and families could be met early and quickly by the resources of those agencies. As one interviewee described, *it has given me a better insight into the kind of services that can help within a particular case* (MC-13-Statutory). One interviewee felt that while this approach may have existed to a degree previously, it was ad-hoc and personality-led. Involvement in the ARM meant that it could now be done in a structured and systematic way.

It's maybe [being] a little bit more conscious of what a young person might need around them and then just go get that and pull those people in irrespective of whether you know so and so or you've used that service before. (MC-12-Voluntary)

Certainly I'm much more aware of getting key players to a table at a much earlier stage. So I think early identification of need, early planning and having a clear sense of shared intervention appropriate to the need. So certainly I'm much more aware of that, just the benefits of that. (MC-1-Statutory)

The extent to which involvement in the ARM impacted on individuals' time varied greatly depending on their role in the ARM. With the exception of those directly involved in leading the

ARM, senior members of the management committee experienced less of an impact on their time, as generally their time commitment involved attendance at the ARM management committee once a month, as well as some preparatory work. Members of the management committee involved in the front-line delivery of services reported a much greater impact on their time, both from directly coordinating interventions if theirs was a lead agency, and also supervising front-line practitioners involved in interventions. In general, interviewees felt that the time commitment involved was worthwhile when the benefits were considered. For many, it involved work that they would be doing anyway, in some other format, if the ARM did not exist. Exceptions to this are discussed below in relation to challenges.

At the **organisational** level there was again consensus that involvement in the ARM had a positive impact. The internal organisational impact was different for large statutory bodies compared to smaller voluntary organisations. For example, for a small voluntary body there was an increase in their confidence in terms of the uniqueness and effectiveness of their model of work and ethos.

If you are lead agency with a family you know? It's a small, relatively small voluntary organisation, you are calling in some of the other bigger voluntary and even statutory organisations to you know? To focus on a family to deliver some, to try and deliver some outcomes for kids...It's about confidence and it's about finding your place really within the kind of plethora of organisations that are involved. (MC-15-Voluntary)

One member of the management committee working in the HSE spoke about how the process had assisted reflection within the organisation locally about how their work is carried out.

Well I would like to think that the HSE have become more open to inter-agency working because I think the flip side of the coin whereby other agencies see the HSE as always being the lead and having all the responsibility, the flip side of that is that the HSE sometimes sees itself as having all the authority and all the power and may not be as transparent or open as it could be in the collaboration process. So I suppose what I would hope is, and I've seen some signs of it, is that there is more openness within the HSE to sharing and collaborating in a real way, not in a piecemeal way. Because we do hold the power. We fund most of the organisations around the table you know and we have to recognise that power relationship. (MC-5-Statutory)

Most interviewees reported that their colleagues within their organisation were aware of the ARM. A small number said that they either already had reconfigured their service so as to align itself more closely with the ARM or were in the process of doing so.

Most of the impact of the ARM was experienced at the **inter-organisational** level. There was consensus that the ARM had increased the quantum of inter-agency working, both directly through the ARM but also beyond cases that were part of the ARM. The terms “spillover” and “knock-on effect” were used by numerous interviewees to describe how the ARM had allowed them to build relationships with individuals and organisations that they were now using to progress cases not within the scope of the ARM, and in working with families outside of Jobstown in other parts of Tallaght. There was a strong sense that the level of mutual

understanding between organisations had increased during the term of the ARM, and that as a result relationships and lines of communication were stronger.

My sense is it certainly enhances closer interaction between agencies, and I think it enhances our understanding of each other's modus operandi if you like and it certainly creates that forum for, I believe, really useful conversations in terms of helping us to have similar grammar if you like and a similar language and understanding where our remits begin and end. I think it's been invaluable in that respect. (MC-8-Voluntary)

I think it's allowed us to have a stronger level of communication just because we're meeting on a more formal basis and a more regular basis, I think, and that's certainly strengthened how we work. So it's just I think it's improved communication and improved I suppose trust maybe between the organisations in terms of how we can collaborate and it's broken down some of those maybe barriers that existed. (MC-10-Statutory)

Some interviewees also mentioned increased awareness of South Dublin County Council as a key agency, and increased knowledge of the services offered by their accommodation service. In particular, numerous interviewees reported a greater understanding of the processes and procedures of the HSE Social Work Department, and that this had led to an improvement in and strengthening of relationships with the Social Work Department. Comments from two interviewees illustrate:

It has probably taken some of the mystique and mystery out of all the world of intervention by Social Services (MC-15-Voluntary).

I would have had a sense at times that sometimes approaching social work and child protection issues in quite chaotic families, it was kind of like firing something into the darkness, you weren't really sure what happened and that's much clearer now. (MC-12-Voluntary)

This evaluation does not seek to make any summative conclusions about the impact of the ARM on **children and families**, and neither group was interviewed as part of the research. Some interviewees related their perceptions of the impact of the ARM on children and families, although others who had no contact with children and families in their roles chose not to comment. For those who did refer directly to impact, there was a general consensus that any assessment of outcomes for children and families was difficult, and there was a sense that it was too early to make any definitive statements in this regard. *I think people are meeting and the services are going into the family, I don't know that we've actually had a clear outcome as yet (MC-4-Statutory).* However, there was an awareness of outcomes and outcomes-focused working with children and families. Most interviewees felt that families were likely to receive a coordinated inter-agency response as a result of the ARM and were likely to receive this in a much shorter time-frame than they would if the ARM was not in place. Some interviewees felt that families were more aware of inter-agency working as a result of the ARM, and were reassured in the knowledge that the agencies that were working with them were working together in a coordinated way.

Certainly there seemed to me to be much more engagement, solid engagement with planning and putting supports in, in a timely manner...so that children and families weren't left waiting, it was about identifying where there was space so there wouldn't be too long a delay in terms of being put on a waiting list. (MC-7-Statutory)

I think that [families] knowing that there is a multi-agency approach, empowers them as people, as families, because they're involved in the meetings, they're involved in the process, they're involved in feeding back, they know that it's anonymous but they do know it's been discussed at a higher level, they know all the agencies involved are in communication, they've given consent for that, I think that helps the families function and avail of services on a better level than in the absence of that. (MC-17- Stat)

So we're less likely to have five and six agencies working with the family, where the family are running around from agency to agency, one for a three-year-old, another for a five-year-old, another for a 10-year-old and maybe getting even different kind of messages in relation to parenting that aren't helpful. (MC-8-Voluntary)

It was also felt that there was no evidence that the ARM had reduced the number of children and families notified under the child protection notification system, which is an aim of the model, but it was considered too early for ARM to have had such an impact and this remains a long-term goal of the ARM. Box 3.3 summarises stakeholder perceptions of the impact of the ARM.

Box 3.3: Summary of Stakeholders' Perception of the Impact of the ARM

- On the **individual** level, a substantial number of interviewees felt that they had learned a lot from being involved in the process.
- At the **organisational** level, there was again consensus that involvement in the ARM had a positive impact.
- Most of the impact of the ARM was experienced at the **inter-organisational** level; the amount of inter-agency working had increased, as had the level of mutual understanding.
- As a result, relationships and lines of communication were stronger.
- It was too early to fully assess the impact on **children and families**, but some interviewees felt that families were likely to receive a coordinated inter-agency response as a result of the ARM, and were likely to receive this in a much shorter time-frame than they would if the ARM was not in place.

3.5 Stakeholders' Views on the Strengths of the ARM

There was considerable consensus amongst the interviewees about the ARM's strengths. The most commonly mentioned was having a substantial number of agencies sitting around the table together. In addition to this, the high level of attendance from all agencies at the management committee meetings, was identified by most interviewees. It was felt that this reflected a strong commitment, and a level of engagement and enthusiasm, that was particularly impressive for some.

I think the strengths have been people's commitment to it and people's attendance, I think there's been really good commitment to it and good buy in from all the agencies and that has been continuous right the way through the process. (MC-10-Stat)

Interviewees also felt that the inter-agency collaboration that was at the heart of the ARM was an important strength. Specific strengths associated with inter-agency collaboration were the benefit of hearing about different approaches by people with different backgrounds to individual cases. One such example involved contrasting a social work approach with a youth work approach to working with a particular young person. It was felt that this pooling of expertise was an important strength of the ARM. Some interviewees mentioned that the ARM meetings at management committee and intervention level were supportive, and helped to build trust between agencies. The networking opportunities provided by the ARM were also identified as a further strength associated with the inter-agency collaboration of the ARM.

A considerable number of interviewees felt that a core strength of the ARM was the speed at which it connected families with services. Some felt that whilst inter-agency working had previously been occurring in the area, a unique strength of the ARM was the speed at which families received a coordinated inter-agency response.

Rather than, kind of, one agency picks up the case and then they gradually kind of cobble together an inter-agency group, that inter-agency group is established right from the beginning of the case so I think those are main strengths really. (MC-13-Stat)

It was felt that the process of joint case planning and review was a strength of the ARM. Some felt again that whilst inter-agency working had been ongoing, the process of structured case review was a unique strength of the ARM.

It is different in that I suppose there is follow-through, and there is the review process as well, that agencies come back and give some sort of update. (MC-2-Stat)

I think there's more accountability on organisations, more transparency, if you're there you need to be, you know, it's coming back to the management committee, is that done, did the meeting happen, who did what, I think that's really useful and I think in terms of the intervention, there's a sort of formalised more regular review of what's being done and what's actually happening for the family. (MC-4-Statutory)

Many interviewees emphasised the focus on child welfare rather than child protection as being a strength of the ARM and that this focus allowed services to work with families in a more preventative way. Some interviewees felt that the ARM was very responsive to need and that the intervention was a needs-led intervention.

Suddenly a family in need and everybody descends on it and the help may not be attuned or suited fully to what the family's needs were, so it seemed to me that there was a conversation happening there all the time where what was being fed into the family, questions and discussions were happening as to whether that was what they needed. (Case FG – 2)

As outlined above in relation to descriptions of the ARM, some interviewees felt that there is a perceived mandate attached to the interventions by virtue of the involvement of senior managers in the management committee and, for some, due to the link with the SDCSC. This was an important strength for some interviewees.

The majority of the interviewees on the management committee emphasised the facilitation and leadership of that meeting as a key strength of the ARM. Related to this was the view that the ARM is not hierarchical, but instead is an equal partnership between agencies, where the HSE is the overall lead, but in a way that facilitated equal participation of all agencies. This view was expressed about the ARM process at both the management committee level and also by some front-line practitioners.

The strengths are we cut to the chase.... it's not hierarchical, it's focused on outcomes for people and not organisations. (MC-15-Voluntary)

What I've noticed is that compared to regular work is that there is more shared ownership, that it isn't seen as other agencies attending a HSE meeting, do you know what I mean? There's more of a sense that it's an inter-agency meeting fully. (MC-5-Statutory)

It's been very well facilitated and the chair has really, has moved things along very well and again I would feel has played a huge role in, from my point of view, allowing that space for a bit of questioning, for you to be heard and listened to when you needed it. (MC-12-Voluntary)

Box 3.4 summarises briefly the key points from this section.

Box 3.4: Summary of Stakeholder Views on the Strengths of the ARM

- The number of agencies involved and their level of commitment and enthusiasm were considered a strength.
- The contrasting approaches, pooling of expertise and networking associated with inter-agency working were considered a strength.
- The speed at which the ARM delivers a coordinated response to families was considered a strength.
- Other strengths noted were the joint case planning and review, the focus on child welfare, the perceived mandate, and the facilitation and leadership of the management committee meeting.

3.6 Stakeholder's Views on the Challenges Encountered in Implementing the ARM

Stakeholders identified a number of challenges encountered in implementing the ARM. These were the anonymising of referrals; the membership of the management committee; communication between management committee and front-line practitioners; consent and family participation; child protection and welfare thresholds; the capacity of agencies to lead; joint case planning and review; and communication between the Social Work Department and lead agencies in relation to cases open to the HSE but led by another agency. The findings on each are outlined below.

Anonymising of Referrals

There was broad consensus amongst stakeholders about the key challenges encountered in implementing the ARM. The most commonly-mentioned challenge was that of discussing cases anonymously. As outlined in the model characterisation, the ARM process involves discussing new referrals and existing cases at the ARM management committee, using a numbering system in order to maintain confidentiality. Almost all members of the management committee identified this system as a major challenge in interviews, and it was also identified in both focus groups with the management committee. Interviewees felt that the system was confusing, and that it was difficult to be sure whether new referrals involved families that were known to their service. It was also difficult to keep track of the ongoing cases, in their view. Interviewees said this challenge had been openly acknowledged and discussed at the ARM management committee meetings and that despite this, the issue had not been fully resolved.

I suppose one of the difficulties is just how the cases are presented. They are anonymised and numbered at the moment, and I think that can be very confusing for committee members. As time goes on and more and more cases come to the system, it can be very kind of difficult to recall immediately well what case they are actually you know? (MC-13-Statutory)

Sometimes you kind of think is that the case that I'm dealing with, but it's just not quite enough for you to be sure that it's the one that you're already working on. So it can be quite confusing. (MC-FC- Statutory)

Membership of the Management Committee

A number of challenges were raised in relation to membership of the committee. Although the mandate provided by having senior managers from various agencies around the one table was identified as a strength of the ARM process, it also presented a challenge in terms of case discussion. The relationship of members of the management committee to front-line practice varied greatly. Some were directly involved with working with children and families, some supervised workers who were working with children and families, and others ordinarily had no direct contact with children and families. The presence of managers who had no involvement in front-line practice was identified by some interviewees as contributing to the difficulty outlined above regarding the anonymisation of referrals. Many interviewees felt that while having so many agencies around the table is a strength of the ARM, it also meant that that the process could be unwieldy with so many people attending the ARM management meeting.

I suppose my concern is that using the numbers and using such a big committee, are you actually, you know, is it less effective or less informed. (MC-FG-Statutory)

It seems a bit unwieldy at times. Having twenty people around a table does lend itself to very efficient, effective interaction and I'm not sure that's always required. (MC-8-Voluntary)

Also, in relation to membership, most interviewees considered the absence of key agencies from the management committee as a significant issue. Child and Adolescent Mental Health Services were mentioned by numerous respondents as a critical agency for the well-being of children that is not currently represented on the management committee. Some interviewees felt that the absence of adult mental health services and addiction services, in particular drug-addiction services, is also a significant gap. The absence of direct representation from schools on the management committee was identified as a gap, as was the involvement of the community sector. Both the representation of schools and the community sector were identified as issues relevant to the SDCSC rather than the ARM alone. A small number of interviewees viewed the representation of justice-related services such as the Gardaí and the Probation Service on the management committee as a potential obstacle to engagement by families.

I think again we don't have child and adolescent psychiatry there and part of me wonders is the management committee too big? (MC-4-Statutory)

There was a gap...in not having, particularly schools as such a key component in children's lives I suppose. (MC-FG-Statutory)

Communication Between Management Committee and Front-line Practitioners

A small number of members of the management committee were concerned that there was a disconnect between the ARM at management committee level and the ARM at the front-line service delivery level. This view was more common amongst front-line workers; some front-line workers were familiar with the overall structure and process of the ARM, but most were not. Most front-line practitioners said they were not clear about the structure of the ARM or the process of referral and assessment and review. Whilst the idea of having a lead agency was broadly welcomed by some interviewees, in particular, front-line practitioners felt that the lack of guidance meant the role was not clear.

I'm not sure how clear all of the workers on the ground are about the actual ARM process and I'm not sure whether how well that's being fed down to them from their management in relation to what it means to technically be the lead agency in a family. (MC-2-Statutory)

To be honest my involvement has been that I've had a couple of families who I've known are part of the process and through my line manager who attends the meetings, I've asked her to raise one or two questions from time to time in relation to issues that we want brought forward with some of the agencies that are also part of that process for that particular client so that's been the extent of it. (FP-1)

Consent and Family Participation

The issue of consent and family participation was identified as a challenge by many interviewees. The process of getting consent was not clear for everyone. Responsibility for getting consent, what type of consent was required, whether this should be verbal or written, and when the consent should be obtained, were all identified as issues. Interviewees said that challenges around consent were openly acknowledged and discussed at the ARM management committee meetings, but were not yet fully resolved. Although the model specifies that written consent would be sought before cases would be discussed by the committee, in practice, cases are currently being discussed on the basis of verbal consent.

That's the bit we definitely come up against difficulties with, who has got consent? Have we got consent? Does mum understand consent? Does she know how we got here? You know? And through no one's fault it's been a difficult one. (MC-FG-Voluntary)

Child Protection and Welfare Thresholds

The issue of thresholds between child protection and welfare was a major issue for many of the interviewees, both on the management committee and for front-line workers. As outlined in the model characterisation, the alternative response is provided to child welfare cases referred to the ARM management committee by the HSE intake team. Also, as outlined above in relation to the inter-organisational impact of the ARM, it was acknowledged that the ARM has led to an increased understanding of the process and procedures of the HSE Social Work Department. Whilst interviewees felt that the dialogue in relation child protection and welfare, and the HSE assessment of risk, was beneficial, for all it still remains a considerable challenge.

We have been able to start having debates and discussions around a common language as regards what is child protection, what is child welfare. I don't think we've tackled it fully yet but it's emerging, it's evolving so the ARM is actually facilitating those kind of discussions. (MC-1-Statutory)

What one agency describes as high-end family support, another agency can describe as low-end child protection. I think there a lot of issues in ARM about thresholds, and I think those have come alive in the ARM process. (MC-6-Voluntary)

There has been some discussions about interpretations and thresholds and I know if you go to different areas, they will interpret Children First differently, which maybe is a fault with Children First, I don't know, but certainly that came up, it wasn't a huge issue, it was just something that struck us. (MC-FG-Voluntary)

While there was consensus that thresholds were an issue, perspectives on thresholds varied depending on interviewees' role within the ARM. Some staff within the HSE highlighted cases that had been referred to the ARM management committee that were formally re-referred back to the Social Work Department, or contact was made with the Social Work Department about concerns while the case remained within the ARM. This resulted in the Social Work Department having more involvement in the case than initially anticipated, and as a consequence had an

impact on resources. Other agencies felt there was sense that they were working with families within the ARM process where they felt border-line child protection concerns existed.

I think it's really hard to see this as a high-end child welfare case and ultimately it's really in the realm of child protection I think. (Case-FG-1)

There were diverging views on the types of families that are suitable for referral to the ARM management committee. A small number of interviewees said they did not know whether certain types of families are more suitable for receiving an alternative response. Some interviewees used the Hardiker model, levels two or three, to express their view on the types of families that were suitable for receiving an alternative response. Views ranged from:

- Families where there is a low level of welfare concerns are most suitable.
- Families that are motivated to change are most suitable.
- Families with a high level of complex need are suitable.
- Families with lower less complex need are suitable.

Extremely low welfare cases where you've got a very engaging family. (MC-2-Statutory)

Where there's a range of issues, like maybe there's housing, maybe there's mental health, maybe there's an education piece, so where there's a lot of different pieces to the jigsaw. I think they're the ones that this process really is most, works best with. (MC-4-Statutory)

I suppose one of the things that struck us is that we are not sure if chaotic families with multiple problems are working well within the ARM. I think it is to do with the fact that if a support service that wouldn't be HSE takes on a case there are risks that are inherent in these families and it can be difficult for those services to lead without support from HSE social work teams. (MC-14-Statutory)

Capacity of Agencies to Lead

Having a range of agencies to perform the role of lead agency was identified as challenging. For some agencies taking on a case management role and leading a complex inter-agency intervention, for a whole family and not just individual members, was a new experience. Some interviewees felt that the number and range of agencies taking on a lead role was limited and that this represented an increased draw on resources for those agencies that had taken on the role. Some interviewees felt that agencies not experienced in case management found it difficult to be lead agency with families that had a high level of need, or where high-level child welfare concerns exist.

Sometimes the assessed need doesn't fit neatly into the agencies sitting around the table for them to take the lead, you know, because it might cross a number of children of different ages, it might be an aspect of it that's relevant to one service but then not all of it's relevant to that service so I think it's difficult then for an agency to say well I'll lead on this but I've only one little part of it so I need everyone around the table. (MC-FG-Statutory)

Joint Case Planning and Reviewing

The process of case review was highlighted by many interviewees. While some had identified the review of cases referred to the ARM as a strength others felt that the case review process within the ARM is not sufficiently robust. This issue was related to other issues identified by the interviewees; such as the anonymised discussion of cases; and the dual role of the committee who undertake case reviews in addition to management issues, possibly meaning that neither role is permitted enough attention. A specific issue relating to the review process identified by some interviewees is that there is no minimum time-frame within which a case must be reviewed by the committee.

I think there is no mechanism really is there? Like maybe because there are cases that we haven't heard in ages, I'm sure they're being worked quite well, but you know? They should be reviewed at monthly meetings. (MC-FG-Voluntary)

I think because there is not a separate meeting as such to discuss cases, other areas of the ARM sort of development and that sometimes took over and then there would have been a gap in actually cases being heard. (MC-2-Statutory)

If for some reason you don't get to discuss a case at a monthly meeting it's a long delay if nothing has happened, it could actually slow up the process for families I think, you know, when there's two sort of levels of, when there's the practitioner doing the work yet there's also the review thing then through the management, I think that can be a block as well. (MC-4-Statutory)

Communication Between the Social Work Department and Lead Agencies

The overall governance of the ARM, and the relationship of the HSE to cases that are receiving an alternative response led by another agency, were issues raised by interviewees. It was a concern for both interviewees working in the HSE and in other agencies that this relationship was not always clear. As highlighted in the model characterisation, cases that are referred to the ARM management committee and are receiving an alternative response remain as open cases to the HSE even when the HSE is not directly involved in the intervention. This caused concern for staff in the HSE, because there are cases open to the HSE where the HSE does not necessarily have an up-to-date record on the status of the case. This caused a concern for other agencies because they are not clear what information should be brought to the HSE's attention and through what channels. Interviewees related this issue to the thresholds issue discussed above, whereby it was felt that the lack of clarity about thresholds, combined with the lack of clarity on the relationship of the HSE to these cases, led to confusion. Some interviewees also related both these issues to the issue of the capacity of agencies to lead where a family has a high level of need or high-level child welfare concerns exist.

In relation to the HSE holding open all of these cases, even though a lead agency might be another agency, that we have held them open and I think really as a back-up, I suppose for ourselves as well as for the agencies. But I suppose there have been problems around that as well in that the lead agencies may feel that they need to be reporting back to us which probably doesn't you know? There is confusion around who is the lead agency you know? (MC-14-Statutory)

I'd be very keen that it is not the HSE stepping off the pitch if its only welfare concerns....I don't want it to be an opportunity for HSE social child protection services to say we're doing child protection, we'll set up a group that are going to do welfare and off you go. That we do need them at the table for some of these cases even if they are not the driver. (MC-4-Statutory)

I suppose one of the difficulties that has been emerging lately is if a lead agency takes on a family and the case is still open in the Social Work Department but not involved in the ARM intervention, people have been feeling anxious about whether there should be an information flow then back to the HSE....so who actually is governing that intervention in its totality? (MC-1-Statutory)

Almost all interviewees raised the issue of resources as a challenge; both the resources needed specifically to implement the ARM and the general resources of agencies to permit them to contribute to the ARM. Half a senior practitioner post is allocated to supporting the ARM within the Social Work Department, but many interviewees felt that more resources were required.

Box 3.5 summarises the key findings in this section.

Box 3.5: Summary of Stakeholders' Views on the Challenges Encountered in Implementing the ARM

The following areas were considered challenging:

- The anonymising of referrals for discussion on the management committee meeting.
- Developing the appropriate membership of the management committee.
- Ensuring effective communication between management committee and front-line practitioners.
- Consent and family participation.
- Child protection and welfare thresholds.
- Capacity of agencies to lead.
- Joint case planning and review.
- Communication between the Social Work Department and lead agencies in relation to cases open to the HSE but led by another agency.

3.7 Stakeholders' Views on Improving the ARM

There was consensus amongst all interviewees that the ARM should continue and that it should be expanded to cover a larger geographical area and deal with a greater volume of cases. As one interviewee said, *I mean you would like to work with every case in this way* (Case FG 1). Many of the areas identified as needing improvement mirror the areas identified above as challenging in the implementation of the ARM. There was a considerable diversity of views on how those challenges could be overcome, and no overall consensus on what exact form ARM should take in the future.

There was some consensus and the majority of interviewees felt that the structure of the ARM needs to change so as to allow for an operational tier and for the greater involvement of front-line workers. This view was particularly common among front-line workers. Many interviewees felt that although the current structure had served its purpose during the initial pilot phase, it would not be a sustainable structure for the future of the ARM. Some interviewees felt that the structure is contributing to the challenges encountered (discussed above) in implementing the ARM.

Well I suppose I think it would be better if we were better briefed on the ground in relation to the process and how to keep the connections and be involved, more front-line, yeah. (FP-1-Statutory)

I think we need to have at least a two-tiered structure process under the ARM, because I think there is a gap here between senior managers and what happens then on some of the cases and I certainly think there should be an operational management committee maybe of front-line managers and maybe practitioners. (MC-FG-Statutory)

Most interviewees felt that the ARM would be improved by having child and adolescent mental health services represented. Some interviewees also felt that schools needed to be directly represented. Others felt that the community sector and in particular community drugs organisations needed to be represented. However, many interviewees also felt that the management committee was too big, and that the above absences needed to be addressed in the context of reviewing the structure of the ARM, for example, considering whether some agencies did not need to be represented. Although interviewees felt this issue would become particularly relevant in considering the expansion of the ARM to cover a broader geographical area, it was also an issue for the current implementation of the ARM.

There were many suggestions on how the overall process of the ARM as expressed in the model characterisation could be improved. A small number of interviewees felt that there should be a separate referral route for the ARM, independent of the Social Work Department. Most interviewees felt that the system of anonymising referrals needed to be amended due to the challenges outlined above. Some interviewees related the resolution of this issue to the structure of the ARM, and in particular the role of the ARM management committee in reviewing cases. Interviewees also felt that regardless of whether cases were anonymised, the practice on consent needs to be improved in line with the points made above. Some interviewees proposed that there should be a leaflet about the ARM for families, and a specific consent form, in order to assist with ensuring consent is informed and ensuring a high level of participation by families. Some interviewees suggested that timetabling should be used to try to avoid professional stakeholders being present for cases that are not relevant to them.

There are cases that I don't need to know about, so shouldn't hear, but if you had a smaller, more relevant, practitioner's management committee I think you should be probably identifying and you get rid of that difficulty. (MC-FC-Statutory)

As stated above, while there was consensus amongst interviewees that thresholds between child protection and child welfare are an issue, perspectives varied depending on individuals' roles.

Some interviewees from the voluntary sector felt that after the HSE initial assessment, cases classified as low-risk child protection that did not require an investigative response and would benefit from a supportive intervention, should be offered an alternative response. Others felt that the alternative response should be offered to families where only low-level child welfare concerns existed; most interviewees felt that there should be clarity on the assessment and definition of child protection and welfare concerns.

I have a question mark about whether the service should be more geared into the child protection, into the low child protection arena, and whether there's an ability of the HSE to take an educated risk in relation to families where it's clear there is a child protection issue but that is best addressed by the family support as opposed to by a full-blown child protection assessment. (MC-6-Voluntary)

I mean there is obviously a cross-over between welfare and child protection issues, and we tend to only look at welfare of a sort of general nature. I'm not sure how useful that absolute boundary is, and whether or not it would be useful to widen the brief a little bit. (MC-15-Voluntary)

The piece around child protection versus child welfare, maybe around the thresholds, maybe need to be defined a bit, I think we find that quite frustrating...and... I know that the differential response model would have looked at child protection cases and child welfare cases, maybe we just need to call this case a child protection case, and say what it is, instead of pretending it's child welfare just to fit it into our, I think I'd rather be more realistic. (Case-FG-1)

Interviewees felt there were a number of improvements that could be made to the intervention offered under the ARM. A small number of interviewees felt that a greater range of agencies should be involved in taking on the role of lead agency. Some interviewees felt it was critical that the process for reviewing the progress of cases be strengthened, including clarity on the procedure for case reviewing and, where relevant, closure.

I think that's where the gaps have arisen through the pilot, that people have goodwill to take on cases but they are high-need cases so I think that's where the struggle is in terms of what do we mean by what are the needs, how are they being reviewed...having some standardised reporting or some type of consistent review. (MC-FG-Statutory)

I think if the lead agency were told you need to come back and review this every number of weeks, and there is a very clear maybe ARM practice for how you would review it. (Case-FG-2)

I think the idea of operational meetings, I just think the whole casework piece needs to be supported more. The whole idea of the lead professional, supervision within that and training and then inter-agency work review of families, I think that whole piece has lacked support up to now. (MC-FG-Statutory)

I think....we should be looking at outcomes for children and families much more. (MC-1-Statutory)

Interviewees also felt it was important that there be more support and guidance on the intervention and that planning for interventions must be realistic and, where necessary, be more long-term where a long-term intervention is required. One interviewee felt that the response to domestic violence should be strengthened within the ARM. Some front-line practitioners felt that the principle of involving families should be more concrete within the ARM.

I don't know if the families are involved in every case, I don't know if that was just specific to this case, but I think I would love to see the families would always be involved in their own meeting (Case-FG-2).

Front-line practitioners in particular felt that there was a need for more support and guidance in the form of written documents and training, for example, on inter-agency working, being the lead agency, information sharing and recording. Some interviewees were aware that the inter-agency case working sub-committee of the SDCSC was in the process of developing an inter-agency case working protocol and guidelines on sharing information, and felt that these documents should be used to support the ARM process.

I think if we were doing it again it would need to be a defined agency....this is your lead agency, this is who goes and there is a clear role description...what they should be doing...like we didn't know really what needed to be happening, it was very much feel your way through. (Case-FG-2)

I know that the work of the Children's Services Committee around information sharing and inter-agency workings, I think we need to get those right first, and I know they are happening but I think it needs to be agreed you know? This is how we are working together and this is how we share information. (MC-2-Voluntary)

Theoretically if you were setting up, if you were looking at the workload of the children's services committee in my mind you would do your directory first, then you would do your information sharing policy, then you would do your inter-agency working together policy and then you would do ARM but we haven't done it in that way but if we were rolling out elsewhere I think you would try to do it in that way, that you'd build your foundations and build ARM on top of the foundations of good information on services, a shared approach to information sharing and a very clear inter-agency working protocol. (MC-6-Voluntary)

Developing more clarity on communication between the HSE Social Work Department and lead agencies in cases where the Social Work Department are not directly involved was considered to be a critical area requiring improvement. Some interviewees felt that the procedures for communication needed to be more explicit and that this issue needed to be addressed in conjunction with the thresholds issue.

I think that whole piece of what the HSE's role is in the ARM needs to be spelt out to....any agency and all staff involved, so they're clear on that. (MC-FG-Voluntary)

For me there's a lot of things to be clarified and I think it will happen over time with practice....it's almost like an education awareness around the distinction between child protection, child welfare, where one ends and the other begins...and the bit about the Social

Work Department...while they hand over the lead to an agency like ours how they remain involved? (MC-8-Voluntary)

Isn't the traditional thing sending it somewhere and closing it off, not sharing responsibility. I thought part of this was not necessarily that we had nothing to do with the case but that someone else is leading on it, doesn't mean the HSE aren't involved at all....it's a collaborative process so that everyone stays involved as necessary and it's not about getting out, it's staying in along with everybody else, it's only the lead that changes. (MC-FG-Statutory)

Many interviewees felt that additional resources are required in order to improve the implementation of the ARM. In particular, interviewees working in the HSE felt that the half post currently allocated to facilitate the implementation of the ARM within the Social Work Department would not be sufficient if the volume of cases being dealt with increased. Some interviewees felt that existing resources also needed to be reassigned and services reconfigured, and the strategic role of the ARM management committee should be focused on this task.

I certainly think there is a need for a...dedicated coordinator at HSE level to be working not just on the initial assessment, but coordinating the initial assessment and making that transition then with the families to other ARM agencies who could take a lead role. (MC-1-Statutory)

I think the other issue is just the availability of services to respond to the need. One of the things we need to be doing is looking critically at how existing services are configured and are they configured in ways that are responsive to the needs that are coming through the process.... Also we should be able to identify service gaps and have a mechanism for addressing service gaps so that if there's a blatant need that keeps coming up in five, six, seven cases that there's a way to address that and say ok, we're either going to redirect this resource so that gap can be filled, or we'll find a way to get an additional resource in place. At the very least we're sort of documenting the service gaps and identifying what needs to happen when the opportunity arises to plug those gaps. (MC-6-Voluntary)

One interviewee felt that participation in the ARM should be linked to the funding of agencies through the funding agencies present on SDCSC, so that there is a clear mandate to dedicate resources to it.

Box 3.6 summarises views from this section.

Box 3.6: Summary of Stakeholders' Views on Improving the ARM

- There was consensus amongst all interviewees that the ARM should continue and that it should be expanded to cover a larger geographical area and deal with a greater volume of cases.
- There were diverse views on how the challenges could be overcome.
- The majority of interviewees felt that the structure of the ARM needs to change so as to allow for an operational tier and for the greater involvement of front-line workers.
- Most interviewees felt that the membership of the ARM management committee should be reviewed.
- Most interviewees felt that the system of anonymising referrals needed to be amended, and that clarity in relation to consent is required.
- There were differing views about how child protection and child welfare thresholds should be addressed.
- Many interviewees felt that the ARM intervention needed better support through guidance and training.
- Developing more clarity on communication between the HSE Social Work Department and lead agencies in cases where the Social Work Department are not directly involved was considered to be a critical area requiring improvement.
- Many interviewees felt that additional resources are required in order to improve the implementation of the ARM.

3.8 Training Needs

As part of the evaluation process, a short online survey was developed to discover training needs of those participating in the ARM. Unfortunately, by the final cut-off time, a total of 14 completed questionnaires were returned out of an intended population of 49. While the amount and quality of the data concerning training needs is therefore limited, in order to honour the time respondents took to complete the questionnaire, set out in this section are some summary points relating to the survey. In all, nine respondents worked for the HSE, two for the Probation service, one for Barnardos and two for Family Centres. The respondents' roles varied but included managers, team leaders and front-line workers in Social Work, Community Work, Family Support and Probation.

Most respondents had good or very good knowledge of Irish Policy and Legislation and of the ARM, its underpinnings, membership and operation. The areas in which there was more likely to be partial knowledge were the role and work plan of the South Dublin Children's Services Committee. When asked to indicate other areas of knowledge required for the implementation of ARM, respondents suggested child protection guidelines, thresholds, ARM roles and responsibilities, case management, inter-agency working, knowledge of local services and assessment tools. Responses to a further question on training needs mostly referred to the areas just cited, with training on the underpinning and operation of ARM mentioned slightly more often.

When asked to rate the relevance of the following values to carry out their work, all suggested that they were either relevant or very relevant (the vast majority rated as the latter).

- Commitment to integrated working with other children's services, both statutory and community / voluntary.
- Commitment to realising the rights of children.
- Commitment to working towards outcomes for children.

When asked if there were other values which were important to ARM implementation, only two further responses emerged – these highlighted trust and respect, and sensitivity in relation to information sharing. Three respondents mentioned the value of rights as being one they would value training in. Respondents felt that all of the listed values would be important for wider ARM training.

When asked about their own skills levels, all respondents rated themselves as having good or very good skill levels in relation to communication (with children, parents and other agencies), in facilitating the participation of children and parents, in assessment, planning (with other agencies and in an outcomes-focused way) and reviewing. Presentation skills and skills in advocacy were cited as two additional skill areas necessary for implementing ARM. The small number of respondents who identified skill areas they needed for ARM implementation referred to outcome-focused working, and joint assessment and recording. When asked what skills should be focused on in wider training for ARM implementation, respondents highlighted all the above areas (e.g. communication, facilitating participation, assessment, planning and reviewing).

When asked if they had further reflections on ARM training requirements or thoughts on training for implementation outside of the area, few additional points emerged from respondents apart from those outlined above – one comment related to the need for tiered training (reflecting management and front-line levels) and one to an emphasis on the presentation of ongoing learning from implementation.

Overall, this chapter has outlined the findings of the study concerning the perspectives of stakeholders in relation to the ARM. The findings have been very positive, indicating the many positive impacts and strengths of the ARM, as well as identifying the challenges encountered and the opportunities for further development. These positive impacts and challenges are discussed in the next chapter.

Chapter 4 - Discussion

4.1 Introduction

This chapter discusses the core findings presented in Chapter 3. In Section 4.2, the ARM, as reflected in the findings, will be situated within the relevant literature on inter-agency working and in respect of differential response. The positive impacts and strengths of the ARM will also be examined, with reference to the literature on similar initiatives. The remainder of the chapter examines the challenges and areas of further development for the ARM.

4.2 Defining the ARM Within the Literature on Inter-Agency Working

It is not strictly part of the aim of this study to categorise or classify the ARM. It is, however, an aim of the study “to describe the development of the model to date”. In light of this aim, it may be useful to think of the ARM as strategic partnership for children, as described by Percy-Smith (2006). She outlines the characteristics of partnership:

- *The structure and/or way of working involves two or more organisations.*
- *These organisations retain their own separate identities (i.e., this is not integration).*
- *The relationship between the organisations is not that of contractor to provider.*
- *There is some kind of agreement between the organisations to work together in pursuit of an agreed aim.*
- *This aim could not be achieved, or is unlikely to be achieved, by any one organization working alone.*
- *Relationships between organisations are formalised (i.e. partnership is more than a network) and are expressed through an organisational structure and the planning, implementation and review of an agreed programme of work.* (Percy-Smith, 2006, p.16)

The ARM as described in chapters 2 and 3 has the above characteristics. Although some organisations involved in the ARM are providers on behalf of the HSE, this does not characterise the ARM, and many of the participating organisations do not have that relationship.

Also useful is Frost’s (2005) hierarchy of partnerships, moving from cooperation, to collaboration, to coordination through to integration:

Level 1: co-operation – services work together toward consistent goals and complementary services, while maintaining their independence

Level 2: collaboration – services plan together and address issues of overlap, duplication and gaps in service provision towards common outcomes

Level 3: co-ordination – services work together in a planned and systematic manner towards shared and agreed goals

Level 4: merger/integration – different services become one organisation in order to enhance service delivery

The ARM would certainly seem to involve the co-operation described in Level 1 of Frost's hierarchy. There would seem to be elements of Level 2, with some challenges emerging, as outlined in the findings and which is now discussed below, using Yuan's common characteristics of the of the DRM, already outlined in Chapter 2:

- AR is provided to families that are the subject of an accepted report alleging child maltreatment.
- **It is also the case in Jobstown that the AR is only provided to families that reach the initial threshold of acceptance as an appropriate referral to the Social Work Department.**
- The decision to provide a traditional investigation or AR is made at initial screening, with a provision that the response can be changed based on risk and safety assessments.
- **In Jobstown an initial assessment is carried out which is more comprehensive than initial screening.**
- AR may be provided by community-based providers or public child welfare case-workers. In some localities, these workers may conduct investigations; in others, these workers may be in different units from investigation workers.
- **In Jobstown the alternative response is delivered by a partnership of agencies which can involve the HSE, other statutory organisations and voluntary organisations. It can be led by any of these agencies depending on need.**
- AR is not considered appropriate for cases that are likely to require court intervention, such as sexual abuse or severe physical harm to a child. Other restrictions may apply based on state statute or departmental policy.
- **This is the case in Jobstown.**
- If an AR assessment is refused by a family, the agency may conduct an investigation. Post-assessment, if voluntary services are refused, the agency may close the case.
- **This is the case in Jobstown.**
- A formal determination of whether the child has been abused is not required.
- **This does not apply in Jobstown as only cases assessed as involving a child welfare concern are considered.**
- Since abuse or neglect is not determined, caregivers are not labelled as perpetrators of child maltreatment and do not become part of the state's central registry of perpetrators.
- **Again, as the cases referred to Jobstown ARM involve child welfare, this does not arise.**

Also outlined in Section 2.3 (Chapter 2) is Sawyer and Lohrbach's (2005) description of the circumstances in which the alternative response is offered:

- Low or moderate risk of physical abuse.
- **The Jobstown ARM considers child welfare concerns only and not cases where there is a low or moderate child protection risk.**

- Children who are without basic necessities such as food, shelter, or clothing.
➤ **May be offered alternative response depending on the initial assessment.**
- Health and medical needs that, if left unattended, can result in harm.
➤ **May be offered alternative response depending on the initial assessment.**
- Concerning or damaging adult-child relationships.
➤ **May be offered alternative response depending on the initial assessment.**
- The absence of supervision or proper care.
➤ **May be offered alternative response depending on the initial assessment.**
- Educational neglect.
➤ **Would be suitable for alternative response.**

There are elements of the Jobstown ARM that are similar to the common characteristics of the differential response model, but there are also aspects that are different. This is as a result of adaptations to the model that were made by the management committee to suit the local context. As demonstrated in the findings, stakeholders were aware of these differences, and there was a variety of views about whether the model outlined in the literature should be followed more closely, such as offering an alternative response to families where there are low-level child protection concerns.

4.3 Positive Impact and Strengths

Many of the positive impacts and strengths of the ARM identified by stakeholders and set out in the findings reflect the literature on the benefits of inter-agency working. The findings of the ARM evaluation resonate with many aspects of the *Guidance to Support Effective Inter-agency Working Across Irish Children's Services* (CAAB, 2009). The CAAB Guidance identifies the creation of an inter-agency culture, and removing cultural barriers, as a feature of good inter-agency cooperation. This was successfully achieved in the ARM; key people were engaged positively at an early stage in its development. The necessary buy-in from senior managers in relevant organisations was sought, and generally was secured. This led to a strong sense of partnership and shared ownership from the beginning, which continued throughout the duration of the pilot initiative. The ARM management meetings were viewed as inter-agency meetings rather than HSE meetings. This partnership approach appears to have worked well, and allowed agencies to feel fully part of the process, while not detracting from the HSE's overall lead role under the *Child Care Act 1991*.

It is also worth noting the pre-existing factors that stakeholders considered conducive to the setting up of the ARM. There was a sense that a culture of good inter-agency working relationships already existed in the target locality, and in particular a pattern of collaboration already existed between the senior managers of key agencies. The approach of the HSE Social Department to the development of services locally was also viewed as an important factor. The existence of a patch system in Jobstown meant that there were well-established relationships

between Social Work staff and other key service providers, and deeper links than might otherwise have been the case. It is not contended here that this structure is essential to achieving integrated working, just that it was identified as being helpful in this instance.

In the *New Beginnings Programme* in Foyle Trust, the move from a patch system to a more specialised team structure was intended to help social workers develop skills and to ensure targets were met within specialist teams. Some Health Visitors in *New Beginnings* did, however, express concern at being cut off from social work colleagues as a result of the change from the previous geographically patch-based staff groups to specialised teams (Child and Family Research and Policy Unit, 2006). ARM stakeholders similarly valued the consistent engagement with individual social workers as a result of the patch system. Also the provision of a Family Support Team and Family Resource Centre was interpreted by stakeholders as indicative of the local HSE management's commitment to a family-support-oriented approach rather than a narrow focus on child protection.

The consistency in descriptions of the ARM given by members of the management committee showed a reasonably good understanding of the aims of the model. Despite this, the model evolved throughout the duration of the pilot, and the model characterisation exercise carried out as part of the research process was the first attempt to formally capture and document the model. However, there was sufficient common understanding of the model to ensure a sense of a shared purpose amongst the group. This shared purpose was underpinned by shared values which were applied in a more systematic and structured way in the ARM than they would otherwise have been. Developing a shared purpose is identified as a feature associated with good practice in inter-agency cooperation (CAAB, 2009; Percy-Smith, 2005; Gray, 2002). The fact that members of the management committee viewed the ARM in the context of the *Agenda for Children's Services* (2007) and as part of the work of SDCSC illustrates the importance of the national policy context to the development of the ARM. As a result, the ARM had a perceived mandate. Horwath and Morrison (2007) define mandate as the need, authority or requirement for collaboration. At the intervention level, although the links to the SDCSC or policy were not as explicit, there was a sense that the perceived mandate was mediated through the involvement of managers on the management committee.

ARM generally had a positive impact at both the individual and organisational level. At the individual level, those involved learned from being involved in the ARM, and practice improved as a result of being more informed about other services, and developing relationships with them. As a result, families were linked more effectively with the service most appropriate to their needs, and inter-agency interventions were more time-efficient. These outcomes reflect the well-established benefits of inter-agency working (Costongs and Springnett, 1997; Richardson and Asthana, 2006; Whyte, 1997 cited in Canavan, 2009). These benefits applied not just to cases within the ARM; the relationships built up resulted in an increase in inter-agency working in relation to interventions outside of the ARM, and in other parts of Tallaght. This "spill over effect" has been noted in other studies (Atkinson et al, 2002). Voluntary organisations increased in confidence as a result of the opportunity to engage with other organisations on an equal footing, and the inter-relationships and communication between all the participating organisations were strengthened as a result of the increased understanding of each other's roles and responsibilities. In particular, there was increased understanding of the HSE Social Work

Department's work, and of social work assessment of child protection and welfare concerns. This aligns with the findings of Moran et al (2007), who found that multi-agency working by social workers within an early intervention family support team "helped other professionals to gain greater understanding of the threshold between statutory and non-statutory social work intervention and when referral about child protection concerns were appropriate" (2007, p. 148).

As already stated, this evaluation did not seek to make any summative conclusions about outcomes for children and families, and they were not interviewed as part of the research. There was tentative optimism about outcomes for children and families. As a starting point, it was felt that families were receiving a much more coordinated inter-agency intervention in a much more timely fashion than they would outside of the ARM. More comprehensive interventions are cited as a rationale for integrated working (Browne et al, 2004) as is quicker access to services (Atkinson et al, 2007). These tentative considerations of outcomes reflect Frost and Stein's contention that outcomes-focused working and integrated working are intimately connected. Achieving the intended outcome necessitates thinking about how agencies work together (Canavan et al, 2009).

The very simple idea of having all the relevant agencies providing services to children and families sitting around a table together was the core strength of the ARM, both at the management committee level and the intervention level. Securing commitment from staff at all levels is identified by the CAAB Guidance as a feature of good inter-agency cooperation. Many of the benefits of the ARM, such as the pooling of knowledge and expertise; networking opportunities; mutual support, and trusting relationships are typical benefits of inter-agency working (CAAB, 2009). The ARM created a culture of peer accountability to deliver and review interventions with children and families. Importantly, in light of concerns such as those of Parton (1997, 1998) regarding the dominance of child protection over child welfare, the ARM was also considered an opportunity to focus on the welfare of children rather than solely on child protection issues, although the interface between child protection and child welfare concerns was not straightforward.

4.4 Challenges and Areas for Further Development

The complexity of the issues involved mean that the likelihood of significant challenges being encountered is very high. This point is borne out by much of the literature on inter-agency working (Horwath and Morrison, 2007, Johnson et al, 2003; Valentine et al, 2006; Park and Turnbull, 2003). Many of the challenges identified and improvements suggested in the findings were inter-related. The membership of the management committee; anonymising referrals to preserve confidentiality; consent; the relationship between the management committee and front-line practitioners; child protection and welfare thresholds; the capacity of agencies to lead complex multi-agency interventions with families with a high level of need; joint case planning and review; and the relationship between the Social Work Department and lead agencies were all cross-cutting and inter-related issues, both in terms of the challenges they present and the potential solutions. Resource issues, both generally, and specifically for the ARM, were challenging, including financial, human and training resources. These challenges are now discussed in more detail.

Structure and Membership of the Management Committee

Getting the right membership within the right structure for the ARM is challenging both for its current purpose in Jobstown and even more so in terms of future development. The management committee is made up of members who operate at different levels of management and who cover different geographical areas. Cameron et al (2000) found that in some studies the lack of coterminosity of agencies hindered joint working (cited in Sloper, 2004, p.576). Some managers on the committee are directly involved in practice in their role as first-line supervisors, and others are not. According to the UK National Audit Office, “deciding on the membership of the emergent partnership involves balancing the need to involve all organisations that have an interest and the need to deliver the partnership’s objectives as efficiently as possible” (National Audit Office, 2001 in Percy-Smith, 2006, p.318). This inconsistency was overcome in the initial stages of the pilot by the goodwill and commitment of the members of the committee to the initiative, and by careful facilitation of the meetings.

The current structure makes it difficult to address concerns about the absence of key agencies. Expanding the membership to include representatives of child and adolescent mental health, schools or community organisations would lead to a committee already identified as quite large, becoming potentially too large to operate effectively. These challenges are normal. As Percy-Smith (2006) stresses, there is a need for flexibility around the structure of partnerships, as they may need to be constituted differently depending on the stage of development. The structure and membership of the ARM has been effective in getting the initiative operational. There may be other structures more suited to further development.

Anonymising of Referrals

The anonymising of new referrals and ongoing cases at the management committee level of the ARM requires improvement, both currently and in terms of future development. If the volume of cases were to increase, the practice of numbering the cases would become unworkable. There is a very real risk of confusion and misunderstanding, leading to adverse outcomes for children and families. This decision to maintain anonymity is connected to the presence of senior managers highlighted above. The committee felt that it was not appropriate for managers with no day-to-day involvement in service provision to hear identifying details, as is consistent with the concept of sharing information on a “need to know” basis. Therefore, addressing the issue of anonymised cases is intimately linked to addressing the structure of ARM and the membership of the management committee. As outlined above, different stages of development of partnership require flexibility in structure. The direct involvement of senior managers was critical to the establishment of the ARM, but may not be required at the level of case discussion as the ARM develops.

Consent and Family Participation

The issue of consent was problematic for many participants in the ARM initiative. That this issue was robustly discussed and that the pilot proceeded without it being fully resolved is indicative of the positive approach by the committee to jointly grappling with challenges. The literature on inter-agency working frequently cites lack of clarity regarding information-sharing as a potential obstacle or barrier to effective inter-agency working (Sloper, 2004; Percy-Smith, 2006). The issue of consent is related to the structure in terms of the extent to which families understand the structure and are in a position to give informed consent for their case to be discussed, or the

extent to which they may be discouraged from consenting by the presence of justice organisations. Irrespective of structure, there needs to be greater clarity in relation to consent. Greater clarity in information-sharing in general will be brought about by the introduction of the *Sharing Information about Children and Families Best Practice Guidelines* to be introduced in South Dublin by SDCSC. Although these guidelines will assist the process, the particular procedure in relation to consent for the ARM needs to be clearly prescribed to address the gaps outlined in the findings. Also, having informed consent is linked to facilitating the effective participation of families. It is difficult to empower families to participate in outcomes planning if they are not informed (CAWT, 2008).

Communication between the Management Committee and Front-line Practitioners

It is evident from the findings that not all front-line practitioners were clear about the overall structure of the ARM, or its precise aims, and many felt dependent on their managers for information. This represents a significant challenge to the effectiveness of the ARM. If front-line practitioners are unclear about the overall structure and process, it is difficult for them to be clear about their role within it.

The initial phase of the ARM has been management-led which, as outlined in the findings and discussed above, has helped to create a perceived mandate and ensure buy-in from relevant agencies. However, the commitment of staff at all levels, including operational and service delivery, is also required to ensure good inter-agency working (CAAB, 2009). This issue is also related to the structure of the ARM. Front-line practitioners are only involved at the individual case level. Therefore, their experience of ARM is very much dependent on the particular intervention in which they are involved. The absence of clear guidance on how that intervention is to be carried out means that the experience of front-line staff is unlikely to be consistent. As staff are involved at the individual intervention level, they do not benefit from the global view of the process that their managers do. Also, they may not experience some of the benefits described above. The findings indicated a strong belief amongst management committee members and front-line practitioners that the structure of the ARM should be amended to facilitate more direct participation by front-line practitioners.

Child Protection and Welfare Thresholds

One of the main benefits of the ARM was the extent to which participants on the management committee from outside the HSE felt that they had learned about the Social Work assessment of child protection and welfare concerns. It was also one of the greatest challenges. For some, this reflected the reality of the complexity of the issue, and complete resolution was not expected. This reflects Parton's (1997, 1998) view on embracing the uncertainty and ambiguity of the work. The challenging nature of this issue is also consistent with research by Horwath (2005) and Platt (2006) and with the absence of any clear evidence of national consensus in relation to this issue. Furthermore, the fact that Jobstown is an area of concentrated socio-economic disadvantage impacts on assessment and the application of thresholds. Darlington (2010), citing Donzelot, (1979) and Hardy and Darlington (2008) identifies environmental factors such as poverty and equality as playing a critical role in shaping child outcomes. As stated earlier, Platt considers the notion of a continuum of abuse, with scaling degrees of abuse or neglect in order to set the height of a threshold, as inadequate in the face of the complexity of referrals and the methods used to assess them. For example, in relation to

neglect, the *Children First Guidelines* state that the *threshold of significant harm* is reached when the child's needs are neglected to the extent that his or her well-being and/or development are severely affected. Agreeing the point at which unintentional neglect by a parent reaches this threshold will always result in diverse opinion.

The benefits derived from engaging in relation to thresholds will outweigh the challenges as long as the discourse is progressive and developmental, and occurs within a process that is clear even if the outcome is not always certain. The evolving nature of the ARM in its early stages meant that the process necessarily was not clear. There was an explicit intention by the planners to deal with varying levels of need in order to establish which level of need the ARM is most suited to meeting. This may have influenced the fact that more cases returned to the Social Work Department in the early phase of development than latterly, as the selection process improved through trial and error. The allocation of a part-time social worker to assist in the ARM process is also likely to have improved the process of selecting cases, supporting the agencies involved in ARM.

Although the Hardiker (1991) typology is not part of the model characterisation for the ARM, it was frequently mentioned during the fieldwork as a way of thinking about the ARM. A key distinction in the use of the Hardiker typology is that it is a useful way of reflecting on levels of need at which families need support (*Agenda for Children's Services*, 2007). It is useful for ensuring that services are in place to meet those varying levels of support; it is not, however, a needs-assessment framework. Figure 4.1 displays the four levels of the Hardiker typology.

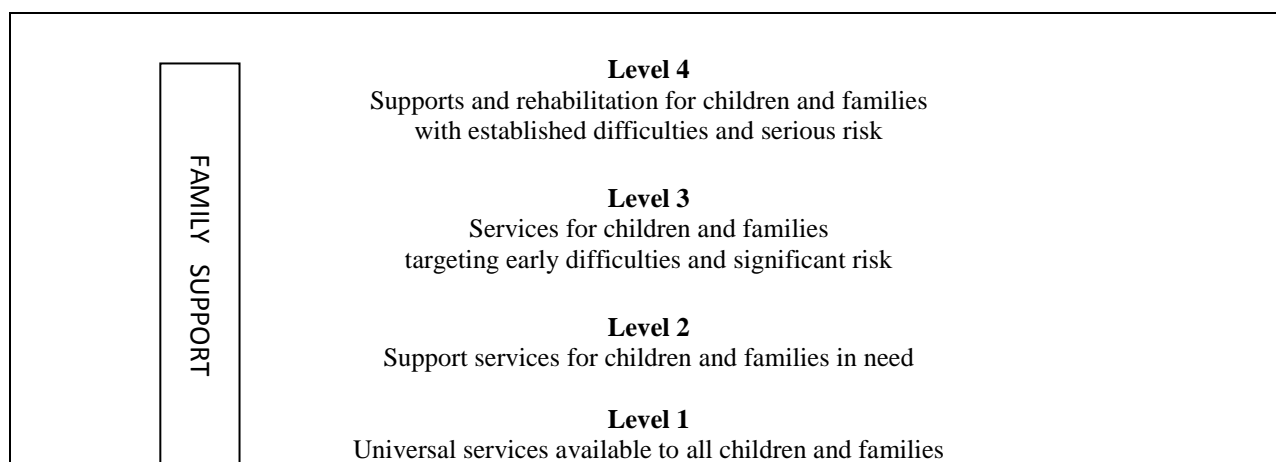


Figure 4.1: The Hardiker Typology

The Hardiker typology is too limited to be of use in thinking about the needs of individual children and families, other than to say that all families could potentially have needs at all levels at different times. Therefore, as the *Agenda for Children's Services* suggests, access to services should be easy, with multiple non-stigmatising points of access (OMCYA, 2007). It was used in the New Beginnings Programme to characterise the model as prioritising need and primarily operating at Levels 3 and 4. Some Stakeholders involved in New Beginnings felt that its focus on Levels 3 and 4 ran contrary to the principle of family support, and that it should go further in terms of proactive prevention within families and communities.

In addition to the Hardiker model, New Beginnings operated a threshold model to “guide decision-making on the categorisation of cases as appropriate for allocation for further investigation and assessment by Foyle Trust, or as requiring less intensive support and intervention by community-based non-statutory services” (Child and Family Research and Policy Unit, 2006, p.24). A specific document offering detailed guidance on case categorisation to ensure a consistent approach was used.

Although fewer cases returned to the Social Work Department towards the latter phase of the ARM, this does not necessarily indicate consensus about the levels of need it should address. Views varied from some feeling that the alternative response should only be offered to families where a low level child welfare concern exists, (based on the assessment of the Social Work Department), to others who felt that it should be offered in cases where a low to moderate child protection risk exists. The actual process by which families are selected for the ARM is through the Social Work Department’s initial assessment, which is a framework for assessing the needs of children and families, but also incorporates an assessment of risk. The tendency to use the Hardiker typology to reflect on an individual family’s need may be a response to the absence of a common way of thinking about the needs and levels of child protection concern. Also, the Hardiker typology may be one of the more broadly-known conceptual models.

As the ARM moves from a phase of development and experimentation, consideration must be given to achieving greater clarity on child protection and welfare thresholds. This does not mean that there must be absolute consensus on the level of need or concern in any one family. It is, however, possible to achieve greater clarity and transparency about the mechanism for selection of families for an alternative response, and a clear process for ensuring agencies understand the Social Work Department’s assessment of need or child protection concern without detracting from the unambiguous statutory responsibility of the HSE.

Spratt (2001) contrasts narrow versus broad participation by professionals in the assessment and meeting of need. He proposes the possibility of more fully integrating social workers’ decision-making with involvement of other health and social care professionals. For example, in relation to neglect, the *Children First Guidelines* state that the *threshold of significant harm* is reached when the child’s needs are neglected to the extent that his or her well-being and/or development are severely affected. Agreeing the point at which unintentional neglect by parent reaches this threshold will always result in diverse opinion. Darlington et al (2010), in examining approaches to assessment and intervention across four types of child and family welfare services, suggest joint training based on the recognition that all agencies are involved in the assessment process. Greater clarity on child protection and welfare thresholds is linked to the structure of the ARM through the impact the structure has on the capacity of agencies to lead; joint case planning and review, and the relationship between the Social work Department and lead agencies.

Capacity of Agencies to Lead

The capacity of agencies to take a lead role in the ARM interventions must be viewed in the context of the setting up and development of the ARM. Due to the commitment and enthusiasm of the participants, the ARM went from initial planning to operation quite quickly. Subsequently,

organisations experienced some difficulties in carrying out the role of lead agency. No training took place on leading inter-agency interventions, and there was no written guidance provided. Both written guidance (Sloper, 2004; Worall-Davies and Cotrell, 2009) and training (Charles and Horwath, 2009) are considered important factors for effective inter-agency working. Some time was given to developing the management committee through planning and discussion, but less to the preparation of front-line workers. A presentation was given to front-line practitioners at the outset of the pilot, but, as outlined in the findings, this type of engagement was not sustained.

Some interviewees linked the issue of capacity to that of thresholds due to the tendency of agencies to quickly report back to the HSE Social Work Department when high levels of need and/or concern emerged in cases. It is not possible to establish whether this arose due to a lack of capacity of agencies to perform the lead role in these cases. The absence of guidance or training, and the lack of clarity between the Social Work Department and lead agencies in respect of cases open to social work, but led by another agency, is also likely to have influenced this. Agencies' own Child Protection Policies also influenced their decision to contact the HSE about concerns. A change in structure of the ARM to incorporate meeting collectively at the front-line level could assist in better supporting lead agencies.

Joint Case Planning and Reviewing

Although the ARM was identified as being unique in how it brought about structured and systematic joint case planning and reviewing in inter-agency working, case reviewing was also identified as a challenge, and an area requiring improvement. This issue must also be viewed in the context of the commitment and enthusiasm within the ARM management committee to quickly become operational. There was no written guidance or training on case planning or reviewing at either the intervention level or at the management committee level. The model characterisation states that the ARM management committee regularly reviews the plan. The findings indicate that after cases initially came before the committee, they were not always regularly reviewed. This was due to time being spent on issues to do with refining the process of the ARM and discussing strategic issues, in addition to the committee's role in reviewing cases.

Also, the return of cases was on the basis of "as prioritised by the committee for discussion thereafter". There was no minimum time-period after which a case would automatically be recalled. The model characterisation also states that the committee agree if and when a case is closed to the ARM. There are no written criteria for how this decision is made.

One aim of the ARM is to *improve outcomes for children and families through enhancing inter-agency collaboration and the cohesive response of services to families*. This aim reflects the intimate connection between outcomes and integrated working (Frost and Stein, 2009). However, greater clarity is required about how this aim is to be achieved. The *Framework for Integrated Planning for Outcomes for Children* (CAWT, 2008) proposes three reflective questions:

1. *Are we making a positive difference for children (as a result of planning for the right outcomes)?*
2. *How will we know it (by monitoring achievement of agreed outcomes)?*
3. *How will we measure this (through evaluation that gets us to full information or "the true story behind the apparent story")?*

It is difficult to see the ARM achieving the above aim in relation to outcomes without a more structured way of thinking about outcomes, such as that set out in the CAWT framework. According to Canavan et al (2009), thinking about outcomes necessitates thinking about how organisations work with each other and with services users. Collaboration should be key to how outcomes are decided upon, as well as how they are achieved. Therefore, enhancing the approach to case planning and review in the ARM has the potential to improve the way organisations work together; increase the participation of children and families; make the ARM more outcomes-focused and ultimately, through applying reflective questions such as those above, make the whole process more accountable.

The structure of the ARM impacts on the process of case review and planning. Under the current system, one group (the management committee) decides on a broad plan and another (the front-line practitioners) implements the plan. As in the case of the capacity of lead agencies, a change in structure of the ARM to incorporate meeting collectively at the front-line level could assist in enhancing the approach to case planning and review.

Communication Between the Social Work Department and Lead Agencies

The findings identified as a challenge communication between the Social Work Department and lead agencies in respect of cases that are open to the Social Work Department, but are being led by another agency. According to the model characterisation, such cases are overseen by the ARM management committee. As highlighted above and in the findings, the planning and review of these cases has not been consistent. As a result there are cases open to the HSE where the Social Work Department does not necessarily have an up-to-date record on the status of the case. Also, lead agencies are not always clear on what information should be brought to the HSE's attention, or through what channels, especially in between the ARM management committee meetings.

This issue is relevant to much of the discussion above. The lack of clarity in relation to this issue has the potential to exacerbate the issue of child protection and welfare thresholds, the perceived capacity of lead agencies, and the process of case planning and review. Outside of the ARM, where a case was closed by the HSE and referred to another agency, that agency would report any subsequent concerns in relation to the protection and welfare of children to the HSE under Children First. The procedure for a similar scenario within the ARM must not be confused in any way by virtue of the case being open to the Social Work Department.

The stated rationale of the ARM is to offer, as part of Jobstown Social Work Department's role in promoting the well-being of children and families, a comprehensive family assessment and intervention in partnership with a broad range of statutory and voluntary partners. Greater clarity on the governance and oversight of cases within the ARM is needed in order to preserve this rationale. As in the case of the capacity of lead agencies and case planning and reviewing, a change in structure of the ARM to incorporate meeting collectively at the front-line level could assist in clarifying the relationship between the Social Work Department and lead agencies. Collective planning and reviewing under such a structure would have the effect of ensuring that the HSE is kept up to date on the cases, and it would provide greater clarity for lead agencies on

the information flow between them and the HSE. Written guidance on the role of the lead agency, and a structured approach to case planning and review, would also assist this process.

Resources

The ARM has been implemented thus far without any additional resources and in an environment of general pressure on resources. This is a reflection of the commitment and enthusiasm of the stakeholders to become operational. A senior practitioner within the Social Work Department has been assigned to work half-time on facilitating the ARM. More recently, a Project Manager has been appointed, whose duties will include overseeing training in respect of the ARM. As highlighted in the findings, the need for specific resources for the ARM was an issue for many stakeholders. These concerns are reflected in the literature on inter-agency working, regarding the need to ensure that sufficient resources are in place. For example, Sloper (2004, p.576) refers to the need for “shared and adequate resources, including administrative support and protected time to undertake joint working activities”.

Training

As highlighted in the findings, the sequencing of the ARM development meant that there was generally a lack of guidance and training for front-line practitioners. An Inter-agency Case Working Protocol and Information Sharing Guidelines have been developed in parallel with the ARM. The availability of these documents, and the provision of training to support their implementation, will provide a key support to the ongoing implementation of the ARM in Jobstown and to its expansion to cover a larger geographic area. The role of lead agency in particular requires support through written guidance and through training. Given the ground-work of the ARM in developing a dialogue around child protection and welfare thresholds, needs assessment and outcomes-focussed working, there is an excellent opportunity to develop inter-agency training in these areas. Additional points for consideration from the training needs survey are rights-based approaches and tiered training, meeting the needs of both management and front-line practitioners. Bennett et al (2010) propose a child-rights-based approach to child protection and care giving. A tiered approach to training is also supported by the literature (Glennie and Horwath, 2000).

Summary

This chapter discussed the findings presented in Chapter 3. In the first section, the ARM, as reflected in the findings, was situated within the relevant literature on inter-agency working and in respect of differential response. The positive impacts and strengths of the ARM were also examined, with reference to the literature on similar initiatives. The remainder of the chapter examined the challenges and areas of further development for the ARM.

Chapter 5 – Conclusion and Recommendations

This chapter revisits the aims and objectives of the evaluation outlined in Chapter 1, and demonstrates how they have been addressed by the evaluators. Chapter 5 summarises the overall achievements and challenges of the Jobstown ARM, and includes recommendations for future development.

5.1 Evaluation Aims and Objectives Revisited

The overall aim of the evaluation was to describe the development of the model to date, and to inform its continued evolution and implementation. The specific objectives of the evaluation were:

1. To establish stakeholders' experiences of the ARM committee process;
2. To establish stakeholders' experiences of the interventions occurring under the oversight of the ARM committee;
3. To establish stakeholders' views on how the ARM is progressing in respect of its aims;
4. To improve outcomes for children and families through enhancing inter-agency collaboration and the cohesive response of services to families;
5. To facilitate timely access by children and families to appropriate early intervention support services on the basis of assessed need;
6. To reduce the number of children and families notified under the child protection notification system;
7. To establish the level of training needs of staff involved in the delivery of the ARM;
8. To identify recurring themes, issues, barriers or challenges in respect of the aims of the ARM.

The study was formative in nature, reflecting the early stage of development of the ARM, resulting in qualitative data being the primary type of data gathered. The principal evaluation methods used were:

- A review of relevant policy, legislation and literature focusing on the growing interest in integrated working, outcomes-focused working and family support orientation;
- An analysis of all documentation generated by the ARM management committee;
- Individual telephone interviews with members of the ARM management committee and with front-line practitioners;

- Focus group interviews with the ARM management committee and with front-line practitioners; and
- An online training needs survey with members of the management committee and front-line practitioners.

As the report demonstrates, these methods were successful in generating the necessary data for the study. The development of the model to date was described in the model characterisation and further built upon in the findings and the discussion. The findings and discussion inform the ARM's continued evolution and implementation. Specifically, the findings outline the stakeholders' perspectives on the committee process, and on the ARM interventions. The findings demonstrate that stakeholders feel the model is achieving its stated aim "to facilitate timely access by children and families to appropriate early intervention support services on the basis of assessed need". The stakeholders indicated that the model's aim "to improve outcomes for children and families through enhancing inter-agency collaboration and the cohesive response of services to families" was in train, but that it was too early to assess the extent to which outcomes had been achieved. The study found that the aim of reducing the number of children and families notified under the child protection notification system was a longer-term aim that would require a period of years to assess. Data were generated on the level of training needs of staff from the telephone interviews, focus groups and from an online survey. Recurring themes, issues, barriers and challenges in respect of the aims of the ARM were identified in the findings, and subsequently discussed in Chapter 4.

5.2 Achievements, Challenges and Recommendations

This study has shown that achieving integrated working in children's services through close inter-agency cooperation can potentially be fraught with difficulty. However, it is possible to make substantial gains when there is strong leadership in place and a commitment by a range of relevant agencies to work towards a shared purpose. The study has confirmed that the fields of child protection and welfare work, and social work assessment are complex, and that developing a common language or achieving consensus on the precise meaning of key terms is not a straightforward matter. It has shown that mutual understanding can be enhanced in an environment where power differentials are openly acknowledged, and relationships of trust and open channels of communication exist between professionals and organisations. This reflects the importance of inter-personal and inter-organisational relations based on trust, openness and honesty. As a result there was a shared sense of ownership and partnership amongst most of the participants in the ARM.

The study has drawn attention to the unique landscape of children's services in Ireland whereby a rich variety of voluntary providers coexist with a range of statutory providers. It has shown how policy such as the *Agenda for Children's Services* and governance structures such as SDCSC can provide a framework to bring cohesion to these types of groupings, and change how services are delivered to children and families on the ground. As a result of this initiative, 18 families in Jobstown were offered a substantially different service than they otherwise would have been. They received a coordinated inter-agency response in a timely manner. The Jobstown ARM is a successful example of localised response to need through service innovation. As

outlined in the findings, participation in the Jobstown ARM has generally been a positive experience for all the agencies and has provided a focal-point for shared learning and development, and interesting and fruitful challenges were encountered along the way.

Challenges

The findings and discussion have identified a set of more or less interrelated challenges for the next stage of the development and implementation of the ARM, which are as follows:

- Addressing the issue of anonymising of referrals for discussion at the management committee meeting;
- Developing the appropriate structure and membership of the management committee;
- Ensuring effective communication between management committee and front-line practitioners;
- Ensuring the process of gaining consent is clear and ensuring family participation is facilitated;
- Developing a common way of understanding and assessing child protection and welfare concerns and need;
- Developing the capacity of a range of agencies to lead interventions;
- Enhancing joint case planning and review in order to effectively work towards outcomes;
- Developing a clear procedure in relation to cases open to the HSE but led by another agency, so that the governance and oversight of interventions is clear to everyone involved at all times.

The evaluators are of the view that these are all areas that are within the capacity of the stakeholder to resolve without the need for external guidance. However, the following recommendations are intended to support the process of reflection on these challenges:

1. Consideration should be given to reviewing the structure and membership of the ARM to allow for the direct involvement of front-line practitioners. In the context of this review, the process of the ARM should also be reviewed, in particular the process of discussing anonymised cases.
2. The management committee should oversee the direct involvement of front-line practitioners to ensure that the process is functioning well, that strategic service planning is carried out and gaps are identified and if possible, addressed.
3. Consideration should be given to formalising the role of the lead agency and providing training to build up the range of agencies with sufficient capacity to lead interventions.

4. The training on leading interventions could also address issues such as joint case planning and review, outcomes focused working; needs assessment; child protection and welfare thresholds; rights-based approaches and facilitating the participation of families and young people. There is a synergy and scope for integration between this training requirement and the training strategy of the Inter-agency Case Working Sub-committee of SDCSC.
5. The procedure for gaining consent from families to be referred to the ARM should be agreed and written up.
6. The procedure for dealing with child protection or welfare concerns that emerge during an ARM intervention should be agreed and written up.
7. Information on the ARM, including the agreed procedures, should be available in writing for front-line practitioners and families.
8. Consideration could be given to those elements of DRM/ARM that do not currently apply to the Jobstown ARM, such as initial screening to decide on cases suitable for the alternative response, offering the alternative response to cases where low-risk child protection concerns exist, and risk inclusive, strengths-based assessment.
9. In light of the previous recommendation, the procedure for selecting families to be offered an alternative response should be agreed and written up.
10. The positive engagement in relation to child protection and welfare thresholds initiated by the ARM management committee should continue. In the light of recommendations 1, 6 and 9, the level of engagement, understanding and collaboration between all relevant partners could be deepened. Mutual understanding around assessment of need and threshold criteria for alternative response could be developed in workshop-style contexts, and in the light of the forthcoming revised *Children First Guidelines*, or in the context of common assessment frameworks.
11. Inter-agency working needs to be supported and resourced in order to maintain its effectiveness. Consideration should be given to providing specific financial and human resources in order to sustain and develop the initial progress made by the Jobstown ARM.

Considering the well-established challenges of inter-agency working in general, and in particular within the context of complex child protection and welfare work in an area of concentrated socio-economic disadvantage, the Jobstown ARM has achieved a great deal in a short period of time. The beginnings of a very new and different way of working have emerged. This approach has been piloted with a relatively small number of families, with a view to gradually evolving and improving the model. There were both advantages and disadvantages to the 'evolving in action' approach taken by the Jobstown ARM Management Committee, and this initiative needs to be viewed realistically in that light and in terms of its small scale. Also, the initiative has taken place within a national policy context whereby differential response and other innovations in

child protection and family support are being piloted. The findings and discussion in this report are intended to inform the continued evolution and implementation of the Jobstown ARM, and will also be very useful to the national discourse about protecting children and supporting families.

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South Dublin Children's Services Committee

Interagency Case Working Sub-Committee

Sharing Information about
Children & Families

Best Practice Guidelines for Practitioners,
Managers and Agencies
Working in South Dublin County

January 2011

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Introduction - South Dublin Children's Services Committee

In Towards 2016, a national agreement between the social partners, the government committed to establishing at local level, a multi-agency Children's Committee in every City/County Development Board area. The committee was to be chaired by the HSE who were deemed best placed to drive the initiative. Four Pilot sites were identified, Donegal, Dublin City, Limerick and South Dublin for setting up Children's Services Committees. This process is overseen by the National Children's Strategy Implementation Group which is managed by the Office of the Minister for Children and Youth Affairs.

The Children's Services Committee was established in South Dublin in May 2007 with a specific direction to "Test Models of best practice that promote cooperative, locally led, strategic planning for Children's Services". It is a constituent member of the County Development Board.

Membership of the Committee is drawn from a range of services, statutory and non-statutory who work in the South Dublin area. It has 24 members drawn from 17 organisations, The HSE, South Dublin County Council, Department of Education and Science, Gardai, National Educational psychological Services, National Educational Welfare Board, Probation, Childhood Development Initiative, Dodder Valley Partnership, Clondalkin Palmerstown, Lucan, Newcastle Partnership (CPLN), Co Dublin VEC, National Council for Special Education, Lucena, Tallaght Hospital, Barnardos, Archways and the County Childcare Committee

The group developed a Work plan. Six areas were identified for the development of actions and six sub-groups established. These areas included Education and Development; Safe and Secure; Interagency Case Working; Communications, Data and Planning; Child Welfare, Child Protection and Family Support; and Participation

This document has been produced by the Interagency Case Working sub group. It is a response to the need to promote best practice between agencies for the sharing of key information in order to achieve positive outcomes for children.

It has been reviewed by two focus groups of frontline agency staff, it has been commented on by the Office of the Data Protection Commissioner, quality proofed by the Child and Family Research Centre, University College, Galway and it has been adopted as policy by the South Dublin Children's Services Committee and by the following agencies:

For further information on the South Dublin Children's Services Committee please contact mdonohoe@sdublincoco.ie or mick.mckiernan@hse.ie or go to www.southdublinchildren.ie

1. Why Information Sharing is Important - Rationale and Aims of these Guidelines

1.1 These best practice guidelines are intended to:

- Improve outcomes for children and families
- help practitioners to think about the issues involved in sharing information before making a decision.
- To promote a standardized approach to sharing information between practitioners and their agencies in South Dublin County.

1.2 For families with complex needs to receive the services they require in an integrated and coordinated fashion, the effective and appropriate sharing of information between agencies is essential. It is also essential for agencies to share information about individual children and families in order to protect children and young people from suffering harm from abuse or neglect. Appropriate information sharing is a cornerstone of any strategy to improve outcomes for children.

1.3 In Ireland the main relevant policies we work to are:

- Office of the Minister for Children and Young People - Agenda for Children's Services 2007
- National Children's Strategy 2000
- Children First 1999 updated in 2009
- Child Care Act 1991
- Children Act 2001
- Protection for Persons Reporting Child Abuse Act 1998.

1.4 The Children's Services Committees have been set up to improve interagency working in relation to children. A key element of this is information sharing in a way that is lawful, appropriate and respects the rights of the individuals involved.

1.5 We should always explain to children and their families, openly and honestly, how information about them will be shared and why and we should seek their agreement. The only exceptions to this are where to do so would put a child at increased risk of harm, or where it would undermine the detection or prosecution of a serious crime. Each case is different and professional judgement is always required. In general, however, the spirit of Child Care Policy in Ireland, which puts the child's welfare at the heart of all service provision, indicates that sharing information using the correct legal safeguards is essential to effectively addressing the needs of children and families.

- 1.6 Practitioners recognise the importance of information sharing and there is already much good practice. However, in some situations they feel constrained from sharing information by uncertainty about when they can do so lawfully, especially in early intervention and preventive work where information sharing decisions may be less clear cut than in child protection.
- 1.7 From the outset it is important to recognise that where you have cause to believe that a child or young person may be experiencing harm or be at risk of harm or where you are concerned about their welfare, you should refer your concerns to the HSE or Gardai as per Children First National Guidelines for the Protection and Welfare of Children¹. Also, where you have a statutory duty or court order to share information you must do so unless, in the case of a court order, your organisation challenges it.
- 1.8 Sharing information that is not for the purpose of child protection is less clear cut and depends heavily on professional judgement.

¹ Children First Guidelines identify 4 types of child abuse:

- Neglect
- Emotional abuse
- Physical abuse
- Sexual abuse

2. **Eight Golden Rules for Information Sharing**

1. **Be open and honest** with children and families from the outset about why, what, how and with whom information will or could be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
2. Always keep the **safety and well-being** of the child and of other children **central to your considerations**.
3. Always be **clear about the purpose** for which you have received the information and the purpose you are using it for - they should be the same.
4. **Know the relevant policies** in your agency in relation to confidentiality and information sharing and consult them as necessary. **Seek advice** if you are in any doubt, without disclosing the identity of the person.
5. Remember that the Data Protection Act is **not a barrier** for sharing information but **provides a framework** to ensure that personal information is shared appropriately.
6. **Aim to share with consent except where this is not appropriate.** Wherever possible, respect the wishes of those who do not consent to you sharing their confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the vital interest of the child. You will need to base your judgement on the facts of the case
7. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary and relevant for the purpose for which you are sharing it, is shared only with those people who need it, is accurate and up to date, is shared in a timely fashion and is shared securely.
8. **Keep a record** of your decisions and the reasons for them - whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

3 Legal Framework

- 3.1. Whether you work for a statutory agency or within the private/community/voluntary sector, any sharing of information must comply with the law relating to confidentiality, human rights and data protection. In all cases, the purpose for sharing is the most important consideration.
- 3.2. In the Irish constitution there is an implicit right to personal privacy under Article 40.3.1 “The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizens.”
- 3.3. Article 8 of the European Convention for the Protection of Human rights also underscores the right to privacy; “there shall be no interference by a public authority with the exercise of this right except as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others.”
- 3.4 The Data Protection Acts 1988 & 1993 deal with the right to personal data privacy. There are additional protections required for data which is defined as sensitive personal data as follows:
 - Physical or Mental Health
 - Racial Origin
 - Political Opinions
 - Religious or Other Beliefs
 - Sexual Life
 - Criminal Convictions
 - Alleged Commission of an Offence
 - Trade Union Membership

It should be noted that these Acts refer to personal data only. Aggregate or fully anonymised data can be shared outside the scope of the Data Protection Act.

3.5 Data Protection & Interagency Working

The Data Protection Commissioner has confirmed that there is no impediment in law to sharing information between agencies working in the best interests of children and families where there is consent for the sharing of such information. In fact, it is both legal and necessary to do so under the Child Care Act 1991 and The Children Act 2001 and is protected by the Protection for Persons Reporting Child Abuse Act 1998 where such information is provided for welfare issues to the HSE.

There are however, a number of things to consider in deciding whether to share or not share information:

1. Consent to share information should always be obtained if possible.
2. If consent is not possible, information can be shared as long as it is in the vital interests of the child. There is no test from the Data Protection point of view of what is in the vital interests of the child. This is covered by individual laws pertaining to children.
3. Information sharing without consent should be on a need to know basis only.
4. Agencies should alert service users at the time of collecting personal information that this may be shared.
5. It is necessary to share information with the HSE and/or Gardai if child abuse² is suspected. Because some forms of child abuse are crimes, there will be limitations on their capacity to share information with you at a particular point in time. The HSE and Gardai will advise on this on a case by case basis.
6. Each organisation working with children should have a policy on Information Sharing or adopt this document as their policy. This can highlight the need for consent where possible and the “trigger mechanisms” for sharing when consent isn’t possible.
7. All information about children, young people and families which is shared between agencies should be intended to promote their welfare and protection.
8. All information, whether held on hard copy or electronically, must be kept safe and secure.

² Children First Guidelines identify 4 types of child abuse:

- Neglect
- Emotional abuse
- Physical abuse
- Sexual abuse

3.6 Protection for Persons Reporting Child Abuse Act 1998.

The main provisions of the Act are:

- 1 The provision of immunity from civil liability to any person who reports concerns of child abuse or child welfare³ "reasonably and in good faith" to designated officers of health service executive or any member of An Garda Síochána .
2. The provision of significant protections for employees who report child abuse. These protections cover all employees and all forms of discrimination up to, and including, dismissal.
3. The creation of a new offence of false reporting of child abuse where a person makes a report of child abuse to the appropriate authorities "knowing that statement to be false". This is a new criminal offence designed to protect innocent persons from malicious reports.

The Health Service Executive has appointed a wide range of nursing, medical, paramedical and other staff as designated officers for the purposes of the Act.

3.6 Freedom of Information Acts 1997 and 2003

The Freedom of Information Acts oblige government departments, the Health Service Executive (HSE), local authorities and a range of other statutory agencies to publish information on their activities and to make personal information available to citizens.

³ The Act specifies the information which is protected:

- a) a child has been or is being assaulted, ill-treated, neglected or sexually abused, or
- b) a child's health, development or welfare has been or is being avoidably impaired or neglected,

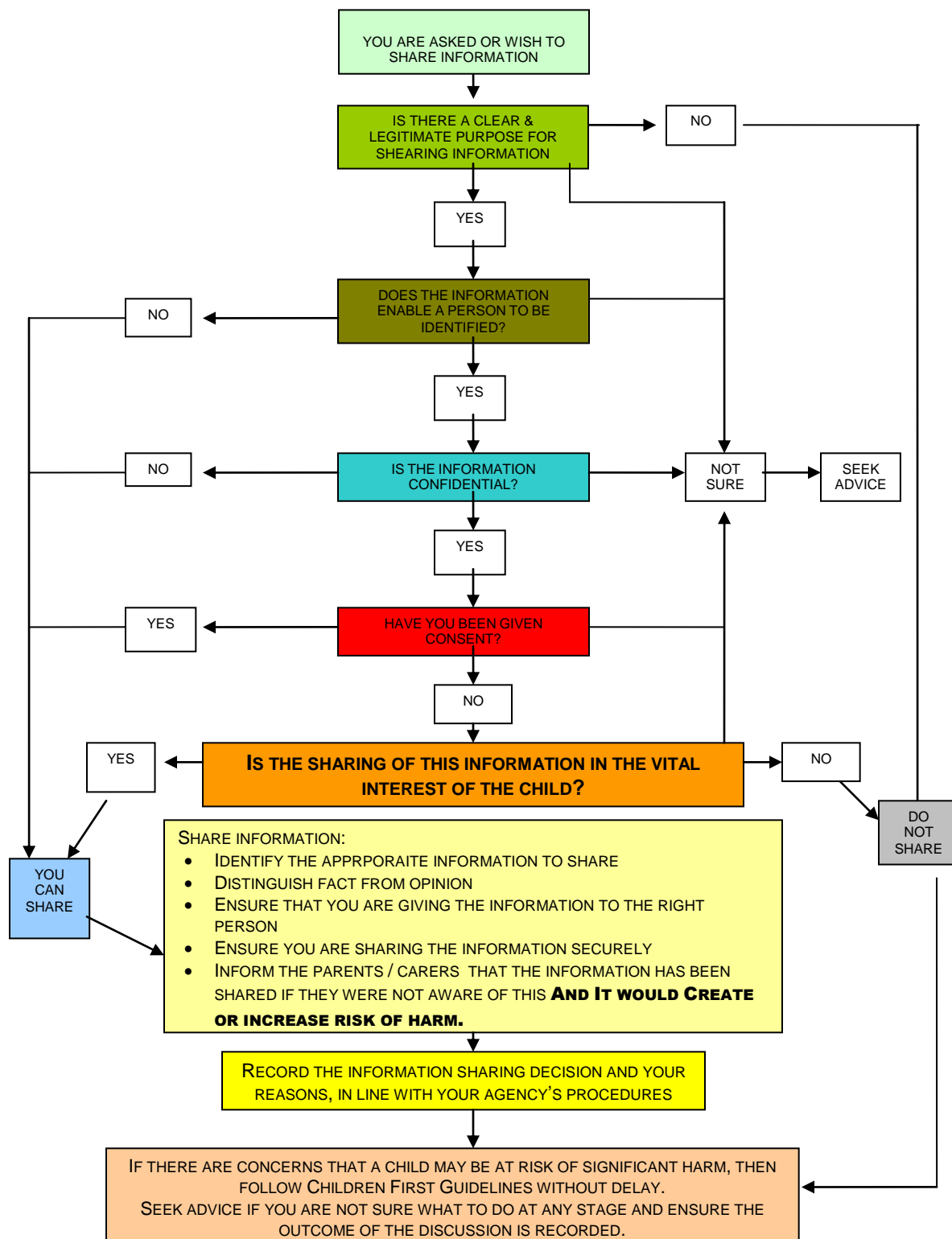
The following statutory rights are established:

- A legal right for each person to access information held by public bodies and government departments
- A legal right for each person to have official information relating to himself/herself amended where it is incomplete, incorrect or misleading
- A legal right to obtain reasons for decisions affecting himself/herself.

If a voluntary or community organisation provides services which are significantly funded by a public body, an individual has the right to make a Freedom of Information request to the public body which funds the organisation for access to the voluntary or community organisation's information on them. There are defined circumstances in which an organisation can refuse to make information available (for example in some circumstances an organisation can refuse to make available information provided in confidence).

In making records regarding children and families, it is best to assume that the person the record relates to may have a right to read the record in future. Ideally practice is that the service user is involved in agreeing the record and has regular access to their file.

4 Flowchart of Key Questions for Information Sharing



5 Frequently asked questions

1. What information is considered confidential?

Confidential information is:

- Personal information about an individual child or family. Anonymous or aggregate information is not confidential.⁴
- Information that is not already in the public domain or available from another public source.⁵
- Information that has been shared in circumstances where the person giving the information could reasonably expect it would not be shared with others.

Sometimes people may not specifically ask you to keep information confidential, but may assume that personal information will be treated as confidential. In these situations you should check with the individual whether the information is or is not confidential, the limits around confidentiality and under what circumstances information may be shared with others.

2. What should I say to service users about confidentiality and consent when they start their involvement with my service?

Practitioners should always proactively inform children, young people and families when they first engage with the service, about agency's policy on when and how information will be shared and on seeking their consent.

They should also be told about what records your agency keeps about them, that these are kept safely and securely and the rights they have of access to them.

⁴ Unless such information may be considered confidential to the organisation although it is not personal data.

⁵ This may not apply in the Data Protection context as even if say conviction information was reported in the media that would not provide a basis to process such information without consent.

3. I think I need to share some confidential information with another service - what should I do?

Firstly be clear that there is a clear and legitimate purpose for you or your agency sharing the information.

Individual agencies may have developed specific guidelines and processes for sharing information. You will need to be guided by your agency's policies and procedures and - where applicable - by your professional code.

Once you are clear about the purpose of sharing the information, you must now consider the issue of consent.

4. Why should I seek consent?

Best practice is that consent should always be sought in relation to sharing confidential information. The benefits are that in most cases, if this is explained openly and honestly to families, consent will be given.

5. Can I ask a person to give me general consent to the sharing of their confidential information?

No. Consent should not be general but for a specific purpose (e.g. for a referral to a particular service) If the purpose changes, new consent should be obtained.

6. Who can give consent to the sharing of confidential information about a child or family?

Consent can be given by an adult regarding information which relates to him or her.

Consent regarding information relating to a child can be given by those holding guardianship rights in respect of the child. These include:

- The mother of child unless the child has been adopted;
- The father of the child if he is married to the mother;
- The father of the child if he is not married to the mother but has secured guardianship of the child by agreement with the mother under the Guardianship of Children (Statutory Declaration) Regulations 1998 or where he has obtained a court order granting him guardianship rights;
- The adoptive parent(s) of the child.

Where a child has more than one guardian, best practice is that consent should be obtained from both guardians when available.

Generally a parent needs to give consent for information on a child under the age of 18 to be shared but good practice is that the child should be consulted, particularly if they are in their teenage years.

7. What is informed consent?

Informed consent means that the person giving the consent fully understands the implications of the consent they are giving. For instance if the person is immature, has a learning difficulty, has mental health difficulties or is under the influence of alcohol or drugs, you need to satisfy yourself that they fully comprehend what information you are proposing to share with whom and for what purpose. If you are not satisfied, then you must conclude that they have not given you their informed consent.

A suggested Consent Form is included in the appendix of the document. However your agency may choose to use its own form.

8. What is explicit and implicit consent?

Consent can be explicit or implicit. Explicit consent means that the person has been directly asked for their consent and they have given it. It is usually by means of a signed agreement. However it can also be by means of a record on your file that consent was given. Ideally you should offer your service user a copy of the consent or access to their file.

Implicit consent is where you consider that the discussion you have had with the service user clearly implies permission for you to pass on confidential information. For instance the service user may ask you to refer them to a particular service. If you believe that the service user understands that this will entail you passing over confidential information about them to the service, you could conclude that you have their implicit consent.

Best practice would be that the service user co-signs the referral to the other service.

9. How long does consent last for?

Consent should be current. Consent given in the distant past needs to be renewed. Best practice is to keep the service user regularly advised on who you have passed information to, for what purpose and what is happening as a result.

A useful question to ask yourself is “Do I believe that the person remembers giving the consent, remembers the purpose they gave it and understands that I might still be operating under that consent?”

10. *Can I use consent given for one purpose for a different purpose?*

No. Consent to share information should be for a specified purpose. If you need to share information for a different purpose, then you need to seek separate consent for that purpose.

You might wish to consider if the consent given for the initial purpose could be considered implied consent for the new purpose if the purposes are related.

11. *Once given, can consent be withdrawn?*

Yes. A person always has the right to withdraw their consent. It would be good practice to explore the reason for withdrawing consent. Ideally consent should be withdrawn in writing. However it is important that you have a written record of when you were advised that consent was withdrawn. This will mean that there can be less likelihood of there being a dispute about information you have shared before the consent was withdrawn.

12. *What is meant by “the vital interests of the child”?*

Even where you do not have consent to share confidential information, you may lawfully share it if this can be justified in “the vital interest of the child.” This is a legal term in the Data Protection Act⁶ which should not be confused with the concept of “the best interests of the child”. The concept of “vital interests” would have a higher threshold than “best interests”.

⁶ In the act the reference is to the “vital interests of the data subject”.

13. If consent is not given, can I still share information?

Seeking consent should be the first option. However, where consent cannot be obtained, is refused, is withdrawn or where seeking it is inappropriate or unsafe, the question of whether sharing it is in the vital interests of the child must be judged by the practitioner on the facts of each case - see Question 12. Therefore, where you have concern about a child, you should not regard refusal of consent as necessarily precluding the sharing of confidential information. Children First National Guidelines on the Protection and Welfare of Children will provide you with further guidance.

The key factors in deciding whether or not to share confidential information are necessity and proportionality, i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the vital interest of the child in sharing information overrides the interest in maintaining confidentiality. In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not and make a decision based on professional judgment.

If information is shared without consent, it is best practice to inform the parent / guardian as soon as possible after you have shared in the information, unless to do so would be dangerous or inappropriate (see Question 14).

14. Are there situations where consent is not required?

You are not required to seek consent when you are required by law to share information through a statutory duty or a court order. In these situations best practice is that you should inform the individual concerned that you are sharing the information, why you are doing so and with whom.

15. How do I ensure that I am sharing the information appropriately and securely?

A clear policy on record keeping and information sharing should be in place in your agency.

Appropriate sharing of information means that wherever possible this is done with consent and that the information provided is relevant for the purpose it is being shared. Therefore you do not share other information you have which has no relevance to the purpose you are sharing information.

Secure sharing of information relates to the appropriate methods of sharing information. In general it is best that information is shared in writing, signed by the person providing the information. Where necessary, sharing of information by phone can be appropriate but should be followed up by confirmation in writing.

Best practice is to avoid sharing information by fax or e-mail. If it is essential to use fax, you should take steps to verify the fax number and ensure that the recipient is available to collect the information from their fax machine immediately.

If it is essential to use e-mail, best practice is to use an encrypted e-mail facility. You should seek advice within your agency on obtaining this facility.

16. How should I properly record my information sharing decision?

In sharing the information, you must ensure that the data is accurate and relevant and you should record the following information:

- What information has been disclosed and to whom
- The source of the information shared.
- Reason for sharing information.
- Date on which data was shared.
- Where consent is not sought, you should record the reason for this.
- Where consent is given you should retain a copy of the signed consent or a record that verbal consent has been given along with the date.
- If consent was refused you should record the reason that it was refused.
- If consent is withdrawn you should record the date and time it was withdrawn along with the reason.

You should record your decisions and the reasons for them, whether or not you decide to share information working within your agency's arrangements for recording information. If you have sought advice, you should note who you consulted, when and the advice they gave you. All records should be signed and dated and stored safely and securely.

6 Seeking Advice

There is no blanket rule that will cover all circumstances. If you are unsure as to whether a piece of information can be shared, seek advice. This should come in the first instance from your line manager. Other avenues to consult are:

- Your agency's Information Sharing Policy
- Your Designated Liaison Person under Children First
- Your agency's legal advisor
- Your professional code.

7 Suggested consent to share information form

Name of agency:_____

Name of worker:_____

Name and composition of family:

Address of family_____

We are seeking your consent to contact other agencies with a view to offering your child(ren) and your family assistance. In order to do this, it will be necessary to discuss your needs and those of your child(ren) and family with other agencies so that they can be of help. The agency / agencies we propose to share information with are:

Please sign below to indicate that you give your free and informed consent to share relevant information about you and your family with other services for the purpose of

I understand that I can withdraw this consent at any time by putting this in writing to the above named worker.

Signed:_____

Name _____

Date: _____

I consider that this consent was given with the full knowledge of its implications.

Worker's signature :_____

Name: _____

Date: _____



South Dublin Children's Services Committee

Interagency Case Working Sub-Committee

Working together for children

An Inter-agency Caseworking Protocol

January 2011

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Appendix 3 Additional resources to support implementation

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Introduction

a. Background context

The Inter-agency Case Working Protocol is an initiative of the Inter-agency Case Working sub-committee which is a sub-committee of South Dublin Children's Services Committee. The membership of South Dublin Children's Services Committee (SDCSC) is drawn from a wide range of key statutory, community and voluntary organizations with a remit for children and young people, in the administrative area of South Dublin County Council.

The main objectives of the SDCSC are:

- To develop strong cross-agency working relationships
- To plan together for children and young people
- To secure support for the joint implementation of policy initiatives
- To maximize integration of service delivery at local level

For further information on the South Dublin Children's Services Committee please contact mdonohoe@sdublincoco.ie or mick.mckiernan@hse.ie or go to www.southdublinchildren.ie

The Inter-agency Case Working Protocol is intended to be used in cases of children⁷ and families where there are child welfare⁸ or child protection⁹ concerns and where it is appropriate for more than one agency to be undertaking a significant level of work with the family.

The Protocol is aligned to the vision for children as set out in the National Children's Strategy: *'An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and wider society; where they enjoy a fulfilling childhood and realise their potential.'* Our Children- Their Lives, The National Children's Strategy (2000)

⁷ In this document "Child" refers to all children and young people under the age of 18.

⁸ A child welfare concern is considered to be any situation where a child is at risk of not achieving their developmental potential

⁹ Child abuse and neglect are defined in the Children First - National Guidelines for the Protection and Welfare of Children

The Protocol aims to translate the 7 national outcomes for children to intervention level outcomes appropriate to the local context. The 7 national level outcomes are that children be:

- healthy, both physically and mentally
- supported in active learning
- safe from accidental and intentional harm
- economically secure
- secure in the immediate and wider physical environment
- part of positive networks of family, friends, neighbours and the community
- included and participating in society

The committee has also produced

- A **Frontline Workers Directory** with detailed information on services for children and families in South Dublin County and how to make referrals to them.
- **Best Practice Guidelines for the Sharing of Information on Individual Children and Families.**

Both of these resources will be of support to staff in the implementation of this protocol.

b. Purpose of Protocol

The purpose of this protocol is to improve outcomes for children and families by providing a practical tool for agencies and professionals working with children and families so that together they can work in a more integrated and outcomes focused way using reflective practice, evidence based practice and a rights based approach in their work with children and families.

c. Key Concepts:

Agency: Any organization (statutory, voluntary, private or community which delivers services to children and families

Lead Agency: Any agency who is designated to take a lead role in the co-ordination of services to meet the needs of a specific child or family. (See Section 3)

Inter-agency collaboration or working can be defined as any joint action by two or more agencies that is intended to increase children's welfare by their working together rather than separately. It can involve the exchange of information, altering activities, sharing resources, and actively enhancing of the capacity of other agencies for mutual benefit. (Adapted from CAAB, 2009)

An outcome is an articulated expression of well-being of a child or family which provides all agencies with the opportunity to contribute to that outcome with their individual programmes. (Adapted from Framework for Integrated planning for Outcomes for Children and Families, 2008)

Outcomes-focused approach: Working towards achieving an articulated expression of wellbeing for children, which provides all agencies and children and families with the opportunity to contribute. (Adapted from Agenda for Children's Services, 2007)

Reflective practice: Checking and changing practice in the light of learning from past

experience (reflection-on-action) through improvisation during the course of interventions with and for children and families (reflection-in-action). (Agenda for Children's Services, 2007)

Evidence-based services: Those services and interventions that have been developed on the basis of the best available scientific research evidence. (Agenda for Children's Services)

A rights based approach to working with children and families means that every intervention is planned and completed in a manner that fully takes into account the human rights of those involved, identifies who's duty it is to fulfil their rights, actively seeks to realise their rights and as far as possible to remove any obstacle to the realisation of their rights.

The committee have in place a Critical Incident Response Policy which should be read in conjunction with this document so that children and families who experience a critical incident can experience a smooth transition from a crisis response to longer term interventions.

d. Child protection:

Whenever a concern arises for the protection of a child, it is the responsibility of the agency that identifies the child protection concern to report their concern to the HSE Social Work Service in line with Children First - National Guidelines for the Protection and Welfare of Children 1999.

This protocol is not an alternative to reporting child protection concerns to the HSE.

Under Children First all organisations working with children have a responsibility to report concerns and should be aware that early action by them is often the best way to protect children and to enable a family to stay together. Having reported concerns, there is an expectation that the organisation will continue to provide services to the child and family to and to work collaboratively with other agencies

The Protection for Persons Reporting Child Abuse Act, 1998 provides immunity from civil liability to any person who reports child protection concerns to the HSE or Gardai.

All agencies participating in the implementation of the Protocol should have a child protection policy and a complaints policy, they should be adhering to Children First, Our Duty to Care and to best practice in relation record keeping.

In addition to the HSE's child protection role under Children's First, it has a role in prevention and early intervention through the provision of child care and family support services. It fulfils this role by the direct provision of services and by contracting other agencies to deliver services on its behalf. In addition a number of other statutory, voluntary and community agencies deliver services which aim to provide support to children and families.

e. Participation of children and families

Best practice indicates that parents and children should be involved to the greatest extent possible in the processes of

- identifying their needs,
- identifying the outcomes they wish to achieve for themselves and their family and
- identifying the supports which will help them achieve these outcomes.

Ideally children and parents should attend and participate in case planning and review meetings. This will require supporting them to prepare for the meeting and to participate fully.

Where children and parents are not in attendance at meetings, the reason should be recorded in the minutes and there should be mechanisms for their opinions to be brought to the meeting (via an agency worker, advocate, letter, tape, etc).

At each meeting there should be clarity about communication arrangements between agencies and with the family.

Consideration should be given to the use of processes including Family Welfare Conferences and Family Meetings, where children and families are supported to come up with their own solutions to their difficulties. Often the most effective supports can be found within the extended family or immediate community.

Children and parents should be made aware of complaints mechanisms and should be kept aware of their rights so that they can participate effectively.

f. A Child Rights Approach to Inter-agency Working with Children, Young People and their Families

Ireland ratified the UN Convention on the Rights of the Child in 1992 which identifies a wide ranging number of rights. However, four guiding principles of the UNCRC should underpin legislative, policy, service developments and each practitioners practice when working with children, young people and their families.

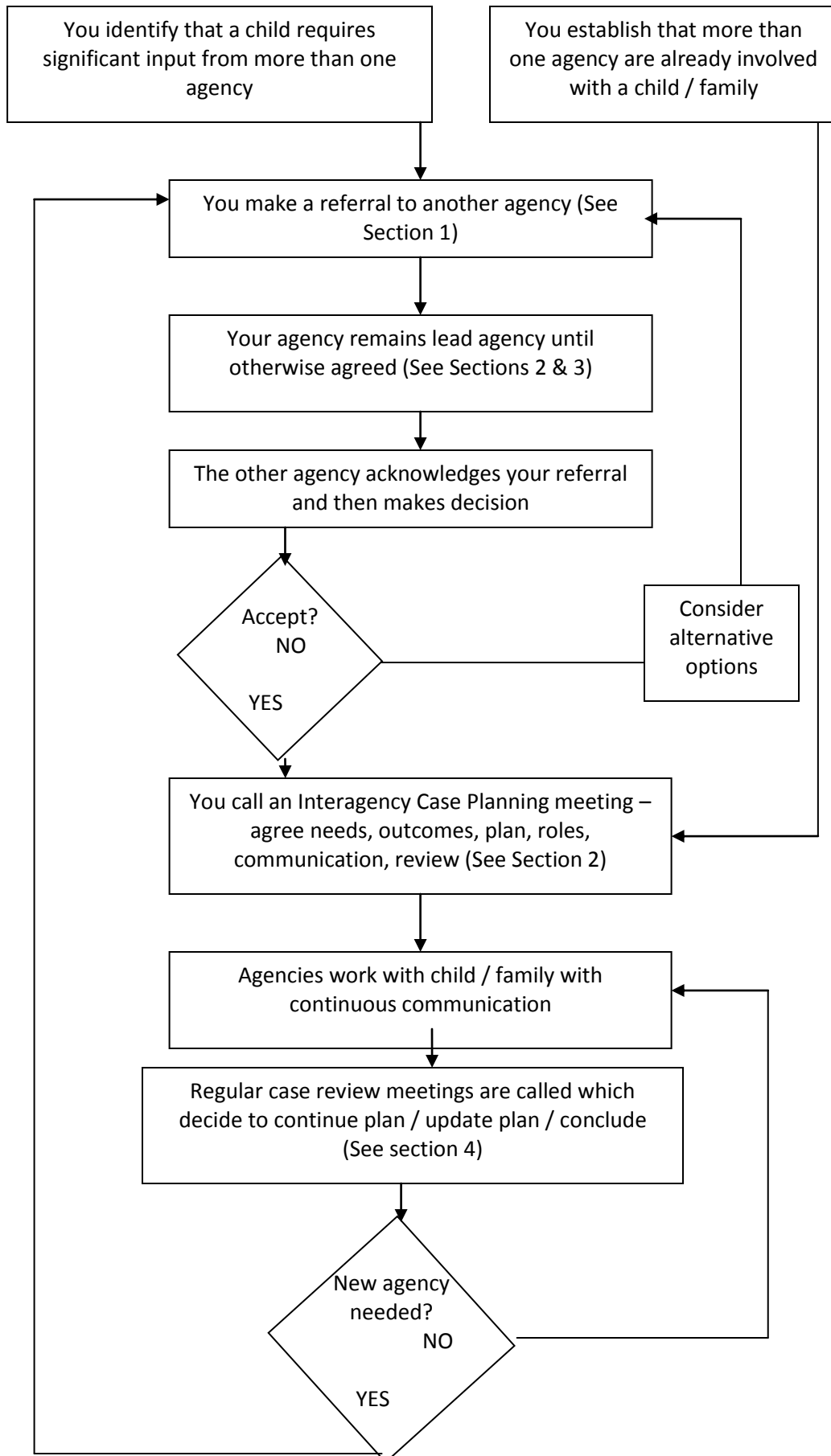
- An express recognition of the right of the **child's voice to be heard** in all matters affecting the child in accordance with age and maturity (UNCRC Article 12).
- The same level of protection and care be afforded **equally to each child** without discrimination of any kind (UNCRC Article 2).
- The **principle of the best interests** of the child should be seen as having paramount importance in all matters of welfare and protection of the child (UNCRC Article 3).
- The principle that each child should be entitled to **support in order to achieve their developmental potential** (UNCRC Article 6 as well as articles dealing with education, health and disability Articles 23, 24, 26, 27, 28, 31 and 39).

Implementing a child rights approach to practice involves thinking about children and young people as individuals with rights and responsibilities and as active participants in all matters concerning them. It also means consciously promoting, protecting and realising the rights of the child in everything we do.

This can be achieved by consciously reflecting on each intervention you are involved in and asking whether the rights of the child or young person, as expressed in the UNCRC, are being promoted, protected and realised by the particular intervention. In practice this can mean not doing anything to violate the rights of the child/young person but also actively seeking to remove any barriers to the realisation of their rights and actively facilitating the child or young person to participate effectively, in the most empowering way possible.

Working together for children- Interagency Caseworking Protocol

1. **Interagency protocol –flowchart**



1. Interagency referrals

This protocol comes into effect when it is established that more than one agency are undertaking a significant role with a family or where one agency, fulfilling a significant role, decides to make a referral to another agency.

Some agencies have their own referral forms while others will accept a referral in any format. At minimum all referrals to another agency should include the following information:

- Name, address, family and household composition, ages of family members, ethnicity (highlight if interpretation is necessary)
- Other services involved currently
- Agency's assessment of the needs of the child / family
- Specific purpose of the referral: outcomes sought / services requested
- Level of priority / risk
- Parents' / child's awareness of and attitude to referral and outcomes sought
- Name of link person in referring agency
- Highlight if there are any staff safety issues involved in working with the family

Referrals should be made with the consent of the family wherever possible. (See Best Practice Guidelines for Sharing Information about Children and Families (SDCSC 2010))

Agencies receiving referrals should acknowledge them and then make a decision within a reasonable timeframe.

Where the agency referred to is refusing a referral or will have a significant delay in providing a service, they should suggest other service options to the referrer.

Due to referral procedure and waiting lists for services, it is not always possible for agencies to open new referrals as quickly as they would wish to. In these circumstances, it may be possible for Team Leaders / Managers in key services to attend meetings in a consultative capacity pending referrals being offered a service.

The original agency making the referral will be the lead agency until the Case Planning Meeting where the lead agency will be agreed. The only exception to this is where there are current child protection concerns, where the HSE will take the role of lead agency. (See section 3 below).

2. Case planning and management

Following the involvement of more than one agency there should be a Case Planning Meeting which should:

- Agree need
- Agreed outcomes sought
- Agree plan for supports / services to be provided
- Agree a lead agency / worker and named workers in other agencies
- Agree timeframe for review (See appendix 1 for Inter-agency meeting template)

Each agency involved with a family should have a named worker.

When a number of agencies are working with a family, there should be a nominated lead agency and lead worker. According to the needs, this can be a shared role or can be agreed to be moved between agencies at review meetings as the work progresses.

If an agency is considering ceasing their involvement in a case, this should first be discussed at a review meeting.

See appendix 2 for Case Planning Meeting Checklist, Agenda and Minutes template.

3. Role of Lead agency:

The role of the lead agency is:

- To convene (and if necessary cancel or reschedule) and chair case planning and review meetings
- To arrange for meetings to be minuted and for minutes to be circulated to all agencies
- To manage the plan and coordinate the interventions
- To act as the key point of contact for the child, family and for other agencies
- To ensure that information is shared appropriately

The H.S.E. Social Work Service will be the lead agency when there are current child protection concerns. In emergency situations this can be agreed by phone.

4. Case Review meetings

At the Inter-agency Case Planning Meeting an agreed timeframe for reviewing progress will have been agreed.

The child, parents or any agency can request the Lead Worker to convene an earlier review if they believe that the circumstances warrant it. If the Lead Worker does not agree with this request, they should explain their reason and offer an alternative strategy to meet the request.

The lead agency is responsible for convening the case review meeting.

The meeting should:

- Review the operation of the plan to date
- Consider any significant changes – positive and negative – since the last meeting
- Review the needs, the outcomes and the supports / services.
- Agree to continue, update or conclude the plan
- Agree if other supports / services are needed
- If necessary agree any change in Lead Agency
- If necessary discuss any agency's proposal to cease their involvement with the child / family
- Agree the date for the next review

See Appendix 3 for Review Meeting Checklist, Agenda and Minutes template.

5. Closure to process

The use of this protocol ceases in any particular case when work with the family progresses to the point that there is only one agency with significant continuing involvement with the family.

This point sought be identified and agreed at a Case Review meeting.

The closure to this process should be used as an opportunity to:

- Provide feedback to the child and family on work done and progress achieved
- Receive feedback from the child and family on services received by them – what they found helpful / unhelpful
- Provide an opportunity for agencies to review their experience of working together with the family and to identify learning – positive and negative – to be taken into account in work with other families
- Provide agencies with an opportunity to identify any service or procedural gap which can be made known to the relevant agency / agencies and, if appropriate to the Children's Services Committee

Appendix 1 Supporting Documentation for Interagency Case Planning Meeting

A. Checklist for Interagency Case Planning Meeting

Prior to the meeting:

- Purpose of the meeting
- Who should convene the meeting – referring agency or lead agency
- Who should attend the meeting – agencies? Which agencies / individuals are essential so the meeting should be scheduled to match their availability?
- Who can minute the meeting?
- Should the family attend the meeting? If so, what support / preparation requirements are there?
- If the family are not attending the meeting, what is the mechanism to ensure their views are available to the meeting?
- What information needs to be circulated prior to the meeting and / or needs to be available at the meeting?
- Are there any staff safety issues to consider?

At the meeting:

Preliminary:

1. Introductions
2. Outline the purpose of the meeting
3. Are the correct agencies / individuals present? Record apologies and absences.
4. Are the family members present? If not, record the reason and explore how their views can be made available to the meeting.

Needs assessment:

- What are the needs of this child / family?
- What are the key factors which are contributing to these needs?
- What are the strengths and resources available within the family (including extended family network)?
- Taking account of the above three points, what are the risks if nothing changes? (i.e. What might happen? How likely is this?)

What are the family's views about the needs and what they would find most helpful?

Outcomes:

- What realistic achievable outcomes would make a significant difference to this child / family?

Action Plan for Services:

What inputs from agencies and from family members are needed to achieve these outcomes?

Who	What	When

- What is the contingency plan required if the plan is not working?
- Record any dissent to the plan

Communication and monitoring

- Each agency should indicate a named worker responsible for the delivery of their element of the plan
- The meeting should agree a lead agency and individual responsible for receiving information from other agencies and ensuring effective communication between agencies.
- If the family are not present, it should be agreed who feeds back to the family and when this will happen
- Arrangements should be agreed for monitoring the implementation of the plan

Review

- What is a reasonable timeframe to review this plan?
Date:
Time:
Venue
- It should always be open to any agency to request an earlier meeting of the lead worker if they feel it is warranted.

After the meeting:

Minutes:

- As soon as possible after the meeting, the minutes of the meeting should be reviewed by the chair and the lead worker and circulated to all attended and to invitees who did not attend.
- If anyone disagrees with the minutes, they should communicate this immediately to the lead worker.
- The minutes should be agreed at the start of the next review meeting.

B. Agenda Template for Interagency Case Planning Meeting

1. Preliminary:

- Introductions
- Purpose of the meeting
- Attendance
 - Are the correct agencies / individuals present?
 - Apologies and absences.
- Family participation: If not present, record the reason and explore how their views can be made available to the meeting.

2. Needs assessment:

- Needs of this child / family
- Key factors which are contributing to these needs
- Strengths and resources available within the family
- What are the risks if nothing changes
- Family's views about the needs and what they would find most helpful

3. Outcomes:

- Agree realistic achievable outcomes

4. Action Plan for Services:

- Detail inputs from agencies and from family members needed to achieve outcomes (Who / What / When)
- Review evidence base for intervention
- Highlight any obstacles to realising the rights of the child.
- Contingency plan (if required)
- Dissent to the plan (if any)

5. Communication and monitoring

- Named worker from each agency
- Lead Agency and Lead Worker
- Arrangements for feedback to the family (if not present)
- Arrangements monitoring the implementation of the plan

6. Review

- Timeframe to review the plan

C. Minutes Template for Interagency Case Planning Meeting

Details of child / family: Name:

Address:

Date:

Time:

Venue:

Chair:

Minute taker:

1. Preliminary:

Purpose of the meeting:

Attendance:

Name of invitees	Title / role	Agency / relationship	Present	Sent apologies	Absent – no apologies	Report submitted

Family participation

2. Needs assessment:

- Needs of this child / family
- Key factors which are contributing to these needs
- Strengths and resources available within the family
- What are the risks if nothing changes
- Family's views about the needs and what they would find most helpful

3. Outcomes sought:

4. Action Plan:

Who	What	When

- Evidence base
- Obstacles to realising child's rights
- Contingency plan (if required)
- Dissent to the plan (if any)

5. Communication and monitoring

- Named worker from each agency
- Lead Agency and Lead Worker
- Arrangements for feedback to the family (if not present)
- Arrangements monitoring the implementation of the plan

6. Review

- Timeframe to review the plan

Date:

Time

Venue:

Minutes agreed by: _____ **Signature**

Name:

Date:

A. Checklist for Interagency Case Review Meeting

The case review meeting represents an opportunity to reflect on the intervention and follows a similar template to the planning meeting and including:

- Agreeing the minutes of the Case Planning Meeting or of the last Case Review Meeting.
- Reviewing the operation of the plan to date (has each action been implemented fully / partially / not at all)
- Consideration of any significant changes – positive and negative – since the last meeting
- Reviewing the needs, the outcomes and the supports / services against the original plan.
- Consider any feedback from the family
- Agreeing to continue, update or conclude the plan
- If necessary agree any change in Lead Agency
- If necessary discuss any agency's proposal to cease their involvement with the child / family
- Agree if other supports / services are needed
- Agree the date for the next case review

If new agencies are being involved with the family, a new Interagency Case Planning Meeting should be held.

B. Agenda Template for Interagency Case Review Meeting

1. Preliminary:

- Introductions
- Purpose of the meeting
- Attendance
 - Are the correct agencies / individuals present?
 - Apologies and absences.
- Family participation: If not present, record the reason and explore how their views can be made available to the meeting.

2. Minutes of last meeting

- Agree the minutes of the Case Planning Meeting or of the last Case Review Meeting.

3. Review the operation of the plan to date

- Has each action been implemented fully / partially / not at all
- Any significant changes since the last meeting
- Review the needs, the outcomes and the supports / services against the original plan.
- Consider any feedback from the family
- Are there evidence based interventions that have not yet been considered?

4. Agree to continue, update or conclude the plan

- Agree if other supports / services are needed
- Review evidence base for intervention
- Highlight any obstacles to realising the rights of the child.

5. Communication and monitoring

- Changes in Lead Agency or Agency involvement (if any)
- Arrangements for feedback to the family (if not present)
- Arrangements monitoring the implementation of the plan

6. Review

- Timeframe to review the plan

C. Minutes Template for Interagency Case Review Meeting

Details of child / family: Name:

Address:

Date:

Time:

Venue:

Chair:

Minute taker:

1. Preliminary:

Purpose of the meeting:

Attendance:

Name of invitees	Title / role	Agency / relationship	Present	Sent apologies	Absent – no apologies	Report submitted

Family participation:

2. Minutes of last meeting

- Minutes of the Case Planning Meeting or of the last Case Review Meeting agreed and signed.

3. Review the operation of the plan to date and reflect on practice

(Copy plan from last minutes and complete right column)

Who	What	When	Implemented (Fully / Partially / Not at all)

- If implementation has been partial or not at all, reasons for this.
- Significant changes since the last meeting
- Changes in the needs, the outcomes and the supports / services in the original plan.
- Feedback from the family

4. Agree to continue, update or conclude the plan

- Continue / Update / Conclude (If Update you should cut and paste the plan from the previous meeting and then update it in these minutes)
- Other supports / services needed (if any)
- Evidence base
- Obstacles to realising child's rights

5. Communication and monitoring

- Changes in Lead Agency or Agency involvement (if any)
- Arrangements for feedback to the family (if not present)
- Arrangements monitoring the implementation of the plan (If changed)

6. Review

- Timeframe to review the plan again
Date:
Time
Venue:

Minutes agreed by: _____ **Signature**

Name:

Date:

Appendix 3 Additional resources to support implementation:

Additional materials may be identified in the training and piloting phases and can be placed on the SDCSC website.