Chapter 4 Residential Child Care in the Republic Ireland

The usage of residential child care in the Republic of Ireland has declined steadily since the 1970s. At the time of the Kennedy Report in 1970 there were approximately 2,200 children in residential care in the Republic of Ireland (O'Sullivan & Breen, 2008:31; O'Sullivan, 2009) compared to 388, representing 7.3% of the total number of children in residential care in 2007 (HSE, Analysis of Child Care Dataset, 2007:7). In 2011 this figure was 7.2% (HSE Review of Adequacy Report, 2011).

This decrease shows no sign of abating with recent data showing a further projected decline to 5% or less for residential child care. This is clearly stated in Section 8.3.4, Placement Type for Children in Care, of the Review of Adequacy of HSE Children and Family Services, 2010, published in April 2012:

"*Performance indicators in the HSE National Service Plan 2010 included targets that at least 61% of children in care would be placed in general foster care, 28% in relative foster care, and no more than 7% in residential care. These targets were met in 2010 for foster care and relative care, with 60.6% (n=3,612/5,965) of placements in Foster Care General and a further 29.2% (n=1,742) of children in Relative Foster Care (figure 12). Around 7.4% (n=440) of placements were in residential care, a rise from 6.8% (n=383) in December 2009. The HSE Corporate long term plan is for children in residential care to be 5% or less: on a total care population of 5,965, this would*

equate to 298 i.e. 142 fewer children in residential care than in 2010."

Within the context of the above and with specific regard to the previously referenced Australian experience as set out by Ainsworth & Hanson the following table compiled by Eurochild (2010) and taken from Ainsworth's & Thoburn's (2014:16) paper bears the readers full attention:

Table 2. Percentage of children in care in residential placements by country.

Percentage	Country
0–10	Australia, Ireland
11–20	England, USA
21–30	Hungary, Scotland, Spain, Sweden
31–40	France, Romania
41–50	Denmark, Italy, Poland, Russian Federation
51–60	Germany, Lithuania, Ukraine
70–95+	Armenia, Czech Republic, Israel, Japan

It must be noted that the numbers in residential care in Northern Ireland, England and Scotland had also declined to below 10% in 2013. In Northern Ireland the figure was 8% (DHSSPNI, 2013) and in England and Scotland the figure was 9% (Department of

Education, 2013; Scottish Government, 2014). Germany, with a predominately social pedagogical approach to care and conservative welfare state regime (Esping-Adnderson, 1990) maintains its higher usage of residential care than foster care. In 2012 there were 60,451 children in foster care and 63,191 in residential care (Koch & Sievers, 2012). In Germany children in care have a legally defined right for 'upbringing and education' until the age of 21 (Stein, 2014).

It is timely that, in December 2013, the Irish Ombudsman for Children published a Meta-Analysis of Repetitive Root Cause Issues Regarding the Provision of Services for Children in Care. Within this report the issue of sufficient availability of residential care is identified as one of the seven repetitive root cause issues arising for children in care. The report states:

"Residential care should be considered as having the potential to offer an effective early intervention and support to and for some young children, young people and their families…These cases illustrate the inadequacies in the range of residential accommodation for children and young people in terms of their availability and suitability." (16-17)

Within the recommendation section of the Ombudsman's report the following preamble and recommendation is made:

"There is a pressing need to identify the place that residential child care should occupy in the range of services for children

in the care of the State, in order to open up its potential for a more creative and effective role in responding to the needs of children and young people."

and

"It is recommended that the Health Service Executive/Child and Family Agency urgently develops a strategic development plan for residential child care services which would shape the future direction of services, plan for the provision of sufficient services in locations throughout the country and ensure that the needs of children and young people are met" (p. 30-31).

However, just as with the Stockholm Declaration there are already different interpretations of this Meta-Analysis. There are those who have chosen to interpret this report as an indictment of our residential child care services. They apparently conceive of residential child care services as an individual and autonomous segment of the system of care services rather than acknowledging the macro picture, as intended by the authors, which indicts the HSE for the residualisation of residential child care services. In the UK similar misinterpretation was identified as a finding of a House of Commons Education Committee Review of Residential Care Report 2014 which found that:

"*One of the messages from the evidence we received was the importance of looking at residential care within the overall*

context of provision for looked after children, and not as a discrete entity." (House of Commons, 2014)

The reality is that residential care, whether within the private, statutory or voluntary sectors, is delivered within parameters, including both quality and quantity, determined by Tusla management with compliance from providers ensured by funding mechanisms, contracts and Service Level Agreements. Additionally, The Health Information and Quality Authority (HIQA) and Tusla Registration & Inspection and Monitoring Service, play a powerful role in shaping practices within residential care via inspection and monitoring regimes. Clearly, critiques of residential care require encompassing these agencies for their role in determining how the service is delivered and configured. No residential child care centre can operate without licence from HIQA/Registration & Inspection and Monitoring Services and placements therein being sanctioned, ideally, via Service Level Agreements from Tusla.

Yet neither the Ombudsman's Report nor this research can claim to be the first to highlight such residualisation of children's residential child care. As far back as 1970 the Association of Resident Managers of Reformatories and Industrial Schools issued the following response to the Kennedy Report which prompts reflection as to why we are still questioning this same issue in 2014:

"Substitute Care 4.8

Residential care should be regarded in itself as a particular service. For children who require this service residential care is essential in many areas, and is often superior to broken family life, it should not be regarded as a last resort. However, the Association stresses that it should be resorted to when nothing more can be done for the family at home." (Cited in O'Sullivan, 2009:Appendix 2)

The same report makes the following point in regard to aftercare and once again induces reflection as to what progress has been made in the intervening 45 years given that still today we have young people leaving care poorly prepared and without adequate support (Carr, 2014):

"Aftercare 8.6

Aftercare is in dire need of attention. The lack of proper aftercare is perhaps responsible for the many failures in our system to-date. This matter deserves strong government financial support" (Cited in O'Sullivan, 2009:Appendix 2).

Current residential care services are being denigrated by many without being given the opportunity to function as they optimally can. Children whose needs can only be met within specialist placements requiring enhanced levels of support compared to children whose needs can be met within mainstream residential care services are mixed together within these centres thus weakening the efficacy of these centres. By operating as a

placement of last resort it is thereby ensured that few children within these services can actually optimally benefit from such placements. In this regard the efficacy of these centres is compromised.

Special Care, High Support and Secure Care

This situation where children with different levels of need are being placed in the same centres has been exacerbated with the closure in 2014 of the last of the former 13 High Support Units and the elimination of this High Support Service. In 2005 the High Support Service provided 93 specialist beds nationally (O'Sullivan, 2009, Point 4.3). The final two High Support Units, Rath na nÓg was closed in 2013 and Crannóg Nua closed in May 2014 (Dáil Debates, 2013, Written Answers, 47701/13). This has been compounded by the fact that there are only three Special Care Units currently operating with all three under ongoing critique from HIQA, the media (Irish Independent, 2014) and children's representative organisations (EPIC, 2011c, 2012a).

The HSE define Special Care and High Support as:

"Special care refers to a type of care that is provided to children and young people who are in need of special care or protection by the HSE and would usually be placed in a 'special care unit' (SCU). These units are purpose built secure locked facilities, managed by HSE Children and Families Services (there is one in Dublin, one in Limerick and one in Cork). This means

that children/young people placed in a special care unit by order of the High Court cannot leave of their own accord."

and

"High support units offer a residential service to children and young people who are in need of specialised targeted intervention: they are 'open' in that the young person is not detained. High support units aim to assist young people in developing internal controls of behaviour, to enhance self-esteem, facilitate personal abilities and strengths, and to build a capacity for constructive choice, resilience and responsibility. There are high supports units that are managed locally and two high support units that are managed nationally."

(HSE, 2012:58-59)

The published HIQA Inspection Reports for 2013 for these three Special Care Units, Coovagh House in County Limerick; Ballydowd in County Dublin; and Gleann Álainn in County Cork, highlighted ongoing issues of either partially met standards of practice or previously recommendations or, in some instances, practices that failed to meet the required standards. A summary of the findings highlighting the number of residents within each unit and the standards either partially met or failed within these reports (HIQA, 2013a) is as follows:

Table 3 Summary of HIQU findings for Special Care Units

Special Care Unit	Year	Residents	Partially Met Standard	Failed to Meet Standard
Ballydowd, Dublin	2013	8	7	2
Ballydowd, Dublin	2012	9	10	1
Ballydowd, Dublin	2011	9	12	2
Ballydowd, Dublin	2010	4	18	15
Ballydowd, Dublin	2009	12	20	14
Coovagh House, Cork	2013	3	10	-
Coovagh House, Cork	2012	2	9	-
Coovagh House, Cork	2011	Closed 7/2011-6/2012	Closed 7/2011-6/2012	Closed 7/2011-6/2012
Coovagh House, Cork	2010	2	18	2
Coovagh House, Cork	2009	2	15	-
Gleann Álainn, Limerick	2013	4	8	-
Gleann Álainn, Limerick	2012	5	11	1
Gleann Álainn, Limerick	2011	7	*	3
Gleann Álainn, Limerick	2010	6	16	-
Gleann Álainn, Limerick	2009	3	17	-

* Unclear from report exact number of partially met practice standards due to non-standardisation of Inspection Reports and narrative format of this particular report.

The Children's Detention Schools located at Oberstown, Lusk, County Dublin comprising Trinity House School and Oberstown Girls and Boys Centres achieved the following inspection findings (HIQA, 2013b):

Table 4 Summary of HIQA findings for Detention Schools

Oberstown Campus	Year	Residents	Partially Met	Failed to Meet
Oberstown Campus	2013	36	7	1
Oberstown Campus	2012	-	5	-
Oberstown Campus	2011*	41	21	

* *"Of the standards reviewed in the course of this inspection there were no practices that fully met the required standard."* (HIQA, 2011:8)

Coupled with the closure of High Support Units (HSUs) the fact that the newly commissioned detention centre at Oberstown in Lusk, County Dublin with extra capacity for Special Care will not come fully on-stream until late 2015, this cumulatively means

that, other than for the 17 beds occupied in Special Care, there are only mainstream residential care centres attempting to cater for the welfare needs of some of the State's most traumatised children with highly-complex needs. This places these centres under serious operational pressure, if not in some case, crisis.

"EPIC is also concerned about the impact of the closure of high support units for children with high levels needs who do not need placement in special care. These children's needs cannot be adequately met in mainstream residential services." (EPIC, 2014)

The concern voiced by EPIC of unsuitability of placement in terms of meeting the needs of the young person is not without precedence. Kelleher *et al*. (2000) found that 25% of all young people within their study were considered to have been inappropriately placed (Doyle *et al*., 2012) whilst in 2011 a HSE commissioned review identified that 252 young people were unsuitably placed nationally. This review of 600 placements found that 65% were fully suitable, 24% were partially suitable and 9% were unsuitable (Irish Times, 2014b).

The cost of running these Special Care Units and HSUs has been the subject of scrutiny for some time. Operational costs for the Special Care Units in 2012 were identified by identified in the Irish Examiner (2013) as:

Table 5 Cost of Special Care Units

Ballydowd	€5.4 million	€11,538 per-child per-week
Coovagh House	€2 million	€19,230 per-child per-week
Gleann Álainn	€2.4 million	€9,230 per-child per-week

The two remaining HSUs in 2013, Crannóg Nua and Rath na nÓg, had a cost in 2012 of:

Table 6 Cost of High Support Units

Crannóg Nua	€3.9 million caring for 6 children	€12,500 per-child per-week
Rath na nÓg	€3 million caring for 4 children	€14,423 per-child per-week

However, the above referenced costs identified for the High Support and Special Care Units is not a complete cost and therefore not a truly accurate cost per centre. The educational components within these centres operate under the Department of Education and Skills with associated costs, including salaries, funded by this Department as opposed to the Department of Health and Children. Thus the real cost-per-centre and cost-per-placement is actually considerably higher than all the above-

cited figures. It is notable that the Department of Education and Skills website references High Support as a secure environment.

*"**High Support and Special Care Units** provide residential care for children legally termed "out of control". This term refers to children who are at risk and in need of care and protection and who require the provision and delivery of an education service in a secure and therapeutic environment. The age profile of these children is 12-17 years… The Department of Education and Skills has responsibility to provide education services for these young people, and to ensure that it is adequate and meets their needs, and does so in the 'High Support Special Schools' which are an integral part of the High Support and Special Care Units."* (Department of Education and Skills, 2014)

Private Provision in The Republic of Ireland

Six percent of children in care in the Republic of Ireland are placed in private provision.

"On the 31st August 2014; 413 (6%/6,489) of children in care were in a private care placement. Of the children in a private placement 60.0% (248/413) were in foster care general; 36.8% (152/413) residential general; 1.7% (7/413 other care placement

and 1.5% (6/413) in a residential out of state secure placement." (Tusla, 2014d:5)

Private Provision of Residential Child Care

During this period, 2006-2014, the utilisation of private companies to provide children's residential services has increased significantly. Such provision is subject to the budgetary-defined levels of usage, with short-term placements and ongoing placement reviews by HSE/Tusla. The identified cost of placement within the private sector now averages between €4,500-€5,000 per-child per-week (Dáil Debates, 2014, Written Answers, 5126/14; Irish Times, 2014a).

These costs have been significantly reduced from what they were pre-2011 when prices were 'capped' by the HSE at €5,000 per-child per-week. "*In early 2012 Children and Family Services undertook a tendering campaign to secure eighty places at a cost of €18.7m per annum or €4,500 per place purchased for a 2-year period (extendible for a further two years if required). This process is now complete and currently being awarded for 2014. It is estimated that the procurement arrangements utilised will reduce the spend in this area by €3.9m in 2014*" (Joint Committee on Health and Children, 2013, Question 4).

There are clear implications for significant cost savings by utilising the private sector to cater for those children formerly in HSUs. The lack of available data on children in care and more

particularly accurate budgetary data for children's residential services makes accurate financial comparisons problematic (Darmody *et al.*, 2013). Indeed, all evaluation of children's residential services is problematic due to the lack of available data and the poor quality in terms of compatible formatting and inaccuracies contained within what data is available (O'Sullivan & Breen, 2008; Burns & MacCarthy, 2012). However, in 2006 John Smith, on behalf of the HSE, responded to questions posed by Judge Conal Gibbons regarding children's services in the Republic of Ireland. Within this response the annual expenditure on High Support in 2003 was listed by Mr Smith as €25,421,000 for 66 recipients with an annual cost per recipient of €385,178. This yields a weekly cost per-child of €7,407 (Gibbons, 2007:7). However, the only recent data we have is for the last two remaining HSUs in 2013 Crannóg Nua and Rath na nÓg. If we aggregate the cost of placement between Crannóg Nua (€12,500) and Rath na nÓg (€14,423) we obtain an average cost per-child per-week of €13,461 or €699,972 per annum (not including Department of Education costs). The difference between the published weekly cost of placement in 2003, €7,407 per week, and 2012, €13,461 per week, is very marked. Although some of this may be accounted for in terms of different structure and operations within Crannóg Nua and Rath na nÓg, as these were purpose built as HSUs, this disparity would tend to indicate that the running costs for the years preceding 2012 were, pro rata, significantly higher than the figure cited for 2003 of €7,407 per week.

We have an approximate figure for private provision in 2013 of €50m for the 65 private centres which may include children placed out-of-state (Joint Committee on Health and Children, 2013, Question 4). Minister Flanagan most recently identified expenditure in 2012 as €49,323 million and in 2013 as €48.972 million (Dáil Debates, 2014, Written Answers, 27288/14). If we accept the figure put forward by both Tusla and the Minister for Children of €5,000 per-week as the average cost of private placement we now can calculate a figure for the annual expenditure on private provision of children's residential services in 2014 based on 137 identified placements of €35,620,000 (Tusla, 2014). However, this would appear to be significantly at variance with the identified costs for 2012 when there were 142 children in private placements and 2013 when there were 127 children in private placements. In fact, the figures for 2012 and 2013 do not tally with the declared criteria of costings of an average of €5,000 per week. What is clear, however, is that the young people formerly placed in the 93 placements originally available in HSUs, in the cases of the last two remaining HSUs at an average cost of €13,461 per week, may now be placed in the private sector at an identified average cost of circa €5,000 per week.

In the absence of any other residential services other than the identified 17 beds in Special Care and the 36 justice beds in the Oberstown Campus it would appear that, in fact, there is nowhere else other than the children's residential centres and out-of-

state placements that these children can currently be accommodated. The ecology of residential care placements has been condensed. It is notable that in June 2014 usage of private residential provision increased by 34% from that in June 2013 (Tusla, 2014c).

It is worthwhile to consider the cost of private residential services in other jurisdictions such as England, where there is a longer history of usage of private providers for children's residential services, in order to give context to the service in the Republic of Ireland. In England, where in 2011 of 1,810 children's homes registered with OFSTED, 439 were local authority run and 1,317 were in the private or voluntary sector (Department of Education, 2012), the cost of weekly placement can range from €3,000-€11,500 per week depending on level of need (Stanley & Rome, 2013). Curtis (2012) calculated the average cost in England in 2012 as €4,717 per week. It is also noteworthy that the cost of operations in England and the Republic of Ireland are different, most notably owing to qualification requirements for employment within this sector. The qualification requirements in England being lower and therefore attracting a lower salary than is the case in the Republic of Ireland. In the Republic of Ireland the requirement is for an ordinary degree in Applied Social Studies, or acceptable equivalent, as a minimum requirement whilst in England the minimum requirements are less well defined

with, in fact, no clear requirement (College of Social Work, 2012).

Regardless of the efficacy of the service by the very act of identifying the need for 93 beds in HSUs in 2005 there was implicit recognition that a robust system of care required this level of service to function effectively and optimally. Children placed therein were assessed to have a level of need identified as high and therefore likely to attract a cost towards the higher end of the pricing spectrum within the English system. This poses many questions including whether the needs of this cohort of children can be appropriately met for €5,000 per week in the Republic of Ireland (EPIC, 2014) and also what provision is to be put in place to care for these children during the period between the closure of all HSUs and the opening of Special Care beds at the Oberstown campus? Also, the question of whether centres that are registered as children's residential centres are suitable structures to care for these children with higher-levels of need are valid? These centres have achieved compliance for registration with the standards of suitability for caring for children in mainstream residential care, this being the case for the majority if not all private residential centres, but are they suitable structures to care for these children with higher-levels of need?

This is a pertinent question given that part of the rationale for closing the nine HSUs between 2005 and 2013, where only the

purpose built centres of Crannóg Nua and Rath na nÓg remained, was that these centres had been adapted from buildings that had often formerly been residential children’s centres and that these buildings were therefore not-fit-for purpose as HSUs. HSUs were not solely about having higher staff-to-child ratios, there were a range of other criteria such as on-site educational facilities, access to therapeutic services, recreation and leisure facilities and building structure and design, which these centres provided that rendered them eligible to be registered as HSUs. Whilst the private centres may be able to put in place higher staff-to-client ratios they may not be able to replicate these other criteria formerly provided within the HSUs.

It is noteworthy and deeply worrying within the context of structure and design of children’s residential centres that the 2012 HIQA Overview of Findings of Inspection Activity in Children’s Residential Services within the statutory sector found:

“*Over 27% of centres did not meet the fire safety Standard while over 42% met the Standard in part (Figure 10). This was of concern to inspectors…Other deficits which required action were identified. Some premises were identified as being unsuitable for use as a residential centre and not all were in a good state of repair. There was a lack communal space for visitors and not all services had created a homely atmosphere. There were also gaps*

in safety statements. A robust process of risk assessments was required in order to provide a safe and suitable environment." (HIQA, 2013:17)

The question arises as to how and why these centres are allowed to continue to care for vulnerable children and young people when they are not compliant with fire and safety standards? It also calls into question the high-profile media attention with regard to non-compliant fire safety procedures within the last two remaining High Support Units, Rath na nÓg and Crannóg Nua, which were closed following the publication of HIQA Inspections Reports, ID:577 and ID:655 respectively (RTE, 2013; Irish Examiner, 2014b; Irish Independent, 2014)?

The usage of private companies to deliver residential child care services is currently a contentious arena with divided opinion as to the merits and flaws of such provision. However, the paucity of research in this area renders factual assessment problematic.

"There have been some assessments about the differences in public versus at least nonprofit service delivery but very little empirical proof has been offered . . . In sum, there is no definitive answer as to which sector, public, non-profit or for-profit, provides better or "best" social services. . . There is a paucity of research examining whether welfare clients fare better in public, non-profit or for profit-agencies." (Riccucci & Meyers, 2008:1443,1445,1451)

One commonly voiced criticism is that for these companies profit is the primary motive and that this is incompatible with paramountcy of the child principle. The implied assumption being that the mandate to make profit will take precedence over the needs of the children and will influence decision making within these companies. This was an argument put forward by Rees (2010). However, within this study Rees makes some questionable assertions regarding private companies whilst also making some insightful points. Amongst the former is the assertion that:

"State financing of alternative care services for children in the independent sector raises, of course, a number of very real ethical issues. In subcontracting out the care of children the corporate parent has taken on a more distant role and is arguably less able to safeguard the well being and rights of the children." (2010:327)

This is a questionable assertion when we consider the proven poor track record of the state in caring for children in residential care settings. The fact is that the abuse that occurred within statutory and voluntary sector children's residential care services in the 20th century was, thankfully, not recorded within several recent studies in the UK as identified by Biehal *et al*. (2014:123). Here, it must be acknowledged that the private sector has become the largest provider of residential child care in both the UK and the Republic of Ireland in the 21st century. Therefore, whilst there have also been other factors, as previously

identified, that contributed to this very promising finding by Biehal *et al.*, (*ibid*) it is possible to 'argue' that the evidence suggests that the private sector is, at a minimum, as safe as the other sectors, if not, safer. Rees would seem to be implying that these children would be less 'safe' or well cared for in the independent sector than if the state were caring for them when clearly the evidence does not support such a claim.

Rees does make some interesting points including that he acknowledges that the independent sector is not a homogeneous sector. He identifies that some of the not-for-profit companies operate similarly to the for profit companies:

"*Interestingly though, Le Grand (2007) argues that even independent not-for-profit organizations do actually make profits but choose to describe them as "surpluses."* (Rees, 2010:322)

Consequently, the lack of clarity and objectivity with regard to the usage of independent companies to care for children prompts several questions:

1) What evidence is there that the quality of care is diminished within private provision?
2) Given that outcomes for care leavers from residential care have been identified as poor prior to private providers entering the sector is it reasonable to blame private providers for currently contested poor outcomes? Or, are private providers being held accountable for an entire sector, residential child

care, without being afforded the agency to remedy the sector? The real responsibility for the sector rests with those within the statutory sector who monitor, commission, evaluate and develop policy relating to and determining the usage of residential child care as well as the political system as we shall see further along.

3) Are all private companies operating under the same principles and with the same values? Or, are small and large companies being conflated as one group with the high-profile flaws of one segment, the large sometimes multi-national companies with shareholders including private equity, being associated with the smaller operators? These large companies may have a defined mandate and requirement to pursue profit on behalf of the shareholders that smaller companies with only owner shareholding do not necessarily have.

Then there is the moral argument that "*it is wrong to make a profit out of children*" (Sharpe, 2008:46). Whilst a difficult argument to morally, or indeed intellectually, reconcile there are several question that must be posed:

1) If the private sector can provide better-quality care and produce better outcomes for specific cohorts of children than the

statutory or voluntary sectors and, in this process make a profit, is this not beneficial to children in care?

2) Are we intellectualising our moral dilemmas, most often from positions within academia, the statutory or voluntary sectors, and assuaging our feelings or soothing our consciences (or perhaps professional pride) by expressing our moral distaste at the expense, in terms of placement options, of the very children at the centre of the controversy?

3) Have children in care been consulted to illicit their opinion on this issue and thereby empower them with the agency we claim to afford them whilst also, in this process, making service providers accountable to those using the service?

2.35% of the 6489 children in care on 31st August 2014 were in private residential placement in the Republic of Ireland (Tusla, 2014d).

Private Provision of Fostering

Private fostering has developed over the same timeframe with the development of various forms of foster care since 2005. These include: enhanced fostering, short-term foster and emergency fostering now providing a National Out-of-Hours service, to name but a few. Recently it has emerged that since 1995 at any given time up to 50 European children can be placed in Irish fostering

placements by European agencies. One such recent case involved a European teenager who went missing for 48 hours without being reported missing from a foster family that had not been Garda vetted (Irish Independent, 2013).

In 2012 the HSE paid €19.1 million to four private fostering companies for the care of 347 children which equates to a weekly cost of €1,052 (Irish Examiner, 2013b). Similarly to private residential child care the cost of placement was reduced in 2011 to the lower cost of €1,000 per-child per week (Dáil Debates, Written Answer, 40720/12). However, as with much of the data regarding children in care emanating from the HSE the quantity and quality of data on children in private foster care is poor. Minister Fitzgerald in July 2012 within Written Answer 33324/12 to Dáil Debates gave the following information:

"The HSE has advised me that 249 children were placed in private foster care at a cost of €6,727,698 in 2009, 304 children were placed in private foster care at a cost of €9,581,360 in 2010 and 360 children were placed in private foster care at a cost of €12,893,243 in 2011. The information requested for 2007 and 2006 is not available at this time.

While the HSE was unable to provide details of precise costings to date in 2012, it has advised me that there are currently 251 children in private foster care at a weekly cost of €342,265…The HSE generally utilise private foster care companies where

children have a higher level of need including stepping down from high support placements."

According to the data offered to the Dáil by Minister Fitzgerald the cost of placement per week over the period 2009-2012 was as follows:

2009: €519; 2010: €606; 2011: €688; 2012: €1,363.

This is curious as costs were indeed reduced in 2011/12 to on average €1,000 per week having been €1,200 and €1,350 per week for the two largest private fostering organisations prior to this reduction. Minister Fitzgerald herself made this very point in Written Answer 40720/12 of 26/11/2012 wherein she stated:

"I am advised by the HSE that placement charges have been reduced significantly as a result of a review of services and costs of both residential and foster care provided by the private sector."

3.85% of the 6489 children in care were in private foster placement on 31st August 2014 in the Republic of Ireland (Tusla, 2014d).

Out-of-State Care

The cost of placement out-of-state in St. Andrew's in Northampton, one of the most frequently used out-of-state placements with six children placed there in 2012, is €10,000-€12,000 per week (Dáil Debates, Written Answers, 25805/13; 56768/12). Between January – July 2014 there were nine children

placed in Northampton (Dáil Debates, Written Answers, 36473/14). In 2011 four adult patients died at the charity-managed St. Andrew's facility within a seven-month period. All were on the same ward and allegedly whilst on anti-psychotic medication with calls for an independent inquiry (Guardian, 2013).

Children placed in care in other jurisdictions become subject to the laws of those jurisdictions which can have serious implications for the consequences of their actions as opposed to the consequences for similar actions within the Irish justice and care systems.

Length of placement is another serious factor with out-of-state placements. Placements in a foreign country away from family and community for lengthy periods of time can have significant impact of the cultural, psychological and psychosocial development of an adolescent. This makes reintegration into Irish society a difficult process. Such prolonged placements within specialist settings can be seen to have the potential to institutionalise the child. In 2014 a child was returned to the Republic of Ireland following four years in a 'non-secure detention' placement in Boys Town the USA. He experienced serious problems within six months of his return and required a secure placement. However, no secure place had been found after five court hearings. Another child was identified in the same report as being forced to remain in a psychiatric secure detention unit in another jurisdiction as there was no services available to meet his needs in the Republic of Ireland. He had been in this out-of-state placement

for three years at the time of this report (Child Care Law Reporting Project, 2015).

There is also the issue of aftercare for these children on their return to the Republic of Ireland. Without adequate preparation for leaving care continuing robust aftercare support is all the more essential to afford these young people the opportunity to leave care successfully. However, it must be borne in mind that these facilities utilised for out of-state placements are a mixture of general residential placements, secure and private residential placements as well as foster placements. Preparation for leaving care is not the primary remit of these centres let alone to leave care in a foreign jurisdiction, the Republic of Ireland.

Without adequate preparation for leaving care and ongoing appropriately resourced aftercare for this extremely vulnerable group of young people there is the potential for a vista whereby we export one 'human problem' only to import another with these young people entering the homeless services in the Republic of Ireland upon turning 18.

Unaccompanied Minors

"Internationally, research suggests that separated young people are a vulnerable group, with many suffering psychological and emotional problems (Sourander, 1998; Bean et al., 2007). In Ireland, the available literature also points to this

vulnerability (Abunimah & Blower, 2010; Rea, 2001)." (Ní Raghallaigh, 2013:5)

Prior to 2010 unaccompanied minors, children aged under 18, were accommodated in hostels. This was widely criticised (Commissioner for Human Rights, 2008; Corbett, 2008; Charles, 2009; Irish Refuge Council *et al.*, 2011) as exposing these vulnerable children to harm. Poor supervision and models of care with untrained childcare staff, sometimes with only security staff on duty, caring for large numbers of minors, were identified as amongst numerous serious deficiencies. Many children 'went missing' from these placements. Between 2000-2008 463 were reported as missing with only 53 subsequently identified as traced (ESRI, 2009:xiv). The inherent tension between welfare policy and immigration policy has also been identified as salient to this area as also has been the issue of the absence of statutory age assessments to determine eligibility for entry into care and appropriate placement once admitted (Horgan, 2011).
Subsequent to 2010 unaccompanied minors aged twelve and over are generally placed initially in short-term residential care and thereafter in foster care or supported lodgings placements. This is an interesting reversal of the situation where residential care is used as a placement of last resort for children in care in the Republic of Ireland (Ní Raghallaigh, 2013).
A 2014 ESRI report, which updated the above-cited 2009 ESRI report, found that although there has been a marked improvement

in this sector underpinned by the move away from hostel provision, key challenges still remain. These include:

- There is no targeted national strategy for unaccompanied minors. National oversight of care provision to this group is limited and variations in care are in evidence:
    - Several different sections of the *Child Care Act 1991* are used to take unaccompanied minors into TUSLA care. The decision on which section to apply is taken locally and may impact on the minor's legal guardianship.
- Key data and information gaps persist, for example, in the total number of unaccompanied minors in care in the State, although progress towards national-level data is underway.
- Social workers reported practical difficulties arising from the lack of a clear immigration status for many unaccompanied minors, including difficulties accessing a Personal Public Service Number or travelling outside the State, for example on a school trip.
- Some ambiguity exists as to who has the statutory responsibility for determining the age of unaccompanied minors, although a high level of cooperation on age assessment is reported by the agencies involved.
- The experience of unaccompanied minors reaching 18 years of age varies; those who have made an asylum application may

enter the direct provision system. Regional disparities exist in aftercare provision, which depends on local resources and practices.

Unaccompanied minors are first and foremost children and consequently are impacted by the same issues negatively affecting all children in today's society. Additionally, they must deal with those issues known to negatively impact children in care (Dixon, 2008). However, for unaccompanied minors, these issues are magnified and multiplied as they live in a country not of their birth and therefore with major cultural and social challenges to overcome. Then, on turning 18 they may enter Direct Provision services and face a range of specific difficulties (Frazer & Devlin, 2011) including uncertainty regarding aftercare support (Ní Raghallaigh, 2013).

With regard to Direct Provision it must be acknowledged that the situation of children growing up in such an environment is unacceptable. Over one third of residents in Direct Provision are children. The impact on a child's development of growing up in a hostel where they cannot witness their parents acting as role models and working, or in many case centres even cooking, is appalling to contemplate. These centres are often unhygienic and children must share communal bathrooms with other adult residents. Children are exposed to a range of risk, on an ongoing basis, that other children in the Republic of Ireland rarely encounter (Holohan, 2011; Arnold, 2012). In 2015 an Oireachtas

Report found that Direct Provision service was not fit for purpose by causing unnecessary complications and delay in processing asylum applications in a system that was designed and resourced to be a short-term solution. The average length of stay in Direct Provision is five years with one in five residents there for seven years or more and the longest being there for eleven years (Joint Committee on Public Services Oversight and Commissions, 2015).

Supported Lodgings

The fact that in 2012 136 children were placed in 'other placements' which include supported lodgings (HSE, 2012), despite there being limited data accessible regarding supported lodgings placements, warrants attention. This number reduced to 108 in 2013 but rose again to 124 in January 2014.

The HSE 2011 Review of Adequacy for Children and Family Services offers the following information regarding supported lodgings, notably one of the few accessible HSE or Tusla reports to do so, and identifies that there were 147 such providers of supported lodgings in 2011:

9.3.2 Supported Lodgings

Supported lodgings is the provision of accommodation, support and a family setting to young people who cannot live at home, but are not ready to live independently. Supported lodgings should only be considered for young people, aged 16 and above, who are deemed,

through a thorough assessment process capable of living independently without a full range of supports. Children under 16 are not to be accommodated in supported lodgings. (HSE, 2011:47)

The HSE 2010 Review of Adequacy for Children and Family Services identified the following findings from a National Audit of Supported Lodgings (2010) undertaken at the behest of HIQA:

"Some 140 service providers were identified, of whom 98% (n=137) were vetted, 90% (n=120) were assessed and 94% (n=132) were approved. A total of 125 children and young people were identified as being place in supported lodgings, 74% of whom had a care plan…Of 127 children in supported lodgings, four were under 12 years, five were aged 12-14, 23 were aged between 14-16… While most LHOs indicated that safety and quality was monitored by link workers and allocated social workers, only two stipulated that National Foster Care Standards and Regulations were applied." (HSE, 2010:65/66)

Just how and why four children aged under 12, five aged between 12-14 and 23 aged 14-16 were placed in a service catering for young people aged 16-18 is unclear.

Following this National Audit of Supported Lodgings in 2010 and the findings therein the HSE drafted a Policy on Supported Lodgings (2012) which was intended to address these deficiencies. The Office of The Ombudsman for Children made the following observation with regard to this policy:

"Of note some of the other documentation within the policy, namely the letter to GP's and guidance for persons providing a reference, refer to the age of 15 years, as does the FCC document. This creates potential for confusion and varied application of the policy." (OCO, 2012:14)

In September 2014 there were 35 children placed in supported lodgings (Tusla, 2014e).

Trends 1970-2014

O'Sullivan & Breen (2008) conducted a review of children in care from 1970-2006 with the under-cited figures, 2, 3 and 4 evidencing the trends over that timeframe. I propose to expand on this research to address the period 2006-2014 and to encompass trends within different formats of service provision within the private and statutory sectors. The data to inform the period 2006-2014 has been extrapolated from HSE Data Sets, Reviews of Adequacy for HSE Children and Family Services (Figures 4 and 12), Tusla Monthly National Performance Activity Reports, Dáil Debates Written Answers, DCYA website (2014).

Figure 2: illustrates the total number of children in care in the Republic of Ireland, 1970 and 2006. (O'Sullivan & Breen, 2008:29)

Figure 3: illustrates the number of children in foster care placements in the Republic of Ireland, 1970-2006. (O'Sullivan & Breen, 2008:32)

Figure 4: illustrates the number of children in residential care placements in the Republic of Ireland, 1970-2006. (O'Sullivan & Breen, 2008:31)

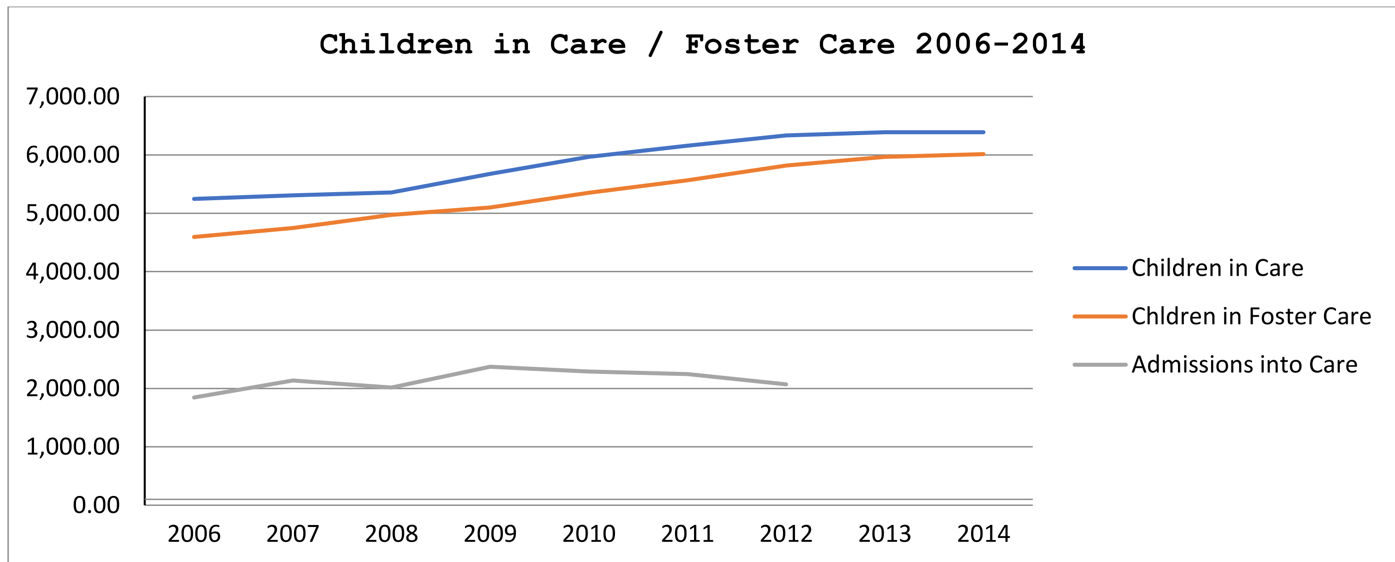

Figure 5: illustrates the number of children in care and admitted into care and the number of children in foster care, 2006-2014.

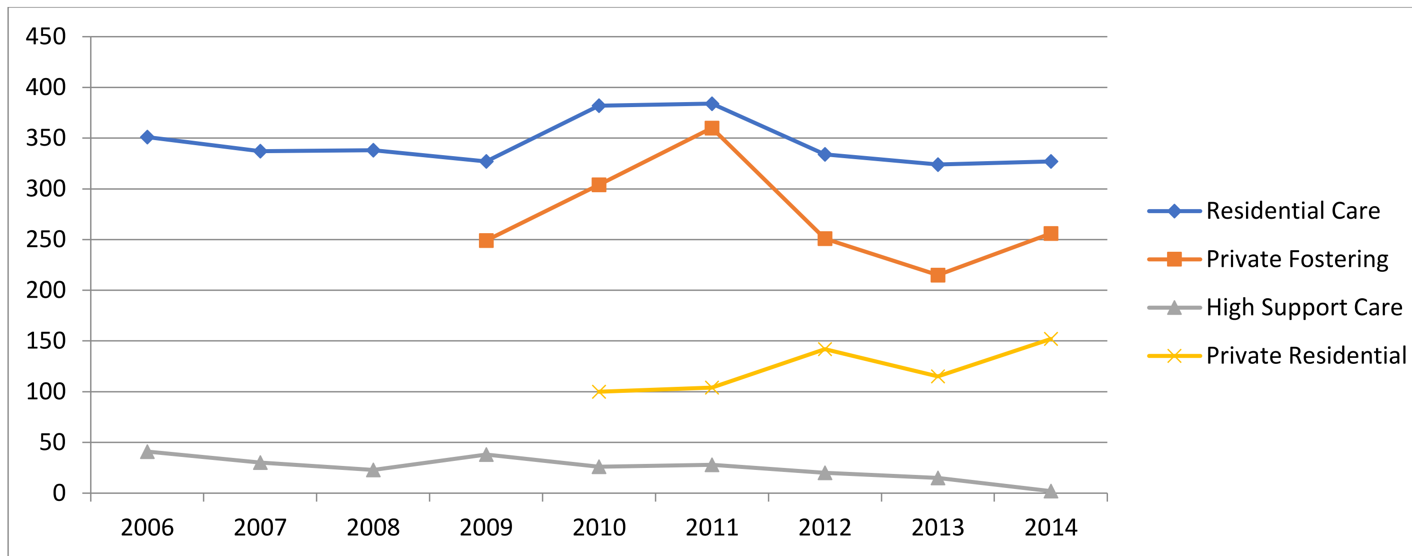

Figure 6: illustrates the number of children in residential care placements, private foster care placements, private residential care placements and High Support placements, 2006-2014.

Table 7: illustrates the data for the period 2006-2014 used to inform Figures 4 and 5 and includes data for children in Special Care placements and Out-of-State placements. There is no data available for private residential care prior to 2010 or private foster care prior to 2009.

	Children in Care	Foster Care	Residential Care	Private Fostering	High Support Care	Private Residential Care	Special Care	Out-of-State
2006	5247	4595	351		41		16	
2007	5307	4750	337		30		31	
2008	5357	4976	328		23		26	
2009	5674	5100	327	249	38		20	13
2010	5965	5354	382	304	26	100	32	22

2011	6160	5564	384	360	20	104	39	27
2012	6332	5821	334	251	19	142	26	25
2013	6389	5966	324	215	15	115	25	?
2014	6389	6014	327	256	3/0	152	17	21

Consideration of Trends

The fall in the number of admissions into care since 2009 whilst there has been an increase in child protection and welfare referrals during the same period is curious.

However, it must be acknowledged that the HSE Child and Family Services were subject to imperatives whereby '*more for less*' was the operational directive in force from 2009 onwards (Doyle *et al.*, 2012). Residential child care provision may be located within this context of more for less and the fact that the budget allocation does not reflect this increase in demand "*of around 91% since 2006 (n=40,187/21,040) and an increase in children in care over the same period of 20.7% (n=6,332/5,247) while the 0-17 population has also grown in the same period by 11.6% (n=1,160,200/1,039,500) and the number of births by 10.4% (n=72,225/65,425)*" (HSE, 2012:3) evidences the success in achieving this imperative of increased service provision with less resources.

One finding of such a consideration of trends is that there is a potential lowering of support, and cost, of service provision

made available to children in care over the same timeframe. Children formerly in HSUs may now be placed in private children's residential centres and many children formerly in children's residential centres may now be placed in fostering arrangements. This results in the reduction of the amount of higher-support services available within the system of care, in effect a reduction in strength of the care system.

Data on Children in Care

The lack of data on children in care has been the subject of repeated calls for improvement from numerous NGOs, academics, the UNCRC and national inquiries such as the Ryan Report (2009). Whilst under Tusla management there has been an improvement in data availability with monthly National Activity Performance Reports and monthly Management Data Activity Reports it is unacceptable that in 2015 we still do not have a figure for the number of young people leaving care each year. From a sociological perspective it can be informative to consider what is not being provided as opposed to what is being provided (Phoenix & Kelly, 2013). In this context making a figure available of how many care leavers are in receipt of an aftercare service but not how many are not in receipt of this service assumes obfuscatory dimensions.

It must also be noted that the level of inaccuracy within data compiled by the HSE is revealed with even a cursory examination of the data, which renders accurate comparative analysis

problematic. For example, one of many issues which arise when comparing Data Sets and Adequacy Reviews published by the HSE between 2006 and 2013 is evidenced by the inefficacy with regard to the calculation of simple mathematics within the Review of Adequacy for Children and Family Services 2008:27:

Table 8 Care Placements, 2006-2008

Type of Care	**2006**	**2007**	**2008**
Residential Care - General	351	337	328
Residential Care – Special Care	16	21	30
Residential Care – High Support	41	30	23
Foster Care – General	3,073	3,141	3,134
Foster Care – Relative	1,482	1,552	1,581
Foster Care - Special	40	31	27
Pre-Adoptive Placements	36	26	24
At Home under Care Order	44	41	38
Other	164	128	172
Total	**5,247**	**5,307**	**5,347**

The total for 2008 is miscalculated and given as 5,347 when it should be 5,357.

Situation in 2014

A recent Tusla Monthly Management Data Analysis Report (July, 2014) affords evidence of the current usage of residential care as of February 2014.

Total number of children in care:	6466
Number of children in Special Care:	17
Number of children in High Support:	3
Number of children in General Residential Care	339
Number in out-of-state secure residential care:	7
Number in out-of-state non-secure care:	15

Table 9: illustrates total number of children in care within July 2014 and the breakdown of placements within the residential care sector.

The July 2014, Tusla Monthly National Performance Activity Report, identifies the following on page 6:

Residential High Support

There were no children in care on the last day of July 2014 in a residential high support placement.

Residential General Care

5.0% (339) of all children in care (6,466) at the end of July (2014) were in a residential general placement. 163 (48%) are in a private placement. There has been an increase of 1 young person placed in a private residential centre in the last month, from 162 in June. This demonstrates an increase of 45 from 118 (36 of 327%) since June 2013 in the use of this placement type. The percentage breakdown of children in a residential general placement who are in a private placement in each region is: Dublin Mid Leinster 50% (61/121); Dublin North East 8% (38/97); South 55% (41/74); and the West 49% (23/47).

2% (7 of 339) of the children in residential care general placements at the end of July were in out of state placement.

Thus we can see that Tusla has succeeded in reducing the number of children in residential care to 5.9% of the care population with a total number in all residential centres, both in the Republic of Ireland and abroad, at 381. In terms of residential

general placement, in February 2014, they have achieved the distinction of having hit their identified corporate target of 5% which is all the more remarkable given that this has been achieved whilst numbers of children in care have increased by 20% over the same timeframe (HSE, 2011, 2012; Tusla, 2014, 2014b). In fact, over a two-year period 2011-2013 they reduced the usage of mainstream residential by 18% going from 384 in 2011 to 315 in 2013 (Tusla, 2014d). The usage of residential care when High Support and Special Care is included over the same period reduced by 18%, going from 443 to 364 placements. Notably, the Management Data Analysis Report also identifies that as of the end of February 2014 there were 505 children in care without an allocated social worker and 811 children without a written care plan with Dublin Mid Leinster reporting only 71% of children in care with a written care plan.

With regard to The Detention Schools the 36 beds are appropriately only utilised for justice cases where young people are either on committal by court order, on remand or on remand for the purpose of assessment. The classification of the new beds created at the Oberstown Campus as either justice beds or welfare beds will be critical to the development of a robust system of care for children given the closure of HSUs and the efficacy of current special care units (€19,230 plus per-child per-week in Coovagh House). There are eight special care beds anticipated for June

2015 on the redeveloped Crannóg Nua site (Dáil Debate, Written Answer, 27325/14).

The HSE has systematically enacted what it terms the 'rationalisation' of HSE/ Tusla operated residential children's centres which resulted in the closure of many such centres over the same time period (2005-2014). In 2005 there were 86 such centres (Smith cited in Gibbons, 2007) nationally. By 2011 this had reduced to 60 centres and by 2013 to 45 centres (Joint Committee on Health and Children, 2013, Question 4). Nationally in 2007 seven HSE children's residential centres closed (HSE, 2007) and in 2008 eleven HSE children's residential centres closed (HSE, 2008). There were 39 private-for-profit centres in operation in 2008 (HSE, 2008) with 65 private children's residential centres in operation in 2013. Cumulatively the elimination of the High Support Service and the 'rationalisation' of statutory residential centres have combined to reduce the capacity to provide a robust system of residential placements for children in the Republic of Ireland whilst we continue to place children in residential children's services outside of the state (EPIC, 2013).

In September 2014 there were 324 children placed in residential care general placement with 159 (49%) placed in private placement thus rendering the private sector the largest provider of residential general placements in the Republic of Ireland (Tusla, 2014e). In January 2015 there were 90 private centres providing

318 placements; 49 statutory centres providing 209 placements and 32 voluntary centres providing 168 placements.

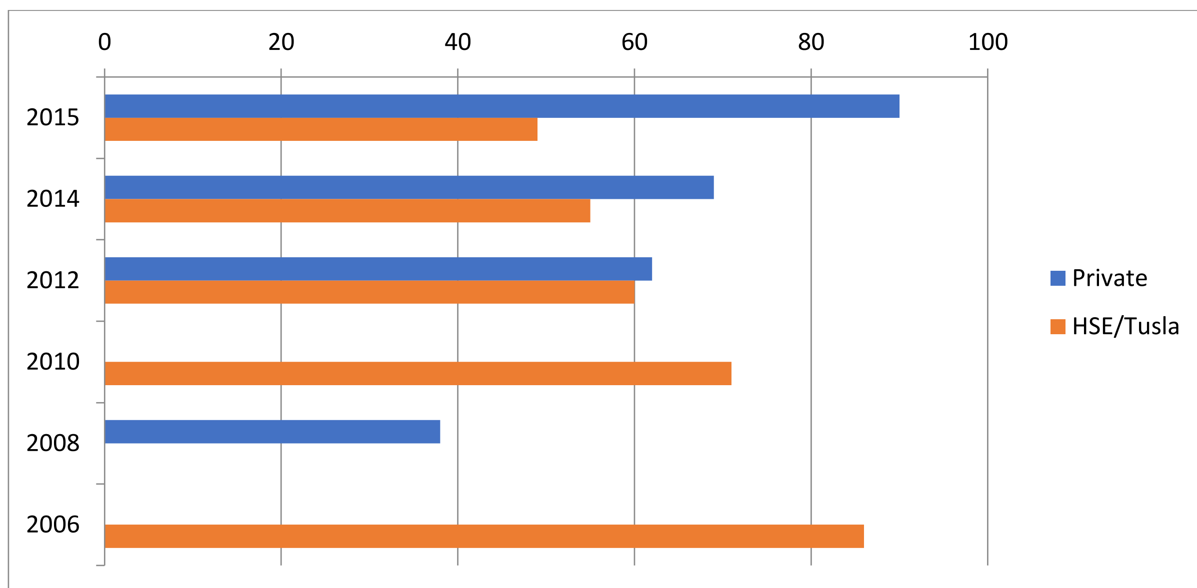

Figure 7: illustrates the number of private residential care centres and HSE/Tusla (statutory) centres over the period 2006-2015.

The issue of pensions with regard to staff is also relevant to trends within the private and statutory sectors. Here the systematic and phased withdrawal of the HSE and now Tusla from residential child care provision under the rubric of 'rationalisation of services' can also be located within the developing public pension crisis in the Republic of Ireland. A recent report published in 2014 highlights the €440 billion 'hidden' state liability for public servant pensions and the shortfall in the Social Insurance Fund which it identifies as a far greater problem for the state than the €192 billion public debt (Irish Times, 2014c). Tusla social care staff is eligible

for public pensions and within this context reducing the numbers of such staff can be located. Private providers' staff is not eligible for these public pensions. Additionally, a recent Labour Court ruling in a case that has been ongoing for some time regarding the issue of overnight allowances and the Working Time Act is also significant. The court found in favour of the union representing Tusla residential social care staff and ruled that the hours where staff sleepover during 24-hour shifts must be counted as working time. Currently these are not counted as working hours and an allowance is paid for each such sleepover. This will have major ramifications for Tusla who argued that to implement these changes will entail a projected cost of €60,000,000 (RTE, 2014). The court recommended that both parties engage in talks over the forthcoming nine months to resolve this issue. These two factors combined with our current neo-liberally defined political paradigms augur for continued, if not increased, levels of usage of private provision of children's residential child care in the Republic of Ireland.

As we have seen the HSE Child and Family Services were subject to imperatives whereby 'more for less' was the operational directive in force from 2009 onwards. In the UK similar demands of 'more for less' were identified by Evans *et al*., (2012) who poses the question: "*how can social care achieve the seemingly impossible task of doing more for less*" (2012:746). They propose that environmentally sustainable systems of social care offer a potential solution. As demonstrated, the HSE in fact achieved

this seemingly impossible mandate over this timeframe with more children in care but without a comparative increase in funding. The focus here, however, appears to have been exclusively on economic sustainability rather than environmental sustainability or indeed the sustainability of a congruent system of care. Notably, over the same timeframe there has been a moratorium on most recruitment for HSE social services posts which has resulted in a decrease in the numbers of employees within the HSE and an attendant increase in use of agency staff. This poses several dilemmas in terms of service delivery with consistency, safety and relationship continuity impaired by high usage of temporary agency staffing. This point was highlighted by HIQA with regard to a HSE run children's centre in Dublin as reported by the Irish Examiner (2014a):

"HIQA said that "staff sickness levels rose and culminated in the majority of the team being on leave" during the period of crisis. Agency staff were brought in and the "young people and external professionals informed the inspector that, given the unsettled atmosphere, the presence of unknown staff did not help the situation to improve."

The level of agency staff usage is recognised within the Policies and Procedures for Children's Residential Centres Dublin North East (2009) wherein policy 8.5: Policy on Agency Staff, states:

"This centre acknowledges that there are two levels of engagement of agency staff; engagement with those that work in the centre on an infrequent and intermittent basis and with those that are

engaged by the centre on a frequent and regular basis." (HSE, 2009:49)

There is also the question of the cost of service provision with regard to usage of agency staff where both recent EU Directive on Temporary Agency Work 2008/104/EC and pension costs are significant factors. The agencies in questions are private-for-profit companies and charge rates accordingly. In 2011 the two largest contracted agencies supplying social care workers to the HSE were TTM who charged an agency fee of 5.9% to the HSE West and CPL which charged an agency fee of 8% to HSE South, Dublin/Dublin North East and Dublin Mid-Leinster (Dáil Debates, Written Answer, 36228/11).

Given the previously identified efficacy levels of data gathering and assimilation within the HSE and the identified anomalies with regard to the true cost of High-Support and Special Care when, for example education costs are factored in, there is also the question as to the accuracy of the identified cost of service delivery within the statutory sector residential child care services. Here, akin to the public/private divide where the public and private sectors were pitted against each other (an issue we shall cover in more detail in section 6), this data on costings has been used as a frame of reference to determine value-for-money and acceptable costings within the private sector. The question as to whether the cost of agency staffing within statutory centres has been calculated within the identified costs of running these centres, as this cost certainly in 2011 and

before was not categorised as a fixed cost, requires clarification. The omission of this cost has the potential to produce an erroneous lower cost of service provision just as the omission of education costs produce a lower figure for High Support and Special Care Units. This, then, could potentially create myths regarding efficiency within the different sectors with serious implications when used to inform funding and costings within other sectors. Having worked within residential care services within the statutory, voluntary and private sectors it has been my experience that each sector has its strengths and limitations. A robust care system is only achievable with a robust system of care. This is best achieved utilising all three sectors and by focusing on developing services that maximise the strengths of each of these sectors. The system of care and children are best served by diversity which is achieved within a developed system of care affording a wide ecology of alternative care placements.

One such example is contained within the 2011 Analysis of Residential Child Care Centres and Places in Statutory, Voluntary and Private Sectors Used by the HSE. This was obtained under the Freedom of Information Act by the Irish Times and findings therein published on 22.4.2014. This analysis offers a cost-per-week for placement within HSE centres of €4,326 but, as referenced above, this figure may well be underestimated if agency costs are not included. The calculation of such costs would benefit from

external oversight by an independent expert party given its potential ramifications.

We now have the private sector providing 80 placements at €4,500 per week, all but price-matching the statutory cost identified in the 2011 analysis. However, what is missing from the 2011 Analysis and indeed much of the official discussion regarding the services provided by the different sectors is the level of need of children and young people being cared for. Simply put, within currently configured children's residential centres, there is a direct correlation between the level of need and the numbers of children capable of being cared for within the one centre, with higher needs dictating lower occupancy. Thus a centre with children with lower to mid-range levels of needs may be able to cater for five-six children whereas a centre with children and young people with higher levels of need may only be able to appropriately cater for two-three such children.

There are also staffing implications in caring for children with higher needs with live night staff often required and higher staff-to-child ratios thus inflating the cost of providing this service. An alternative analysis for the year 2011 where the operation cost-per-centre is compared rather than a per-placement cost would yield a different picture. Here the 60 HSE centres operating at a cost of €61.2 million yields a cost per centre of €1,020,000 per annum whereas the private sector with 56/62 centres operating at a cost of €47 million, as curiously but not uniquely in HSE data within this one document both figures are

identified, as the number of private centres in operation in 2011, yields a cost per centre of €839,285/€758064. Within this methodology the private sector would present as more efficient that the statutory and notably this was prior to the imposition of the pricing caps of €5,000 per week, followed by the €4,500 procurement price currently being implemented. Both of these factors would have the effect of exacerbating this private sector efficiency even further.

This example is not offered as an incontrovertible truth but rather to illustrate some of the flaw inherent in simplistic and one dimensional financial comparisons and thereby illustrate the fact that to compare sectors on price alone yields a flawed and biased picture of the market. This is a case in point of the previously cited issue of statistical integrity and reliability referenced by Disraeli's famous line "*lies, damned lies and statistics*" where figures can be manipulated speciously to strengthen a particular case to achieve a pre-identified goal.

With regard to the aforementioned efficiency initiatives there is always the implicit danger that the law of diminishing returns will result in diminishing or negative returns thereby rendering these efficiency initiatives mechanisms of false economy. In the case of social services such negative economies hold potential for the gravest of consequences. After six years of rolled-over '*more for less*' initiatives and change strategies, where each year more efficiency is demanded with less resources, there are inescapable consequences associated with risk as well as grave

quality implications. It is valid and indeed the professional responsibility of social care/work professionals to query whether this point of negative return has been reached in 2015, if not already having been reached prior to 2015?

As a senior manager overseeing a company operating several children's residential centres I came to recognise the necessity for built-in-redundancy with regard to staffing levels. Built-in redundancy, more staff than the minimum requirement to accomplish the required tasks with elements of duplication and overlap, has been identified by Morgan & Murgatroyd (1994) in their influential book 'Total Quality Management in the Public Sector' (TQM) as possessing strong similarity to the concept of 'non-value-adding activity'. Streeter (1992) identified that: "*In a perfect world, where everything is certain and predictable, there would be no need for redundancy…However, the real world is full of surprises. Human service organizations exist in an environment of uncertainly…Uncertainly is a normal part of organizational life. The greater the uncertainly the greater the potential for failure in organizational systems. Uncertainly is the reason that redundancies exist*" (1992:109). Streeter further identifies that the wholesale removal of these redundancies in the pursuit of efficiency is an inappropriate organising principle within social agencies. Additionally, Streeter identifies the propensity for the extra capacity, when available, to be harnessed for non-customer-related activity thus diluting its potential. A balance has to be struck between staffing costs and quality of service

and within a paradigm of 'more for less' this balance can easily be tilted in favour of cost containment.

I have learnt that to incur extra staffing costs in endeavouring to proactively avoiding potential crises was in fact cheaper in the long-term than dealing with crises after the event. Additionally, and crucially, this also provided a better quality of care. In my experience in residential child care, it is far easier, and in reality often less expensive, to maintain an equilibrium than to have to regain an equilibrium. Placement breakdown is financially expensive for both the organisation and to the system of care and invariably occurs in a reactive, crisis-led manner. It is also deleterious to the developmental trajectory of both staff and the young person (Ward, 2009; Jones *et al.*, 2011).

Avoiding placement breakdown maximises financial efficiency whilst also optimising the benefit of services to children and young people's development and wellbeing as well as promoting staff and service development (Dixon, et al., 2006; Hannon *et al.*, 2010). Administrators, financial departments, boards of management or business owners without practice experience may not readily perceive this as sustaining the placement may require unplanned, and therefore unbudgeted, expenditure targeted, preemptively, at averting the crisis. In fact, it may appear counter-intuitive if considered solely from a financial perspective. System reflexivity is critical in regard to accessing the resources that will be required at short notice and

systems that demand prolonged procedures with rigid financial control mechanisms to access such resources preclude such reflexivity. This is an area where a modest unplanned expenditure may result in a significant future cost saving and is one example within our care system where negative returns have been invoked by an overly-dominant focus on cost containment.

> By focusing more on doing what services are intended to do and doing this to the highest possible standard the cost element of the service is optimised. The key, of course, is to do this well which includes taking account of financial parameters, but in the correct balance. Whereas, by focusing more on cost containment both quality and cost efficiency may actually deteriorate.

With regard to the question posed in the previous chapter as to the move from institutions to community located settings there are several questions arising here. The location of children's homes in rural settings, sometimes isolated, can be seen to be a significant factor in the context of community integration. These locations may be more conducive to managing the children's risk behaviours but often, and for the same reasons, they minimise potential for community interaction and integration. There may be few close neighbours or community resources within the locality. It may be that in meeting the needs of a specific cohort of children such locations are validated due to the reduced levels of negative peer influence or access to alcohol or other negative

stimuli in the immediate locality. However, in terms of medium to long-term placements their suitability requires ongoing review. The link between resilience development and community protective factors including neighbourhood networks and appropriate role models is well established (Daniel & Wassell, 2002; Zolkoski & Bullock, 2012). As far back as 1992 Gambrill & Paquin identified the benefits of positive relations with neighbours for children in care whilst also identifying this as a neglected area of practice. It would appear to have remained underdeveloped subsequently.

"Community support through collective networks can act as a collective agency and socialisation (Fegan & Bowes, 2004) ….In its absence, social isolation from community has been shown to be a critical feature in maltreatment and a host of negatively related youth conditions (Belsky, 1997)." (Brennan, 2008:58)

Additionally, those children's centres located in urban settings may strive for anonymity within the community as their goal rather than meaningful integration within the community. This is understandable in the context of minimising potential stigmatisation of the children where staff and management may err on the side of protecting the children from stigmatisation by not fully engaging with local resources to protect the identity of the children. There is also the practical task of dealing with the resistance from residents and homeowners in the community that can be a factor when establishing children's residential centres. Of the children's residential centres I have been

involved in establishing (n=11), seven received community acceptance whilst four experienced strong resistance. Where there has been resistance this can be difficult to resolve as attitudes can be entrenched. Here the negative perception of youth in today's society may be a significant factor but given the levels of resistance at times encountered the question arises as to whether this alone would engender such resistance.

Vojak identified how the use of language stigmatises and excludes young people and how the community's perception of children in care can be shaped by the use of specific language when referring to children in care. She identifies commonly used terms such as client, risk assessment accountability and foster, amongst others, as examples of such stigmatising language.

"The systematic use of stigmatizing language—language that implies power and status differences, language that assigns blame or moral deficiency, language of illness and abnormality and language of 'otherness'— colours the community's perceptions and consequent sense of responsibility." (2009:943)

These points, then, prompt some further questions:

1) Is there a lack of understanding within the general public as regards to the reasons why children are admitted to care?

2) Does this potential lack of understanding play a role in the public indifference to the plight of care leavers, where they may seen as undeserving, the subjects of criminal proceedings and

delinquent and therefore the authors of their own misfortune and/or perceived parental fecklessness tarring the child with the same brush?

3) Is there a case to be made for a public information and awareness campaign to educate the public to the plight of care leavers and the reasons why children come into care?

4) Has the striving for anonymity rather than real community integration been a factor in propagating this public lack of understanding?

5) What effect does this seeking of anonymity have on children in care? Do they, for example, interpret this imperative to not stand out as a reinforcement of their difference from others within the community?

6) Is this pursuit of anonymity a deficit-based model and would a strengths-based model incorporating real community integration be more appropriate?

7) Have children, young people and those who have left care been consulted on this issue to inform practice and could this be an example of protectionist practice (where children are seen as weak and needing protection) as opposed to personhood (where they are perceived as capable of exercising agency in determining their own wellbeing, capable of rational and moral reasoning skills) with regard to children’s rights?

8) Are children in residential care made more vulnerable by these practices than they are protected? Would improved community

integration lead to positive relationships for children in care within their communities? Would these positive relationships afford enhanced protection via community networks and programmes such as Neighbourhood Watch thereby enhancing the children’s overall functioning as well as their safety?

9) Would a social pedagogical approach, which shall be examined in the forthcoming section, to residential care result in enhanced community relationships for children in residential care owing to the focus on community and society integral to social pedagogy?

10) Has the public associated the failings of institutional care with current residential care and have the seemingly relentless litany of revelations of abuse and misery within some of these institutions and children’s homes reinforced this perception within the public as to the ineffectiveness of residential care?

11) Should residential care be re-branded with the terminology of children’s home or children’s residential centre replaced by more positive terminology to break these connections in public, and professional mindsets and also to communicate to children that residential care is a positive placement rather than placement of last resort?

Clearly there are balances to be struck in the transition from institutions to community-based centres and there is much work still to be done in this regard.

The problem is not residential care; the outcomes achieved in States such as Finland, Germany and Denmark which utilise residential care as the placement of choice in many cases confirms that residential care works. The problem is how, in the Republic of Ireland and the UK, it is utilised, under-resourced, assessed and misrepresented. A robust system of care providing a range of placement options and services for children requiring out-of-home care is a fundamental pre-requisite to achieving positive outcomes for all care leavers. This requires inclusion of a range of foster care options including relative care, mainstream residential care, enhanced-support residential centres, emergency, short-term and respite care and specialist residential centres, including secure care.

Such has been the relentless drive to reduce/eliminate residential child care that the question as to whether we are now seeing residential care recreated within foster care sector arises. In such cases the cost disparity is less pronounced with foster carers who are highly supported with teams of outside professionals coming into the home together with structures, such as, built-in time away, that in essence residential care has been re-created within foster care sector? The lines of demarcation

between group living and family living are becoming more-and-more blurred within some of these placements and this prompts the question as to what has driven this development?

Also, if foster care becomes further professionalised will it still afford the same benefits and to the same degree that it is currently identified by many as providing over residential care?

"Nevertheless, the boundaries between residential and foster care have become somewhat blurred, particularly in relation to the number of children in placement, which may be very small in some residential placements and relatively large in some foster placements. Concerns about cost have also played a part. In 2010 the weekly cost of care in a local authority children's home was estimated at £2,689 per resident per week, compared with an average cost of £676 for foster care, although the cost of specialist foster placements for adolescents with levels of need similar to those of young people placed in children's homes is likely to be considerably higher (Department for Education, 2011a; Berridge et al., 2008)." (Berridge *et al.*, 2010:4)

James Anglin, one of residential child care's most articulate and respected advocates, has likened its place within the social services system as a whole to:

"the tip of an iceberg that protrudes out of the water; if you try to remove it, the iceberg moves upward to maintain its overall

balance……A service that is not valued, or that is considered to be always an unsatisfactory or second-rate option will inevitably deteriorate, and will ultimately reflect these self-fulfilling expectations. Our young people are asking for and deserve the best group care settings that we can provide." (Anglin cited in Eriksson & Tjelflaat, 2004:173,188)

I propose that a better way to consider what service best meets the needs of any individual child or sibling group is the focus on practice underpinned by theory rather than a basic focus on type of placement (foster/residential). Equally, a focus on developmental need rather than chronological age needs to be incorporated into placement selection. I also agree with Holland & Crowley who state:

"We follow Prout (2005) in wishing to abandon some of the cruder dichotomies such as sociological v psychological accounts of childhood, recognising that both disciplines (and, indeed, others too) help us to develop a holistic understanding." (2013:65)

This brings our attention to the subject of theory in social care and aftercare which we shall consider in the following section.

Summary

These two chapters illuminate the misunderstandings, myths and assumptions associated with residential care which it has been demonstrated have led to the residualisation of this service within the Republic of Ireland and the UK. The detailed

examination of costs associated with all forms of out-of-home care have revealed additional reasons for this residualisation and the negative implications for children needing specific levels of support which require residential placement have been identified. Trends within out-of-home care provision in the Republic of Ireland have also been outlined which informed an understanding of the service as it is delivered today.

The case has been made that a robust care system requires a robust system of care placements and this must include sufficient levels well-resourced residential care placements to appropriately meet the needs of all children requiring out-of-home care.

Section Three - Theory and Approaches

Introduction

Birren & Brengtson (1998), Nolan & Downs (2001), Stein (2006b), Tweedle (2007) and Dima & Skehill (2011) highlight the lack of theory informing research and practice. Stein (2006a, 2006b) proposes that theories in addition to attachment should be considered when planning throughcare and aftercare. He explores developmental theories in relation to aftercare, reflecting on four theories in particular: attachment, resilience, focal and life course. Barton *et al.* (2012) proposes that a good

relationship between therapeutic carer and child, accompanied by theoretical consideration, is essential in caring for children in care. Bloom (2005) suggests that by integrating theory into care systems, carers and other professionals work with greater synchronicity and shared understandings of both the problems and the solutions.

"*He who loves practice without theory is like the sailor who boards a ship without a rudder and compass and never knows where he may cast.*" (Leonardo da Vinci)

In addressing some of the issues with regard to leaving care and aftercare identified by Keith I will consider three of the theories highlighted by Stein (2006b), namely attachment, resilience and focal theory. In considering attachment theory I will focus on the area of relationships. Resilience theory is appropriate as Keith's is an excellent case study exemplifying the concept of resilience. Focal theory is relevant as it affords insight into, amongst other things, transition processes. Finally I will consider some theory relevant to listening, the key element of communication.

Then I shall consider two approaches to care. Social pedagogy and relationship-based practice as these are two approaches that, I believe, have much to offer in our pursuit of positive outcomes for children in care and aftercare in 2015. Finally, I will look at the role of mentoring for children in care and aftercare.